NLG(18)303

Northern Lincolnshire and Goole NHS Foundation Trust

DATE OF MEETING	**28 August 2018**
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	**Wendy Booth, Director of Governance & Assurance and Trust Secretary**
CONTACT OFFICER	**As above**
SUBJECT	**KPMG Review of Divisional Governance Arrangements**
BACKGROUND DOCUMENT (IF ANY)	**None**
PURPOSE OF THE REPORT:	**To provide the outcome to the Trust Board of the review of the divisional governance arrangements and to advise of proposed next steps in response to the recommendations**
EXECUTIVE SUMMARY **(PLEASE INCLUDE: A SUMMARY OF THE REPORT, KEY POINTS & / OR ANY RISKS WHICH NEED TO BE BROUGHT TO THE ATTENTION OF THE TRUST BOARD AND ANY MITIGATING ACTIONS, WHERE APPROPRIATE)**	**The report provides the outcome of the review of the divisional governance arrangements undertaken by KPMG using financial resources from the Internal Audit contract with the Trust. The review was led by Sue Cordon, who has a clinical background and is a Director and the Clinical and Quality Assurance Lead at KPMG** **The review considered the arrangements at Trust level to support effective and timely clinical and quality governance processes and assessed in detail the governance arrangements in place within clinical divisions in order to assess the effectiveness of arrangements in place to manage risk, escalate areas of concerns, manage incidents and complaints and how learning from events occurs through the Trust's services** **Inevitably with a review of this nature, the report has identified a number of areas for improvement, where the arrangements in place need to be developed and / or strengthened. In particular, the report identifies the need for increased ownership by the clinical divisions of the Trust's clinical governance agenda** **The conclusions from the review are provided on pages 4 – 7 and, in relation to the divisions, are explored in ore depth on pages 24 - 33.** **The report makes 30 recommendations as to how the Trust can strengthen its clinical and quality governance arrangements at Trust and divisional level and these are provided on pages 43 – 51. Of those recommendations:** • **28 have been rated medium priority** • **2 have been rated low priority** **KPMG categorise a medium priority as:** • **"A potentially significant or medium level weakness in the system or process which could put the organisation at risk of not achieving its strategic objectives. In particular, having the potential for adverse impact on the Trust's reputation or for raising the likelihood of the strategic risks occurring"** **KPMG categorise a low priority as:** • **"Recommendations which could improve the efficiency and / or effectiveness of the system or process but which are not vital to achieving the Trust's strategic objectives. These are generally issues of good practice that the auditors consider would achieve better outcomes"** **Under the revised governance arrangements, the Acting Medical Director, in conjunction with the Chief Operating Officer, will have the lead role for progressing the recommendations. External support to assist the Acting Medical and Chief Operating Officer and to work alongside the central teams and clinical divisions has been sourced and Terms of Reference for this work are being agreed** **The strengthening of the divisional governance arrangements will be progressed alongside the wider strengthening of the leadership and meetings structures within Operations**

TRUST BOARD ACTION REQUIRED	**The Board is asked to note the report**

KPMG

Divisional Governance Review

Final report

Northern Lincolnshire and Goole NHS FT

August 2018

Contents

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Contents **Page**

Executive summary

Background

Quality Governance provides a framework for organisations and individuals to ensure the delivery of safe, effective and high quality healthcare. Its purpose is to help organisations, and their staff, monitor and improve standards of care.

Robust structures and reporting frameworks need to be in place for the Trust to manage quality and safety across all of its sites and services. Reporting structures must ensure risks to the quality and safety of services are escalated via a clear route, and in sufficient time for management to be able to grip and respond to these issues in an appropriate manner. The reporting and escalation processes should be consistent across the Trust. Action taken to mitigate risks and respond to incidents must be structured and communicated to ensure lessons are learned throughout the organisation and the wider health community and that where appropriate attention is focussed on training, development and organisational reform together with changes in business processes and supporting information systems.

Northern Lincolnshire and Goole NHS Foundation Trust provides acute hospital services and community services to a population of more than 350,000 people across North and North East Lincolnshire and East Riding of Yorkshire. The annual budget is circa £300 million, the Trust has 850 beds across three hospital sites and employs around 6,500 members of staff.

Alongside many other NHS organisations the Trust's financial position is a concern and was placed into financial special measure by NHS Improvement (NHSI) in March 2017. Additionally there are challenges that the Trust faces with regard to the provision of high quality care and responding to the 'inadequate' rating for safety from the Care Quality Commission following their last visit in 2016. NHSI placed the Trust into special measures in April 2017 to rapidly improve patient services.

The Trust has re-launched its quality improvement programme that sets out five key areas aimed to lead the Trust out of special measures. These areas are:

— Quality and safety – providing effective, high quality care;

— Access and flow – providing safe, effective and efficient care at the right time and in the right place for its patients;

— Organisational development and culture – how the Trust engages with staff, partners and wider stakeholders;

— Service strategy – working with the wider health and care system to determine the long term future of its services;

— Finance – getting expenditure under control and making sure that services are as efficient as possible to the public purse.

We were asked to undertake a review of Divisional Governance, using financial resources from our Internal Audit contract with the Trust. The review considered the arrangements at Trust and Divisional level to support effective and timely clinical and quality governance processes The full scope of our work is listed in Appendix one.

Executive summary (cont.)

Conclusion

Our review assessed the governance arrangements in place within the Trust's Clinical Divisions. It assessed the effectiveness of arrangements in place to manage risk; escalate areas of concern; manage incidents and complaints; and how learning from events occurs throughout the services.

We have documented our conclusion in the sections below, following the structure of the main body of the report, and have RAG rated issues according to level of risk and priority for improvement.

Clinical Leadership

The Board aims to drive a wave of change through its three hospitals, aimed at engaging staff and changing aspects of its organisational culture and operational practices that has resulted in the Trust being in special measures, both financial and quality. To facilitate some of these changes Director portfolios have been appropriately changed. Importantly the Medical Director is now the lead for Clinical and Quality Governance (effective from 1 August 2018). This is a big agenda and an area where significant development is required. Deputy Medical Director positions are in place to support the governance agenda and a new position of Associate Director of Quality Governance is being recruited to.

A new Divisional structure is now in place with new roles and responsibilities aiming to increase clinical leadership. The Divisional Clinical Directors now lead the Divisional triumvirate teams, and this is an important and significant change in scope of responsibility for these post holders. The roles are new and a post implementation review with be required following a period of time to evaluate the impact of the role in the Division. Clinical Leads have been in place for some years now, however the roles are currently being refreshed, and it is imperative that these roles have key performance indicators and outcome measures to ensure objectives are being met.

Quality and Safety Committee

The Quality and Safety Committee (QSC) is a sub-committee of the Trust Board, chaired by a Non-Executive Director. The purpose of the Committee is 'to provide assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board' In our review of past Committee meetings, the terms of reference and from our attendance we have identified areas for improvement. The Trust has recently changed the Committee's terms of reference to allow Divisional updates to be presented on a rolling programme. These have just commenced, however more rigor and challenge needs to be introduced for the Committee to gain assurance around Divisional activity.

Given the Medical Director's portfolio, the MD should be the lead Executive for the Committee and meet with the NED Chair between the Committee meetings to set the agenda and discuss areas of concern.

Executive summary (cont.)

Conclusion (continued)

Quality Governance Group

A new Clinical Governance Group has been recently formed to support the understanding and mitigation of quality governance risks. Currently the Group is chaired jointly by the Medical Director and Chief Nurse. This arrangement requires review. There should be one Chair and this should be the Medical Director. The Deputy Medical Director (Quality) should deputise in the absence of the Medical Director.

We observed the June 2018 Quality Governance Group and whilst we understand this was just the second meeting, we identified scope to improve the effectiveness of the meetings. Attendance needs to be clearly defined and the purpose of the meeting needs to be made clearer.

Serious Incidents

The Trust does not have a serious incident panel, although we have been told this is planned. It is important to initiate a weekly forum as soon as possible that will introduce rigor and pace into the SI process. The purpose of a weekly SI panel meeting is to ensure a systematic, holistic, multi-disciplinary and proactive approach to the identification and management of SIs and the identification of risks through the review of incidents that have occurred at the Trust.

The allocation of staff to undertake the root cause analysis (RCA) investigations should also be decided at this meeting to ensure an appropriately trained independent investigator is appointed to undertake the root cause analysis investigation and to avoid any element of self-review. Completed RCAs should be presented at the panel and actions plans reviewed to ensure actions have been implemented and lessons learned and shared.

Membership of the SI panel should include: the Head of Risk, Head of Quality, Divisional Heads of Nursing or Divisional Clinical Directors. Clinical representation from each Division is paramount.

Matron roles

Quality Matrons have been in post since 2011. However an unintended consequence of the role has been that quality has been to some degree compartmentalised, and the role of the Divisional Operational Matrons , who in turn now devote much of their time to the management of flow, has been diminished. Whilst all these roles are important, there is a reported lack of clarity between the Operational Matron and Quality Matron roles, responsibilities and accountabilities, with some overlap and duplication of roles and responsibilities. Some staff we spoke to in the clinical areas were confused about the roles and reporting lines, and this requires resolving. The Chief Nurse has produced a Board paper that discusses changes to the Quality Matron and Operational Matron roles. This should resolve the issues we discuss in this report, however the role will require review following implementation to ensure staff are embracing the full remit of the matron's role.

Executive summary (cont.)

Conclusion (continued)

Risk and Governance Facilitators

The Risk and Governance Facilitators are managed centrally by the Head of Risk but are aligned to Divisions. Whilst arrangements work well in some Divisions, usually where other support arrangements are in place, in other Divisions the role does not appear to work as well and is not maximised. The roles are held by Band 5 non clinical staff and additional Divisional support is required to maximise the benefit of this resource.

Complaints Management

The Complaints Team now report through to the Chief Nurse. This change has afforded more alignment to patient experience activities and has assisted in the overall support and direction for the team members following the departure during 2017 of the then Head of Complaints and Legal Services. The Complaints Manager is working on several initiatives to increase Divisional ownership of the complaints process. This should ultimately impact on the timeliness of responses and compliance with key performance indicators e.g. timescales. The letters that are sent to families are consistently of a high standard and the final signing of the letters is personally undertaken by the Chief Executive.

Clinical Audit

The Clinical Audit Team report to the Head of Quality and Assurance. The team need to increase the level of integration within the Divisions to enhance the level of ownership for local clinical audits, including reporting of results, implementation of action plans and the resultant learning opportunities.

Divisional Triumvirate Teams

The Trust has introduced a new structure for its clinical Divisions. This included changes to the roles and responsibilities of the management team. Previously the Clinical Groups were led by the Associate Chief Operating Officer (now General Manager), with support from the Associate Medical Director (now Divisional Clinical Director) the Associate Chief Nurse (now Head of Nursing/Midwifery). In the revised structure the Divisional Clinical Directors now lead the Division and have authority and responsibility for quality, the use of resources (including staffing & finance) and all aspects of Divisional performance. The Divisional General Manager and Divisional Nurse or equivalent will report to the Divisional Clinical Director. The purpose of the change is to facilitate ‘clinically led Divisions’ to improve clinical engagement and decision making. The new roles and responsibilities will need evaluation and monitoring to ensure the roles perform as intended.

Each Division has either acquired new services within its portfolio or had a change of personnel in its Triumvirate team. Interim officers are in place and a number of appointments have recently been made, however until these are in place and established in post there will be a period of instability.

Executive summary (cont.)

Conclusion (continued)

Divisional Governance meetings

These Clinical Governance group meetings are intended to be the focus for local accountability around quality and safety. In our previous Internal Audit report (September 2017) we identified problems regarding consistency, engagement issues, and room for improvement around information. There were however some positive observations about the quality of chairing and of supporting papers.

We were told that clinical commitments prevent attendance of some medical staff and for key Clinical leads this needs to be resolved to allow for their roles to add value to the Division's key governance arrangements.

Review of Clinical areas

We visited the clinical areas within the Emergency Departments and Maternity Units at DPOW and SGH and identified areas of good practice and areas for development. Some of the areas we identified eg medicines safety concerns require immediate improvement. We highlighted areas of concern to the clinical staff and managers within the areas at the time of our visits. We have listed our observations by area and CQC domain in Section Three of this report.

The areas for development identified should be incorporated in the Directorate's CQC action plan.

We have raised recommendations in Section Four to address the areas for development identified as part of our review.

We would like to thank the Trust's staff for their assistance and openness during the course of this review.

KPMG

Trust-wide Clinical and Quality Governance arrangements

Board level governance responsibility

Clinical and quality governance is held within the Medical Director's portfolio with an aim to increase clinical leadership.

The Medical Director is supported by two deputies, each leading in specific areas - quality lead (risk and governance) and medical staffing lead (productivity and performance).

Executive responsibility for quality governance

The Executive Director responsible for clinical and quality governance is the Medical Director (effective from 1 August 2018).

The Board aims to drive a wave of change through its three hospitals, aimed at engaging staff and changing aspects of its organisational culture and operational practices that has resulted in the Trust being in special measures, both financial and quality. To facilitate some of these changes Director portfolios have been changed.

The Medical Director is supported by two deputies, each leading in specific areas - quality lead (risk and governance) and medical staffing lead (productivity and performance). In addition a new post, Associate Director of Quality Governance has been created, reporting to the Deputy Medical Director (Quality) and responsible to the Medical Director.

The new post will support the Medical Director and Deputy Medical Director in strengthening the Trust's quality governance and assurance strategy and arrangements, incorporating issues of compliance, quality and safety and clinical effectiveness and through appropriate training and awareness, to ensure that quality governance is seen as the responsibility of all staff.

The Associate Director of Quality Governance will take a lead role in supporting the five Clinical Divisions to ensure their governance and quality governance arrangements are robust and responsive to internal and external objectives and requirements and reflect the organisation's commitment to quality and safety. The Associate Director of Quality Governance will specifically oversee the work of the central functions of quality and audit and risk and governance.

The substantive Medical Director is currently off work due to long term health problems. An Acting Medical Director has been in post for over six months.

The current structure of the Medical Director's Directorate is shown overleaf.

The Acting Medical Director plans to meet regularly with the five Divisional Clinical Directors (DCDs) who are accountable to the Chief Operating Officer but professionally report to the Medical Director. Clinical leadership has been acknowledged as a growth area and it is paramount that there is divisional grip around the governance agenda. The new structure and new roles and responsibilities aim to facilitate this change. The Divisional Clinical Directors now lead the Divisional triumvirate teams and this is a change in scope of responsibility for these post holders. The roles are new and a post implementation review with be required following a period of time to evaluate the impact of the role in the Division. **(Recommendation 1)**

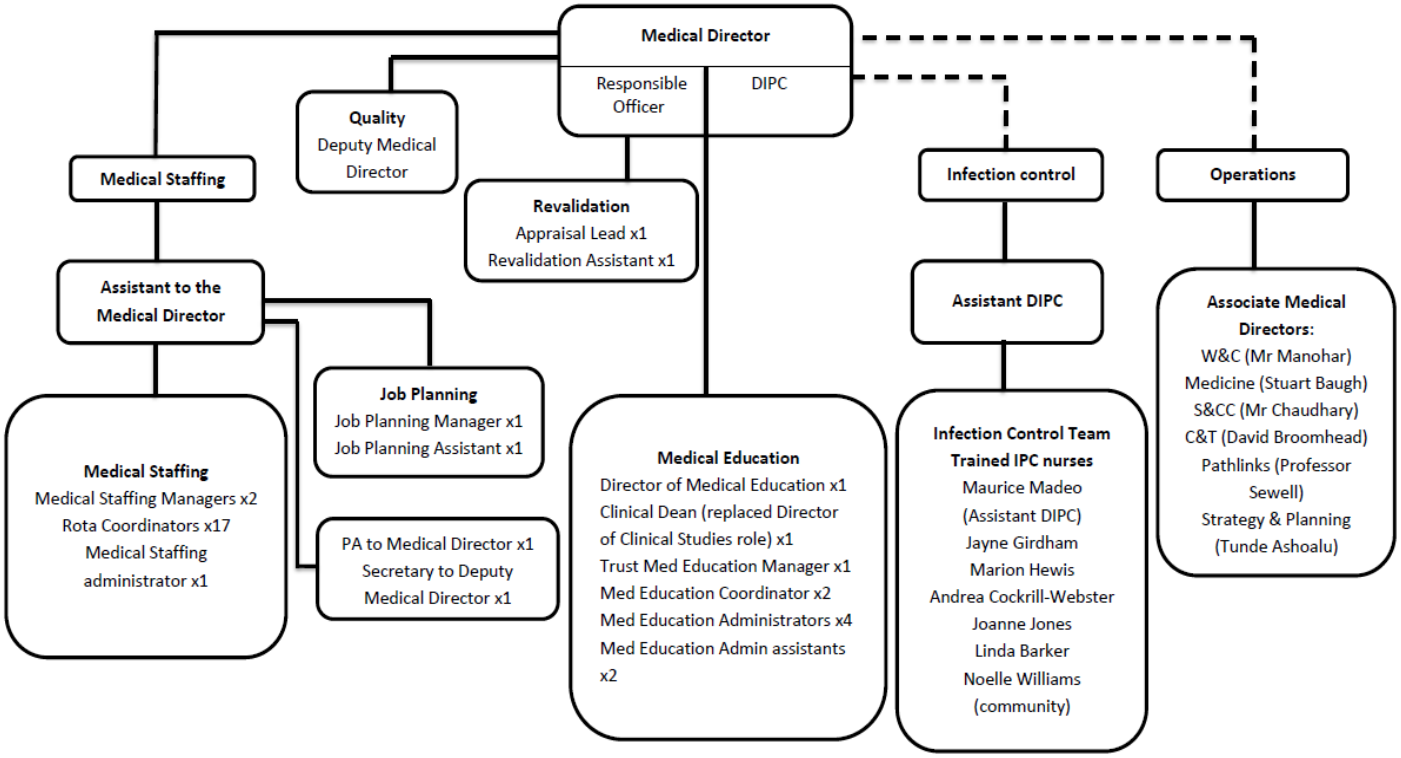
Clinical Lead positions are in place in specialities and these are currently being appointed to. These positions had previously been in place, however to increase clinical leadership and governance within the specialties reappointments are currently underway. The positions should be outcome driven and expectations should be clear and reinforced by the Divisional Clinical Director and ultimately the Medical Director. Review of effectiveness of the positions should be established and built in to the annual appraisal. **(Recommendation 2)**

Medical Director's Structure (current)

A new post – Associate Director of Quality Governance has been advertised. The purpose of this role is to support the Medical Director and Deputy Medical Director (Quality) in developing the Trust's quality governance and assurance strategy and arrangements, incorporating issues of compliance, quality and safety and clinical effectiveness.

Claims is also an additional area of responsibility that will transfer to the Medical Director's portfolio.

Current Medical Director's Directorate structure

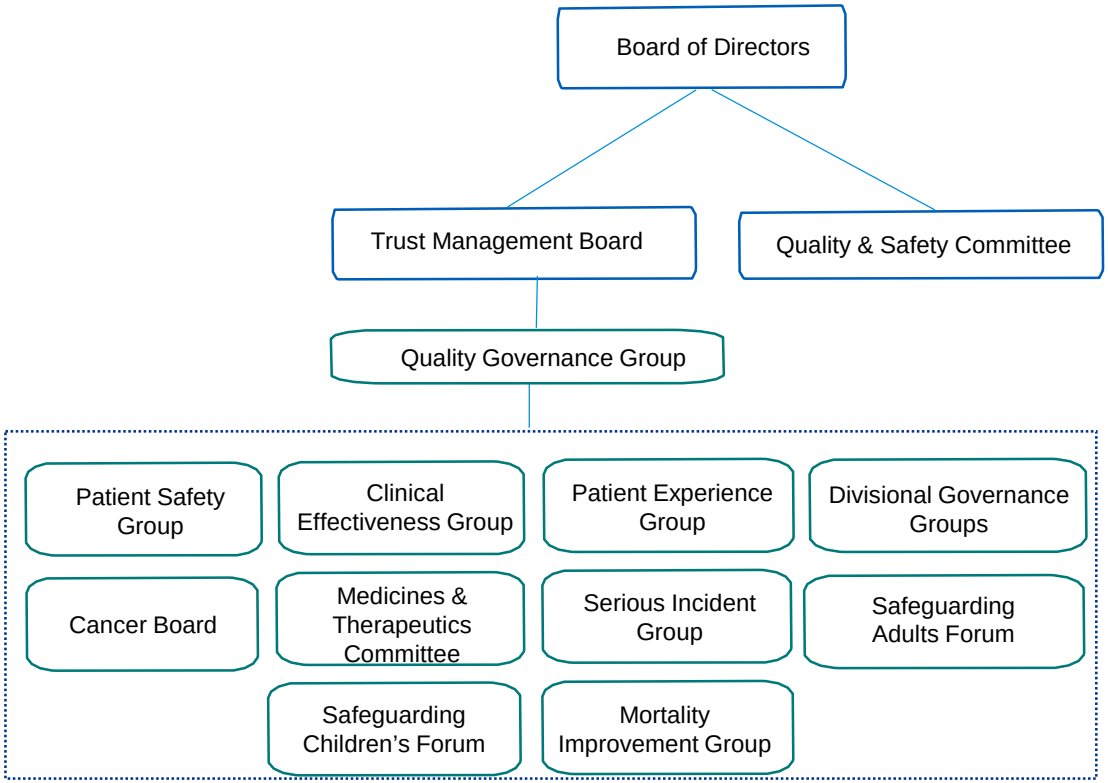


Quality Governance Structure - Trust

Assurance for Clinical and Quality Governance is provided to the Trust Board through the Quality and Safety Committee (QSC), chaired by a Non-Executive Director and the Trust Management Board (TMB).

Trust Quality Governance meeting structure

Assurance for Clinical and Quality Governance is provided to the Trust Board through the Quality and Safety Committee (QSC), chaired by a Non-Executive Director and the Trust Management Board (TMB).



Quality and Safety Committee

The Quality and Safety Committee currently meets monthly.

The purpose of the Committee is 'to provide assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board'.

Quality and Safety Committee

The Quality and Safety Committee (QSC) is a sub-committee of the Trust Board, chaired by a Non-Executive Director. The purpose of the Committee is 'to provide assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board.'

The terms of reference have recently been revised (February 2018). 'Business' meetings of QSC will move to a bi-monthly cycle, with public and private agendas as now, covering statutory and critical business. On alternate months the meeting will be shorter and more focussed with a detailed Divisional report (one per meeting) and a deep dive into an area that requires significant focus, for example mortality.

The terms of reference state that the Committee will receive reports from the Divisional Clinical Governance meetings, at which Divisional risk management processes and patient safety and quality issues are discussed and monitored.

From our review of recent QSC minutes we identified that reports from Divisional Clinical Governance meetings were not being shared with the Committee and therefore it is not clear how the Committee is providing the Board with the assurance that 'Divisional governance meetings are functioning appropriately in terms of governance and risk management and contribute positively to ensuring the delivery of safe, personal and effective care' in line with the Committee's responsibilities. In this report we have raised recommendations to strengthen the Divisional Governance meetings as attendance, content and the identification of issues requires improvement. It is therefore important that the Quality and Safety Committee has assurance from the Divisions as to the effectiveness of their governance meetings and how issues are escalated. Divisions should produce a highlight report to be presented to the Quality and Safety Committee to highlight areas of concern as this is not always evident by the submission of the meeting minutes alone. **(Recommendation 3**)

Quality and Safety Committee

The Terms of Reference for the Quality & Safety Committee have recently been revised to reflect its new aims and objectives.

Membership has been amended to include key stakeholders including the CCG.

Quality and Safety Committee (continued)

The Terms of Reference for the Quality & Safety Committee have recently been revised from the previous 2017 version to reflect the following key changes:

— An increased emphasis on risk analysis, outcomes and assurance;

— A distinction between the management of the QSC agenda (a matter for the Trust's new Quality Governance Group) and assurance on QSC outcomes (the business of QSC);

— The strengthening of the assurance role on mortality issues, following the discontinuation of the former Mortality Assurance & Clinical Improvement Committee;

— The incorporation of relevant workforce and organisational development considerations where they impact the QSC agenda, following the discontinuation of the former Workforce Sustainability and Transformation Committee;

— The strengthening of consideration of the financial (efficiency) consequences of QSC decisions; and

— A reduction in the volume and frequency of reporting to QSC in order to make this less resource intensive, more efficient, and meaningful.

There has also been a significant change in the Committee's membership, including:

— An emphasis on attending for relevant items only; and

— The introduction of formal 'observer' status to the following to enhance transparency:

  – Clinical Commissioning Groups;
  – Governor from the Quality Review Group (QRG);
  – Healthwatch; and
  – NHSI.

Quality and Safety Committee

The Quality and Safety Committee currently meets monthly.

The Trust has recently changed the Committee's terms of reference to allow Divisional updates to be presented on a rolling programme.

These have just commenced, however more rigor and challenge need to be introduced for the Committee to gain assurance around Divisional activity.

Quality and Safety Committee (continued)

We attended the Q&S Committee meeting held on 13 June 2018. The meeting was a thematic meeting. The quarterly meetings have been put in place to allow deep dives into specialist areas. The theme of the meeting was mortality and presentations occurred to assist the Committee members' understanding of the various metrics used in describing hospital mortality and morbidity performance.

The QSC Committee invites Divisions to attend a specific meeting. The Interim Head of Nursing for Medicine attended the April Committee (although the other members of the triumvirate were not in attendance). We observed the Committee meeting held in June and the Obstetrics and Gynaecology triumvirate team had been invited to attend. In order to allow all Divisions to provide succinct information a basic standard template has been designed to allow the Divisions to self-assess and demonstrate progress. However, whilst we acknowledge it is early days in terms of the expectations of the Divisions to present, the presentation from Women and Children's Division was not structured and there was a lack of assurance gained from their presence. Further work is required to ensure the Divisions are aware of the purpose of their attendance and can therefore prepare accordingly. **(Recommendation 4)**

Commissioner attendance at the Committee is not yet as intended. We spoke to North East Lincolnshire CCG and they had welcomed the invite and intend on attend on a regular basis. The CCG welcomed the new style Committee and look forward to the Divisional presentations to increase the assurance from service level activities.

The Committee operates its business in a three hour period. We observed some good and effective challenge from the Non-Executive Director members and also from Executive to Executive for some items. However, some items should have received more discussion at the Committee, for example, the CNST compliance report. It was agreed that as the report was scheduled for the Board any decision making would take place at Board, which was a missed opportunity for the Committee to review any key challenges with compliance and mitigations that may have required discussion prior to the Board meeting. **(Recommendation 5)**

Following each meeting the QSC provides a highlight paper to the Board. The report provides details regarding the key issues to escalate to the Board, summarises the other items discussed and identifies recommendations for action where appropriate.

At the end of each meeting the Committee should self-assess performance, and a formal review of the Committee's effectiveness should be undertaken after the revised terms of reference has operated for six months. **(Recommendation 6)**

Prior to each meeting the Chair of the Quality and Safety Committee should meet with the Medical Director to set the agenda and agree any areas for deep dive that may arise from lack of progress with the action log or from wider intelligence etc. (**Recommendation 7)**

Quality Governance Group

A new Clinical Governance Group has been recently formed to support the understanding and mitigation of quality governance risks.

Currently the Group is chaired jointly by Medical Director and Chief Nurse and there should be one Chair and this should be the Medical Director.

Quality Governance Group

The Trust established a Quality Governance Group (QGG), a management group of the Trust Management Board in May 2018. The Group meets monthly and is chaired jointly by the Trust' Medical Director and Chief Nurse.

Membership of the Group includes:

— Chief Operating Officer;

— Divisional Clinical Directors;

— Divisional Heads of Nursing/Midwifery;

— Chief Pharmacist and Lead for Medicines Management;

— Associate Director of Governance & Assurance; and

— Patient Experience Lead.

The purpose of the Group is 'to ensure that quality governance risks are understood and that there are appropriate mitigation plans in place to ensure the delivery of safe, personal and effective care.'

The Group's draft terms of reference was presented to the first meeting on 23 May 2018 for discussion and was presented to the meeting on 27 June 2018 for approval.

We attended the Trust's second QGG meeting on 27 June 2018. We detail our observations below:

— The draft terms of reference states that to be quorate either the Medical Director and/or Chief Nurse must be in attendance. Both Chairs (Medical Director and Chief Nurse) sent apologies for absence. The meeting was chaired by the Interim Deputy Chief Nurse. However quality governance sits within the Medical Director's portfolio and therefore the Medical Director should Chair the meeting, with the Deputy Medical Director (Quality) deputising in the event of absence. **(Recommendation 8)**

— The agenda included the QGG's terms of reference for approval however key members including: the Medical Director; Chief Nurse; Chief Operating Officer; and Director of Governance & Assurance were not in attendance.

— Meeting attendance was poor. In addition to the Chair, only eight staff members were present. Apologies had not been received from all non-attendees.

Quality Governance Group

We observed the June 2018 Quality Governance Group and whilst we understand this was just the second meeting, we identified scope to improve the effectiveness of the meetings. Attendance needs to be clearly defined and the purpose of the meeting needs to be made clearer.

Quality Governance Group (continued)

— Non-attendance of key members affected the efficiency and effectiveness of the meeting. A number of agenda items were deferred as a result. For example, agenda item six, 'Presentations/ discussions' included six items for discussion however, due to non-attendance of the presenter four of the six items were not discussed. The items deferred included: the action plan in response to the National Inpatient Survey; CQUIN update; and an update on clinical harm and CQC feedback. A paper had been submitted for one of these items.

— The approval of the 'Safer Medical Group' terms of reference was also deferred due to absence of the Medical Director and Chief Nurse.

— The Chair presented a 'Pressure Ulcer Position Statement'. However it was noted that the report had already been presented at two other Committee meetings and the report was not up-to-date as it had been compiled in April 2018.

— The agenda included an item to confirm the 'Standing items'. There was a lack of clarity as to what the item related to during the meeting.

— Agenda item eight included eight items for information (meeting minutes) however, only three items were included in the meeting papers.

— There was limited challenge and discussion of agenda items.

— There was a lack of clarity regarding the Group's overall purpose and direction.

Whilst this was only the second meeting of this group it is imperative that the leadership of the group is clear and the Chair or designated deputy is available when the dates are arranged. In our interviews some staff members were not clear as to the function of the group and this needs to be apparent immediately to gain momentum and achieve the buy-in from members. **(Recommendation 9)**

Serious Incident Panel

The Trust does not have a weekly serious incident panel meeting.

A serious incident panel can support a systematic, holistic, multi-disciplinary and proactive approach to the identification and management of serious incidents and the identification of risks.

Serious Incident Panel

The Trust does not currently have a Serious Incident (SI) Panel. A number of trusts have established a weekly meeting, chaired by the Medical Director or Deputy Medical Director, although we are told this is planned.

The purpose of a weekly SI panel meeting is to ensure a systematic, holistic, multi-disciplinary and proactive approach to the identification and management of SIs and the identification of risks through the review of incidents that have occurred at the Trust.

The allocation of staff to undertake the root cause analysis investigations should also be decided at this meeting to ensure an appropriately trained independent investigator is appointed to undertake the root cause analysis investigation and to avoid any element of self-review.

Membership of the panel should include: the Head of Risk, Head of Quality, Divisional Heads of Nursing or Divisional Clinical Directors. Clinical representation from each Division is paramount.

RCA Lead Investigators and appropriate Divisional triumvirate leads/ relevant senior staff should be expected to attend for relevant agenda items (depending on the type of incident) to present their draft RCA reports and action plans when due to assist the Trust's monitoring of RCA action plans to ensure actions are completed and evidenced on a timely basis. It will also hold individuals, Directorates and Divisions to account for delays regarding investigation timescales, action plan completion and Duty of Candour compliance.

An SI panel should also allow an opportunity to review and act upon any external enquiries on serious incidents and incident reports.

Implementing a SI panel should support effective SI management, investigation and learning. We discussed the implementation of an SI panel with the Executive member of the Board on our initial engagement of this review, however although planned, a panel is not yet in operation and this should be implemented as soon as possible. (**Recommendation 10)**

With the changes of roles and responsibilities for the Divisional triumvirate teams it is important that ownership for the quality and sign off of the serious incident investigations and RCAs sits with the Divisional Clinical Director and this should not be delegated apart from instances of leave where the assigned deputy can undertake this responsibility. **(Recommendation 11)**

Trust-wide Quality Governance arrangements

There is a reported lack of clarity between the Operational Matron and Quality Matron roles, responsibilities and accountabilities, with some overlap and duplication of roles and responsibilities.

Some staff we spoke to in the clinical areas were confused about the roles and reporting lines, and this requires resolving.

Over time the Trust has centralised a number of its quality and governance functions and this was to better support the Divisions and improve compliance, and whilst this may have been required at that time a longer term model of decentralisation is required to increase the ownership of governance within the Divisions.

The role of the Quality Matron

The current Nursing and Midwifery Structure has been in place since 2011 and has not changed fundamentally since implementation. The current structure was founded initially on the 'Fit for the Future' Trust management restructure and the need to change the operational leadership structures of the organisation and its priorities at that time. Part of the structure was the role of the Quality Matron. Whilst the role introduced more focus on quality it is not longer fit for purpose in its current form as it has led to uncertainties regarding the ownership of quality that should clearly sit within the Divisions and Directorate core 'business as usual' responsibilities.

There are currently four Quality Matrons working across the Trust's services. One aspect of the role includes undertaking compliance visits to wards and reporting the results to the Chief Nurse's Directorate. However the compliance visits are nit being undertaken consistently in some areas due to the Quality Matron's other specialist priorities. In our interviews some staff reported that the compliance visit aspect of the role contributes to dysfunctional relationships, conflict and poor co-operation in some Divisions. The specialist area portfolios of the Quality Matron role is divided between the four post holders and covers specialist areas such as pressure ulcers; falls; hydration; nutrition; patient experience; learning disability and vulnerable people.

The Quality Matron role has compartmentalised quality and diminished the role of the Divisional Operational Matrons, who now in turn devote much of their time to the management of flow. Whilst all these roles are important, this has resulted in a reported lack of clarity between the Operational Matron and Quality Matron roles, responsibilities and accountabilities, with some overlap and duplication of roles and responsibilities. Some staff we spoke to in the clinical areas were confused about the roles and reporting lines, and this requires resolving. **(Recommendation 12)**

The Operational Matrons should have their role refocussed to that of the 'Matron' and become engaged in a more cohesive portfolio of work to include all aspects of operational management and quality governance. We note that the Chief Nurse is already addressing this and has developed a plan to reduce the current Operational Matrons' physical areas of responsibility. Matrons will be re-established within the Directorate of Operations and will be responsible for the delivery of quality and safety; performance; staffing; and finance at ward/department level within the Divisions and have professional accountability for nursing and midwifery through their Divisional Heads of Nursing to the Chief Nurse.

Trust-wide Quality Governance arrangements

The Chief Nurse has produced a Board paper that discusses changes to the Quality Matron and Operational Matron roles. This should resolve the issues we raise in this report, however the role will require review following implementation to ensure staff are embracing the full remit of the matron's role.

The role of the Quality Matron (continued)

The new matron role should have a post implementation review at four months to assess the effectiveness of the new scope of role. **(Recommendation 13)**

The Chief Nurse's paper presented to the Trust Board suggests that to be effective, the number of wards and departments that each Matron has responsibility for should be four on average so that they can be afforded the capacity to work clinically in their areas, provide support to ward leaders and their teams and to undertake regular reviews of the quality of care, patient safety outcomes and patient/staff satisfaction.

The revised role will require monitoring as many of the Matrons have concentrated their role predominantly on bed management and flow within their areas, and they will now need to achieve a balance with their expanded responsibilities. Early development sessions would be beneficial for the Matron group to discuss roles and responsibilities and associated performance outcomes. **(Recommendation 13)**

Whist the Quality Matron role in its current format will be disestablished there are a number of roles within the new structure to retain the current developed skills and expertise. The planned development of a ward assurance and accreditation tool will require clinical input to develop and roll out its implementation and continued use, which should offer a more systemic quality assurance model with consistency of application across the Trust's clinical services.

Risk and Governance

The Head of Risk position is currently remunerated at Band 8A. This post has a considerable area of responsibility across the Trust. From our experience nationally we note that the Trust could be considered an outlier in this areas with most trusts we work with employing similar positions at Band 8B - 8D and the Trust should consider whether or not the responsibilities and scope of work align to the current banding. **(Recommendation 14)**

In 2012 the Trust centralised the Risk and Governance Facilitators (RGF) into the Directorate of Governance and Assurance, managed by the Head of Risk, this was to offer support to the Divisions and develop a common approach. There are 8.5 whole time equivalent RGFs (9 posts), and the posts are Band 5 positions. Three staff members are based at DPOW and six at SGH. The staff are non-clinical and although they are aligned to Divisions they are managed centrally and are based in the Risk Department. However in order to increase Divisional ownership of governance a longer term model of decentralisation should be implemented.

Trust-wide Quality Governance arrangements

The Risk and Governance Facilitators are managed centrally by the Head of Risk but are aligned to Divisions. Whilst arrangements work well in some Divisions, usually where other support arrangements are in place, in other Divisions the role does not appear to work as well and is not maximised.

The roles are held by Band 5 non clinical staff and additional Divisional support is required to maximise the benefit of this resource.

Risk and Governance (continued)

Whilst arrangements work well in some Divisions, usually where other support arrangements are in place, for example the Governance Midwife will direct the role and scope of the RGF, in other Divisions, where senior clinical input is not available to support the RGFs, the intended focus of the role may be interpreted differently. Currently in some Divisions both the Divisional management teams and the RGFs have some degree of dissatisfaction with how the RGF role functions, and improvements are required to maximise the use of this resource.

The RGFs are supported by the Head of Risk, however due to the level of these staff there is a significant gap between the Head of Risk and the expected capabilities and role of the RGFs and this impacts heavily on the Head of Risk's portfolio of work. Additionally the Head of Risk has limited administrative support and this impacts on the efficiency of the entire team. **(Recommendation 15)**

The Division's utilise the RGF resource differently.

— Women and Children's Division has one full time RGF working across all sites. However the Division works well with their RGF as the post holder works alongside the Governance Midwife (who has been in the post for approximately one year) and is therefore able to have a collaborative role in directing day to day tasks.

— Community and Therapies state their RGF arrangements work well. The post holder is co-located within the Division and works closely with the triumvirate and managerial services.

— Clinical Support Services also utilises its RGF resource well. However due to the nature of the Division's services the Division has additional governance resource within its services to service and maintain the various accreditations and associated governance requirements. The Division reported that it would be more beneficial to have the RGF based within the Division to further develop working relationships and increase the direction of work and alignment with the Division's priorities.

— Medicine and Surgery both had similar views regarding the role of the RGFs. Each Division has one WTE at DPOW and one WTE at SGH/Goole. Both Divisions stated that they felt these staff should be co-located in the Division as they were previously prior to centralisation, however they appreciate that at that time the RGFs were clinically qualified individuals and graded at Band 7.

Trust-wide Quality Governance arrangements

The Risk and Governance Facilitator role is currently fulfilled by Band 5 non-clinical staff members.

The Trust should consider enhancing the clinical governance capacity within the Medicine and Surgery Divisions to support the coordination, quality and timeliness of governance activities with the Division.

Risk and Governance (continued)

Nationally, trusts have established different governance arrangements - some work well and others do not. At this stage in the Trust's maturity the RGFs should remain centrally managed by the Head of Risk to build a common skill set and resilience in the role. This is important as they need a common approach, direction and support. However the RGFs should be co-located within the Divisions to enable their day-to-day tasks to be directed by the management team and aligned more closely to the Division's priorities. **(Recommendation 16)**

The expectations of the RGF roles should be re-focussed and communicated to the Divisions so it is clear that the role is one of facilitation and support to assist Divisional staff to discharge their governance responsibilities. The RGFs should form part of the Divisional Governance meetings, coordinating the governance activity such as incident reports; RCA progress; action plans; and sharing of learning. On a weekly basis the RGFs should meet as a group to share key messages, learning, and to develop the role to further enhance the quality governance arrangements within the Divisions. **(Recommendation 16)**

The Risk and Governance Facilitator role is currently fulfilled by Band 5 non-clinical staff members. The Board should consider enhancing the Medicine and Surgical Divisions with a clinically qualified Governance Lead – probably at Band 7 (in addition to the Band 5 RGFs in post), to provide a clinical focus on the quality and development of incident management including the RCA investigation process, and the management of actions resulting from complaints or incidents. The Lead would also have a role in liaising with the medical staff and other senior professionals to support a timely response to incident investigations and the coordination of the governance activities within the Division. **(Recommendation 17)**

Whilst we would not usually not suggest additional roles in a Trust that is in financial special measures, the development of these two Governance Lead posts should enhance the clinical and quality governance in the Divisional services. The Governance Leads would work with the Matrons to complement their roles whilst developing specialist governance skills, supported by the RGFs. **(Recommendation 17)**

This will in time assist the organisation to move to more devolved management and accountability, increasing ownership of governance within the Divisions.

Trust-wide Quality Governance arrangements

The Complaints Team now report through to the Chief Nurse. This change has afforded more alignment to patient Experience activities and has assisted in the overall support and direction for the team members.

The Complaints Manager is working on several initiatives to increase Divisional ownership of the complaints process. This should ultimately impact on the timeliness of responses and compliance with key performance indicators e.g. timescales.

Complaints management

Complaints are managed by a central team. The team has recently been transferred to the Chief Nurse's Directorate. The Complaints and PALS Manager now reports to one of the Quality Matrons whose role includes patient experience. This has strengthened the reporting arrangements and support for the team, following the departure during 2017 of the Head of Complaints and Legal Services.

The complaints team is based at the DPOW hospital site and consists of six Band 5 Complaints Facilitators, four Band 3 PALS Assistants and one Band 2 PALS Assistant. Currently the claims team staff are also managed by the Complaints and PALS Manager however this function is relocating to the Medical Director's portfolio.

Prior to the transfer of the Complains and PALS team to the Chief Nurse's Directorate, line management arrangements for the Complaints and PALS Manager had been unsettled following the departure during 2017 of the Head of Complaints and Legal Services. This had stifled the enthusiasm and skills of the Complaints and PALS Manager in taking the service forward. However new arrangements are now in place and the manager feels she is well supported and reporting to people who share the same vision for the service developments that are planned.

The Complaints and PALS Manager has recently aligned the Complaints Facilitators to Divisions to assist the building of relationships and cooperation of the Division/Directorate staff and to ultimately improve the timeliness of responses/investigations. It is intended that the Complaints Facilitators will attend the Divisional Governance meetings to ensure complaints, the required actions and associated learning are more robustly addressed as part of the agenda, although this has not as yet happened. Complaint Facilitator attendance at Divisional Governance meetings should assist in building engagement and increasing the ownership of the Divisions in the complaints processes. The Complaints Team should evaluate the impact of attending the Divisional Governance meetings to ensure it is the most relevant forum to attend. **(Recommendation 18)**

There is a structured complaints process and when we interviewed the Divisions they were aware of the various steps, roles and responsibilities. Most Divisions were heavily reliant on the Complaints Team to write action plans for the complaint outcomes, however these action plans should be compiled by the Divisions. **(Recommendation 19)**

With the changes of roles and responsibilities for the Divisional triumvirate teams it is imperative that ownership for the quality and sign-off of complaint investigations and draft letter sits with the Divisional Clinical Director and this should not be delegated apart from instances of leave where the assigned deputy can undertake this responsibility. The Chief Executive undertakes the final sign off of complaints letters. **(Recommendation 20)**

The Complaints Manager stated that the Trust is not currently meeting the complaints timescales and the team is looking at ways they can enhance the timeliness. As already stated, aligning the Complaints Facilitators to Divisions should assist in reducing response timescales. A 'time-out' with the Chief Nurse and the Complaints team is planned to discuss the challenges of workload, response timescales, and engagement with the Divisions to increase ownership.

Trust-wide Quality Governance arrangements

The Clinical Audit Team report to the Head of Quality and Assurance.

The team need to increase the level of integration with the Divisions to enhance the level of ownership for local clinical audits, including reporting of results, implementation of action plans and the resultant learning opportunities.

Clinical Audit

Clinical Audit is a key component of quality and safety improvement processes and clinical and quality governance. Clinical audit is one of the key compliance tools at the Board's disposal and has an important role within the assurance framework. The Board's role is to ensure that clinical audit is strategic; it happens regularly; is clinically and cost effective; and is linked to the quality agenda.

Clinical Audit sits within the Quality Assurance and Clinical Audit Team and is managed by the Head of Quality and Assurance. Other areas of responsibility include NICE guidance; patient safety (CAS reports); mortality; Information Governance; and document control. Areas not within the portfolio are CQC assurance and the Trust's accreditation scheme. The role is aligned to clinical effectiveness as opposed to quality and assurance and the title of the role could mislead. Consideration should be given to a change of title to more effectively describe the responsibilities and portfolio of the role. **(Recommendation 21)**

The Clinical Audit Team structure is illustrated in Appendix one. There is a Band 7 Quality Assurance Manager who oversees the activity of the Band 5 Quality and Audit Facilitators; Band 4 Project Officers; Band 3 Quality and Audit Assistants and Band 2 Quality Audit Filing Clerks.

During 2017/18, 45 national clinical audits and 5 national confidential enquires covered relevant health services that the Trust provides. During that period the Trust participated in 93% of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The Quality Assurance and Clinical Audit Team is responsible for these national audits and also the Trust's local audit plan and works closely with the Divisions to understand their audit needs and develop the plan, including national and local priorities.

The Quality and Audit team enables the delivery of the clinical audit plan by planning appropriately, taking into account what support is necessary and timescales needed. The team provides support to clinicians in relation to the planning and data collection of their audits and the preparation of the audit report including recommendations. The Clinical Governance groups are responsible for monitoring the action plans. The team is working to increase the level of integration with the Divisions to increase ownership of the development and implementation of clinical audit, and importantly the implementation and learning from resultant actions. **(Recommendation 22)**

We note that the Head of Quality and Assurance is not a member of the Quality and Safety Committee - attendance is by invitation, for example to discuss mortality indicators. However membership should be considered given the breadth of the role.

KPMG

Divisional Clinical and Quality Governance arrangements

Divisional Clinical and Quality Governance arrangements

The Trust's services are delivered through five clinical Divisions:

In January 2018 the Trust proposed a significant change to operational leadership and the Divisional management structure to improve clinical engagement, decision making and the clarity of lines of accountability.

Divisional management structure

The Trust's services are delivered through five clinical Divisions: Medicine; Surgery and Critical Care; Women's and Children's; Clinical Support Services; and Community and Therapy Services.

In January 2018 the Trust proposed a significant change to operational leadership and the Divisional management structure to improve clinical engagement, decision making and the clarity of lines of accountability.

The proposed changes included:

— Changes in the use of language; and

— Changes to responsibilities and accountabilities.

It was proposed that that Clinical Divisions should replace the existing 'Clinical Groups' and the titles of the triumvirate management teams would change from Associate Medical Director (AMD), Associate Chief Operating Officer (ACOO) and Associate Chief Nurse (ACN) to:

— Divisional Clinical Director (Doctor or scientist);

— Divisional General Manager; and

— Divisional Head of Nursing/ Head of Midwifery.

The proposal also included changes to the roles and responsibilities of the management team. Previously the Clinical Groups were led by the ACOO with support from the AMD the ACN. In the revised structure the Divisional Clinical Directors now lead the Division and have authority and responsibility for quality, the use of resources (including staffing & finance) and all aspects of Divisional performance. The Divisional General Manager and Divisional Nurse or equivalent will report to the Divisional Clinical Director. The purpose of the change is to facilitate 'clinically led Divisions' to improve clinical engagement and decision making.

The Divisional General Manager and Divisional Head of Nursing/ Midwifery will report to the Divisional Clinical Director. The Divisional Heads of Nursing/ Midwifery will be professionally accountable to the Chief Nurse.

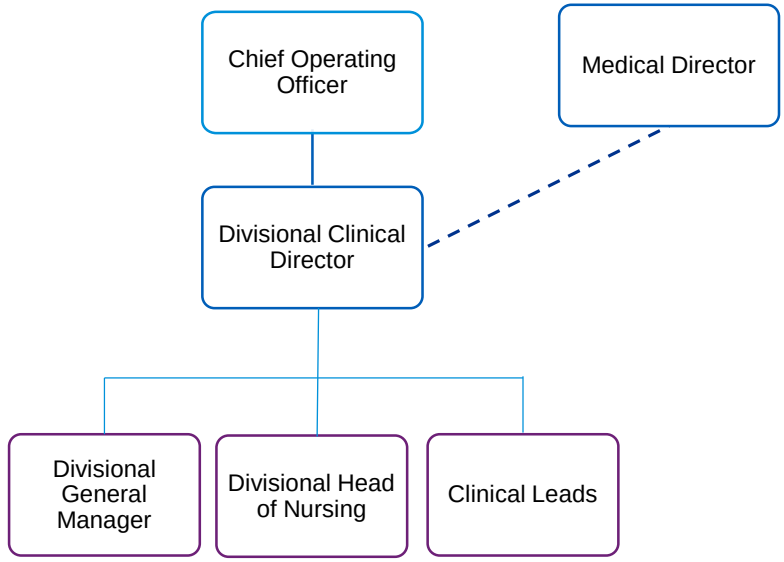
The Divisional Clinical Director will be accountable to the Trust's Chief Operating officer with professional accountability to the Medical Director.

Divisional Clinical and Quality Governance arrangements

The new Divisional management structure is detailed here.

Divisional management structure (continued)

The new Divisional management structure is detailed below:



(Extract from Trust's private Board papers NLG(18)131)

Divisional Clinical and Quality Governance arrangements

Each Division has either acquired new services within its portfolio or had a change of personnel in the triumvirate team.

Interims are in place but a number of appointments have just been made and until these are in place there will be a period of instability.

The new roles and responsibilities will need evaluation and monitoring to ensure the roles perform as intended.

Divisional management structure (continued)

We interviewed each Division as a triumvirate team with the exception of Surgery as the Divisional Clinical Director did not attend the meeting.

The Divisions have very recently restructured. Divisional Clinical Directors have recently been appointed to each Division. These posts were previously Associate Medical Directors. However to increase the clinical leadership of the Divisions the Clinical Directors now lead the Divisional triumvirate, with the General Manager and Heads of Nursing/Midwifery reporting to them. From our interviews it was clear that this change in reporting and lines of accountability was not viewed positively by all members of the teams.

Most, but not all, Clinical Directors could state what programmed activity (PA) allocation they had for the Clinical Director role. Others stated that the PA allocation had not yet been confirmed. The PA allocation will need to be confirmed with the Medical Director as soon as possible to enable the Clinical Directors to fully engage with their role. Direct Clinical Care PAs will need to, in most cases, be reduced to enable sufficient ownership and commitment to the role.

The Divisions are in various stages of maturity regarding their governance agendas. There were some common issues that arose from the interviews with the triumvirate teams.

— Whilst the Divisions are held to account by the Trust Board and performance meetings occur, papers are frequently issued for the meeting the day before the meeting and this does not allow sufficient time for full review and planning of the meeting/actions. **(Recommendation 23)**

— The Divisions holds monthly Board and Clinical Governance meetings. However we were told that in some Divisions clinical commitments limit attendance from clinicians and this is something that needs to be addressed. **(Recommendation 24)**

Divisional Clinical and Quality Governance arrangements

Each Division has either acquired new services within its portfolio or had a change of personnel in the triumvirate team.

Interims are in place but a number of appointments have just been made and until these are in place there will be a period of instability.

The new roles and responsibilities will need evaluation and monitoring to ensure the roles perform as intended.

Women and Children's Division

The Women and Children's Division has encountered a recent spate of serious incidents and these have been investigated in line with the Trust's policy to identify the root causes, identify any trends and learning. External support has been given from NHS Improvement, and a Consultant Obstetrician from Southampton is working with the Division to improve the governance arrangements. The Royal College of Obstetricians and Gynaecologists (RCOG) has also undertaken visits to the services and is issuing a report with recommendations. In our interviews managers reported that based on verbal feedback provided by the RCOG, there are recommendations in relation to the governance infrastructure. A new Head of Midwifery/Nursing has been appointed and will be in post in August 2018. An interim Head of Midwifery is currently in post and has assisted in stabilising the teams and progressing improvements. Staff reported that the General Manager is moving to a post within Operations and this will result in another change of personnel in a team that has a significant amount of work to undertake in terms of its governance structure and arrangements.

The Division has a Clinical Lead for Governance, however until the outcomes from NHS Improvement's and the Royal College's visit is known he feels it is a difficult time to make significant changes, and is therefore awaiting the findings and recommendations that are soon to be published.

Clinical Support Services

The Division has been restructured and a number of services have recently been added to its portfolio including: Pathlinks; Patient Administration; Web V; and digital strategy. We met with the Divisional triumvirate and the Heads of Services. The meeting demonstrated good cooperation and respect of the Divisional members present.

The Division's services contain areas that require external accreditation, which has resulted in some good governance arrangements and management of the required regulations/arrangements. There are however some challenges, for example JAG (Joint Advisory Group) accreditation for Endoscopy at SGH has been withdrawn and the Trust will be reassessed in January 2019. There is a recovery plan in place and the Division are confident that the accreditation will be reinstated.

Pharmacy has some concerns regarding the clinical engagement of its processes and the structures that are in place for the safe and effective management of medicines. The Chief Pharmacist is however taking steps to address this. There are ongoing issues regarding filling all clinical leads positions and in pathology the Clinical Director is currently covering this role until a replacement is identified . There are a significant number of radiologist vacancies and whilst this is actively being addressed it is likely to remain problematic to the Trust due to the scale of the problem.

Divisional Clinical and Quality Governance arrangements

Each Division has either acquired new services within its portfolio or had a change of personnel in the triumvirate team.

Interims are in place but a number of appointments have just been made and until these are in place there will be a period of instability.

The new roles and responsibilities will need evaluation and monitoring to ensure the roles perform as intended.

Clinical Support Services (cont.)

The Division holds a monthly Governance meeting. Meeting attendance is growing and includes members of the newly acquired services to the Division.

The Division feels held to account by the Trust Board. Performance meetings occur however papers are frequently issued for the meeting on the previous day and this does not allow time for full review and planning of the meeting/actions.

Surgery and Critical care

We interviewed the Interim General Manager and Divisional Head of Nursing and the Assistant General Manager for Head and Neck Directorate. The Divisional Clinical Director was unable to attend the meeting. The management team work well with their HR and Finance business partners.

The Division attends performance reviews. Some of the information they receive in preparation for these meetings is late and this can affect the robustness of the meeting. The Divisions hold performance reviews with the specialties, however we were informed that these are relatively new.

The Division were aware of the new Clinical Governance Group and felt this will be an important forum since the discontinuation of the Trust's Governance Assurance Committee. The Division is currently advertising their Clinical Lead positions to enable oversight of governance within their services. For some services these Clinical Leads work trust-wide except for anaesthetics or critical care where they are site specific.

The Division has a monthly Surgical Board where the senior teams from the specialties and the triumvirate meet. In addition there is a Divisional Governance meeting where governance representatives attend from each specialty. The Division has a post for a Clinical Lead for Governance. The Risk and Governance Facilitators (RGF) and Complaints Facilitators also attend this meeting, however they are unable to attend the specialty governance meetings due to resource constraints. The Division reported that the governance within the specialties requires improvement. The Division is concerned regarding the level of input from the current RGFs, as previously the post holders were clinically qualified and Band 7 and therefore were able to play a more prominent role within the Division. We have discussed a recommendation regarding this issue earlier in this report. **(see Recommendation 17)**

Transformation plans are in place for each Division and these are closely monitored.

Divisional Clinical and Quality Governance arrangements

Each Division has either acquired new services within its portfolio or had a change of personnel in the triumvirate team.

Interims are in place but a number of appointments have just been made and until these are in place there will be a period of instability.

The new roles and responsibilities will need evaluation and monitoring to ensure the roles perform as intended.

Medicine

We met with the Triumvirate Management Team. The Divisional Head of Nursing role is currently held by an interim, however the Trust has successfully appointed to the substantive position and this person will take up post in the autumn.

The Division holds a monthly Medicine Cabinet (Board), clinical commitments interfere with maximising the attendance from clinicians and this is something that needs to be addressed.

During winter pressures some of the meetings were cancelled due to increased demands in the clinical areas.

The Division holds its governance meeting each month, chaired by the Divisional Director. The attendance from medical colleagues is an areas that requires improvement. The meeting has video conference capability to maximise attendance across all sites.

Performance meetings are held with the Division, although they do get cancelled, and data, provided by the Trust's Information team, is usually only available on the day before the meetings and this impacts on the effectiveness of the meeting. Staff reported that the meetings are variable but can be challenging at times.

The Division participated in the first meeting of the new Clinical Governance Group and see this as a much needed forum since the abolition of the Trust's Governance & Assurance Committee. Members of the Divisional Triumvirate only attend the Quality and Safety Committee by invitation. Divisions now attend the Committee and present their challenges and achievements on a rolling programme.

The Directorate hold governance meetings , however this is an area that the triumvirate recognise improvements are required. Clinical membership and ownership is lacking, decisions are not implemented at the required pace. Patient safety initiatives are in place such as safety huddles and opportunities to increase learning from events are occurring. The Divisional Clinical Directors has two deputies, one at DPOW site and the other at SGH site, although the backfill is difficult for these posts and Clinical Leads to allow time in the job plan to undertake these managerial sessions. The Division is aware of their areas for improvement and articulated these well.

The Division has two RGFs, one works across the DPOW site and the other covers SGH and Goole. The RGFs work differently across the sites and there needs to be more local direction for these roles. The Division is concerned regarding the level of input from the current RGFs, as previously the post holders were clinically qualified and Band 7 and therefore were able to play a more prominent role within the Division. We have discussed a recommendation regarding this issue earlier in this report. **(see Recommendation 17)**

Divisional Clinical and Quality Governance arrangements

Each Division has either acquired new services within its portfolio or had a change of personnel in the triumvirate team.

Interims are in place but a number of appointments have just been made and until these are in place there will be a period of instability.

The new roles and responsibilities will need evaluation and monitoring to ensure the roles perform as intended.

Community and Therapies

From our observations and interviews the triumvirate team works well together. A new Head of Nursing has recently been appointed and will be in post soon.

The Division states it is appropriately held to account by the Trust Board. Performance meetings occur however papers are frequently issued for the meeting on the previous day and this does not allow time for full review and planning of the meeting/actions.

Divisional Clinical and Quality Governance arrangements

We were told that clinical commitments prevent attendance of some medical staff to the Divisional Governance meetings. For key Clinical Leads this needs to be resolved to allow for their roles to add value to the Division's key governance arrangements.

Divisional Clinical Governance Meetings

Each Division has a clinical governance group meeting (Women's and Children's has a separate governance meeting for 'Children's Services' and 'Obstetrics and Gynecology') to discuss local quality and safety issues.

The focus of these Clinical Governance group meetings is intended to be the focus for local accountability around quality and safety. In our previous Internal Audit we identified problems regarding consistency, engagement issues, and room for improvement around information. There were however some positive observations about the quality of chairing and of supporting papers.

The clinical governance meetings are chaired by the Divisional Clinical Director. Although clinical governance meetings are now well established within the Divisions, improvements are required. As part of the previous Internal Audit report dated September 2017, KPMG reviewed these meetings and the Trust requested that we did not therefore attend the meetings as part of this review. However we reviewed the May 2018 clinical governance meeting minutes and the June 2018 meeting agenda for each Division.

Meeting agendas and papers

We reviewed the meeting agenda for each Division's May 2018 clinical governance meetings. The format of the meetings agendas and meeting papers varied between each Division, for example not all meetings agendas included a standing agenda item to note matters to be disseminated or matters for escalation to the Trust's Quality and Safety Committee and TMB. **(Recommendation 25)**

The clinical governance meeting agendas include items regarding:

— Risk;

— NICE Guidance;

— Patient Safety;

— Complaints;

— Incidents; and

— Serious RCA investigations and action plans.

Divisional Clinical and Quality Governance arrangements

We identified scope to improve aspects of the Divisional Governance meetings to support the efficient running of the meetings.

Meeting agendas and papers (continued)

A significant number of documents are presented to clinical governance meetings, for example, one meeting had 15 policy/ guideline documents for ratification and 19 policy/ procedure items 'for information'. The 'policies for ratification'/ 'documents for approval' are included as the first substantive agenda item (following approval of previous meeting minutes). There is an increased risk that the meeting is orientated towards administrative tasks as opposed to the identification and discussion of key risks; mitigation of risk; actions; and lessons learned. **(Recommendation 26)**

We noted scope to improve the meetings agendas to support the efficient running of the meetings, for example:

— the meeting agendas do not state whether the agenda item is for information, action or approval; and

— the proposed timings for each agenda item are not recorded on the agenda. **(Recommendation 27)**

Whilst we identified areas of good practice the quality of meeting papers was not consistent across the Divisions. For example, we found that in some Divisions a 'Governance Dashboard' and 'Governance Highlight Report' was presented. The reports summarise the data regarding the number of incidents, SIs, complaints, claims and training rates and also provide further narrative whereas in other Divisions separate documents were presented in relation to incidents, serious incidents, complaints and PALS. The information provided in these documents tended to be a brief description of events and did not clearly highlight the key learning points, required actions or theme and trends. **(Recommendation 28)**

In one Division, 18 serious incident RCA action plans were included on the agenda. 13 of the 18 action plans were noted as being overdue.

Action log

We noted that an action log was not included on the agenda for all governance meetings. **(Recommendation 29)**

Attendance

We reviewed the clinical governance meeting minutes for May 2018 and we noted that attendance, particularly medical staff attendance was poor. For example, the Chair was the only doctor present at Medicine's meeting.

If meetings are not well attended or are not quorate it is increasingly difficult for committees to consistently apply effective and efficient decision-making. Similarly, there is a risk that certain directorates or specialties are under-represented at meetings and risks are not appropriately identified, discussed and escalated. **(see Recommendation 24)**

KPMG

Review of clinical areas

Review of clinical areas

We visited the clinical areas within the Emergency Department and Maternity Units at DPOW and SGH and identified areas of good practice and areas for development. We have listed our observations by CQC domain.

The areas for development identified should be incorporated in the Directorate's CQC action plan.

We visited Emergency Departments and Maternity Units at DPOW and SGH sites on 8 and 27 June 2018. We assessed the environment and spoke to staff and, where possible, users of the services.The areas for development identified should be incorporated in the Trust's CQC action plan. **(Recommendation 30)**

Maternity - DPOW

Are services safe?

- ✓ Daily checks are undertaken of emergency equipment in all four maternity areas.
- x CoSHH item left out on side in an unlocked Sluice.
- x A bag of IV fluid left unattended on the side at the Nurses station (Blueberry).
- x IV fluids are stored on open shelving in the clean utility room. The area is accessed by non nursing personnel.
- x There is no programme in place to change digi-lock codes to clean utility area.

Are services effective?

- ✓ Maternity services have redesigned the swab count policy and developed a LocSSIP. A new wipe boards for swab counts has been introduced in theatres.
- ✓ Staff are required to undertake annual CTG competency updates, and records are in place to record compliance.

Are services caring?

- ✓ We observed staff to be caring and supportive to each other and to patients and their relatives/visitors.

Are services responsive to people's needs?

- ✓ There is a good bereavement support for families, and a Bereavement Midwife has been in post since November.
- ✓ There has been an increased focus on education around recognising and managing a deteriorating patient. Monthly audits of patients records are undertaken to monitor staff compliance with the recognition and escalation of deteriorating patients.
- ✓ Training is provided in a multi-disciplinary approach.
- x The location of the Bereavement room is not ideal (directly onto corridor and overlooked by nurses station). Women may be able to hear other patients and babies crying and this may be distressing to them and their families.

Are services well led?

- ✓ Information pertaining to the lessons learnt from significant events is displayed in staff areas.
- ✓ A 'theme of the month' board and 'safety information' boards have been introduced.

Review of clinical areas

We visited the clinical areas within the Emergency Departments and maternity Units at DPOW and SGH and identified areas of good practice and areas for development. We have listed our observations by CQC domain.

The areas for development identified should be incorporated in the Directorate's CQC action plan.

Maternity – SGH

Are services safe?

- ✓ Daily checks of emergency equipment are completed in Central Delivery Suite (CDS) and Ward 26.
- ✓ Staff stated that there are improved staffing levels.
- ✓ There is provision of sepsis boxes in each area.
- x The clinical room temperature is not routinely monitored and recorded and therefore drugs may be stored in an areas where the temperature may affect efficacy.
- x IV fluids are stored on open shelving in clean utility room that is accessed by non nursing personnel.
- x Baby feed and IV fluids are stored in an unlocked stored room.
- x Documentation awaiting archiving containing patient details stored in an unlocked room.
- x No programme in place to change digi-lock code to the clean utility area.
- x CD stationary was left unsecured in the clinical room that is accessed by non-nursing personnel.
- x CoSHH products are accessible to unauthorised personnel in the dirty utility room.

Are services effective?

- ✓ New wipe boards for recording swab counts are in place in the theatres and delivery rooms.
- ✓ Processes are becoming more standardised across the hospital sites.
- ✓ Staff are required to undertake annual CTG competency updates, and records are in place to record compliance.

Are services caring?

- ✓ We observed staff to be caring and supportive to each other and to patients and their relatives/visitors.
- x There is no facility for partners to stay overnight.

Review of clinical areas

We visited the clinical areas within the Emergency Departments and maternity Units at DPOW and SGH and identified areas of good practice and areas for development. We have listed our observations by CQC domain.

The areas for development identified should be incorporated in the Directorate's CQC action plan.

Maternity – SGH (continued)

Are services responsive to people's needs?

- ✓ There is a focus on education and updates around recognising and managing the deteriorating patient. Multi disciplinary training is provided.
- ✓ There is a monthly audit of records to monitor staff compliance with the escalation and management of deteriorating patients.
- x There is no dedicated bereavement room. Women are currently cared for on Central Delivery Suite (CDS).

Are services well led?

- ✓ Lessons learnt information displayed in staff areas.
- ✓ A 'theme of the month' board and 'safety information' boards have been introduced.

Review of clinical areas

We visited the clinical areas within the Emergency Departments and maternity Units at DPOW and SGH and identified areas of good practice and areas for development. We have listed our observations by CQC domain.

The areas for development identified should be incorporated in the Directorate's CQC action plan.

Emergency Department - DPOW

Are services safe?

- ✓ There is good compliance with the completion of twice daily checks and emergency checks on essential equipment.
- ✓ There was evidence of portable appliance testing for equipment that required it.
- ✓ There is good compliance with daily fridge and room temperature monitoring.
- x The drug cupboard in the streaming room was unlocked and door had been left open. The drug cupboard contained blister pack of codeine phosphate stored outside of its original packaging.
- x The drug cupboard contained a variety of medicines but there was no stock list and this could potentially allow diverted drugs to go un-noticed.
- x The opening date of elixirs was not routinely recorded on bottles that were clearly in use.
- x During our visit nursing staff and the HCA that were rostered for the streaming and ambulance handover areas were both absent from their area for a prolonged period of time. This left a patient unattended in ambulance handover.
- x The Department use 'Aboly clic' keys for accessing medication, however staff take their key home at the end of the shift. Many Trusts book these in and out on a shift by shift basis. Agency staff are required to sign keys in and out
- x CoSHH products were accessible to unauthorised personnel in the dirty utility room.
- x IV fluids were left unattended on side in the Resuscitation area.

Are services effective?

- ✓ Staff reported improved multi-disciplinary team working with doctors and good access to escalate concerns.
- ✓ There was wide spread use of Clinell stickers that were dated to indicate equipment had been cleaned.
- x There was reported to be poor utilisation of Primary Care stream due to variable GP input.
- x The Department does not have a dedicated sepsis trolley for easy access and timely management of patients with sepsis.

Are services caring?

- ✓ We observed staff to be caring and respectful to patients and their families.

Review of clinical areas

We visited the clinical areas within the Emergency Departments and maternity Units at DPOW and SGH and identified areas of good practice and areas for development. We have listed our observations by CQC domain.

The areas for development identified should be incorporated in the Directorate's CQC action plan.

Emergency Department – DPOW (continued)

Are services responsive to people's needs?

✓ Patient information regarding waiting times and discharge leaflets is readily available.

Are services well led?

✓ We were told there had been increased Consultant provision.

Review of clinical areas

We visited the clinical areas within the Emergency Departments and maternity Units at DPOW and SGH and identified areas of good practice and areas for development. We have listed our observations by CQC domain.

The areas for development identified should be incorporated in the Directorate's CQC action plan.

Emergency Department – SGH

Are services safe?

- ✓ There is good compliance with the completion of daily equipment and environment checks.
- ✓ There is consistent evidence to support that daily monitoring of emergency equipment is undertaken.
- ✓ There is a daily 'staff safety huddle' for medical and nursing staff that is documented.
- ✓ Electrical portable appliance testing was all in date on the equipment we checked.
- ✓ Swipe card access has been introduced to restrict access to the clinical areas to authorised personnel.
- x The Clean Utility room temperature was noted to be warm, staff reported this was a persistent issue. However the room temperature is not being monitored and any action taken by staff to escalate the concern is not documented.
- x Some IV fluids were decanted and insecurely stored in the clean utility room allowing unrestricted access to non nursing staff
- x The opening date of elixirs was not routinely recorded on medicines that were clearly in used
- x The Department use 'Aboly clic' keys for accessing medication, however staff take their key home at the end of the shift. Many Trusts book these in and out on a shift by shift basis.
- x CoSHH items were insecurely stored in the sluice and some stock was stored directly on the floor.

Are services effective?

- ✓ There is wide spread use of Clinell stickers that had been dated to indicate equipment had been cleaned.
- ✓ There has an Increase in the provision of cleaning hours for the Emergency Department.
- ✓ Monthly environmental audits are undertaken by the Infection Control Nurse who provides feedback. An action plan is in place and is reviewed monthly.
- ✓ Staff are split into teams to allow improved local oversight of staff development and training.
- ✓ There are two hourly documented Board rounds to maintain oversight of flow through ED
- x The Department does not have a dedicated sepsis trolley for easy access and timely management of patients with sepsis.

Review of clinical areas

We visited the clinical areas within the Emergency Departments and maternity Units at DPOW and SGH and identified areas of good practice and areas for development. We have listed our observations by CQC domain.

The areas for development identified should be incorporated in the Directorate's CQC action plan.

Emergency Department – SGH (cont.)

Are services caring?

- ✓ We observed staff to be caring and respectful to patients and their families.
- ✓ We spoke to patients and relatives who told us they were generally kept informed of their plan of care.

Are services responsive to people's needs?

- ✓ Good patient discharge information leaflets were available.
- x The waiting room has been refurbished but there is no visual display to update patients on their anticipated waiting times.

Are services well led?

- ✓ There is a bi-monthly ED newsletter that shares lessons learnt fro significant events.
- ✓ Quarterly staff meetings are held between the Matron and each staff group.
- ✓ The Consultant staff were described as proactive and engaged well with nursing teams.

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Recommendations

Section four

Recommendations

Priority rating for recommendations raised		
High Priority (one) A significant weakness in the system or process which is putting you at serious risk of not achieving its strategic aims and objectives. In particular: significant adverse impact on reputation; non-compliance with key statutory requirements; or substantially raising the likelihood that any of your strategic risks will occur. Any recommendations in this category would require immediate attention.	**Medium Priority (two)** A potentially significant or medium level weakness in the system or process which could put you at risk of not achieving its strategic aims and objectives. In particular, having the potential for adverse impact on your reputation or for raising the likelihood of your strategic risks occurring.	**Low Priority (three)** Recommendations which could improve the efficiency and/or effectiveness of the system or process but which are not vital to achieving your strategic aims and objectives. These are generally issues of good practice that the auditors consider would achieve better outcomes.

#	Priority	Recommendation
1		**Divisional Clinical Director role** The Divisional Clinical Directors now lead the Divisional triumvirate teams and this is a change in scope of responsibility for these post holders. The roles are new and a post implementation review with be required following a period of time to evaluate the impact of the role in the Division.
2		**Clinical Leads** Clinical Lead positions are in place in specialities and these are currently being appointed to. These positions had previously been in place, however to increase clinical leadership and governance within the specialties reappointments are currently underway. These positions should be outcome driven and expectations should be clear and reinforced by the Divisional Clinical Director and ultimately the Medical Director. Review of effectiveness of the positions should be established and built in to annual appraisals.
3		**Quality and Safety Committee - escalation of issues** It is important that the Quality and Safety Committee has assurance from the Divisions as to the effectiveness of their governance meetings and how issues of concern are escalated. It is not always clear from meeting minutes how issues are escalated. The Divisions should produce a highlight report to be presented to the Quality and Safety Committee to highlight any issues and escalate any areas of concern.
4		**Quality and Safety Committee - Divisional presentations** The QSC Committee invites the Divisional triumvirate teams on rotation, to attend the Committee to present their current issues. In order to allow all Divisions to provide succinct information a basic standard template has been designed to allow the Divisions to self-assess and demonstrate progress. However, to date attendance has not always included the full triumvirate team, and presentations are not structured and therefore there was a lack of assurance gained from their presence. Further work is required to ensure the Divisions are aware of the purpose of their attendance and can therefore prepare accordingly.

Recommendations (cont.)

#	Priority	Recommendation
5		**Quality and Safety Committee – challenge and scrutiny** There was some good and effective challenge from the Non-Executive Director members and also from Executive to Executive for some items. However not all items were discussed in sufficient detail. The Trust should ensure that the Committee's remit is clear. The purpose of each paper should also be clear in advance of the meeting i.e. for information, approval or discussion to facilitate effective discussion.
6		**Quality and Safety Committee – terms of reference** The terms of reference for the Trust's Quality and Safety Committee were revised in February 2018. At the end of each meeting the Committee should self-assess performance, and a formal review of the Committee's effectiveness should be reviewed after the revised terms of reference has operated for six months.
7		**Quality and Safety Committee – preparation** Prior to each meeting the Chair of the Quality and Safety Committee should meet with the Medical Director to set the agenda and agree any areas for deep dive that may arise from lack of progress with the action log or from wider intelligence.
8		**Quality Governance Group – chairing responsibilities** The Medical Director and Chief Nurse are currently joint Chairs of the Quality Governance Group. However quality governance sits within the Medical Director's portfolio and therefore the Medical Director should Chair the meeting, with the Deputy Medical Director (Quality) deputising in the event of absence
9		**Quality Governance Group – meeting effectiveness** We attended the QGG meeting on 27 June 2018 and we identified scope for improvement regarding the effectiveness of the meeting. We identified that a number of agenda items were not presented or discussed due to non-attendance of the relevant officer or an appropriate deputy. The Trust should ensure that members of the Quality Governance Group are clear as to the purpose and direction of the Group. The meetings should be scheduled to ensure one of the two Chairs can attend meeting dates, identifying expected attendees should be communicated to all relevant staff in advance of meeting. Where required attendees are unable to attend a deputy should be nominated to attend the meeting where possible and where relevant make decisions on their behalf.

Recommendations (cont.)

#	Priority	Recommendation
10		**Serious Incident Panel** The Trust does not have a weekly SI panel meeting. SI panel meetings can facilitate a systematic, holistic, multi-disciplinary and proactive approach to the identification and management of serious incidents and the identification of risks through the review of incidents that have occurred at the Trust. The Trust should establish an SI panel to support the management of serious incidents.
11		**Serious Incidents – sign off of RCAs** The Divisional Clinical Director, should be responsible for the review and sign-off of root cause analysis reports for serious incidents that occur within the Division. This should not be delegated apart from instances of leave where the assigned deputy can undertake this responsibility.
12		**Clarity of Matron roles and responsibilities** In our interviews some staff members reported a lack of clarity between the Operational Matron and Quality Matron roles. The Trust should ensure that roles, responsibilities and accountabilities of the Quality Matron role and the Divisional Operational Matron role are clearly defined to minimise duplication.
13		**Operational Matron role** The role of the Operational Matrons is due to change. Matrons will be re-established within the Directorate of Operations and be responsible for the delivery of quality and safety; performance; staffing; and finance at ward/department level within the Divisions and have professional accountability for nursing and midwifery through their Divisional Heads of Nursing to the Chief Nurse. The Trust should undertake development sessions with the Matron group to discuss roles and responsibilities and associated performance outcomes. To assess the effectiveness of the revised arrangements a post-implementation review should be undertaken after four months.
14		**Risk and Governance** The Head of Risk position is currently remunerated at Band 8A. This post has a considerable area of responsibility across the Trust. From our experience nationally we note that the Trust could be considered an outlier in this areas with most Trusts we work with employing similar positions at Band 8B - 8D. The Trust should consider whether or not the responsibilities and scope of work align to the current pay banding of the role.

Recommendations (cont.)

#	Priority	Recommendation
15		**Risk and Governance – staffing** The Head of Risk currently has insufficient administrative support and this impacts on the efficiency of the entire team. Support arrangements should be reviewed.
16		**Risk and Governance Facilitator** The Risk and Governance Facilitators are currently located together with the Risk and Governance team. Whilst at this stage in the Trust's maturity the Facilitators should remain centrally managed to build a common skill set and facilitate consistency in approach, being co-located within the Divisions would enable greater alignment of the role with Divisional priorities. The Risk and Governance Facilitators should be co-located within the Divisions to enable their day-to-day tasks to be directed by the Divisional management team to ensure the role is aligned to the Division's priorities. The Facilitators should meet as a group on a weekly basis to share key messages, learning, and develop the role to further enhance the quality governance of the Divisions.
17		**Divisional Clinical Governance Leads** The Risk and Governance Facilitator role is currently fulfilled by Band 5 non-clinical staff members. The Trust should consider enhancing the clinical governance capacity within the Medicine and Surgery Divisions with a clinically qualified Governance Lead – probably at Band 7 (in addition to the Band 5 RGFs in post), to support the coordination, quality and timeliness of governance activities with the Division.

Recommendations (cont.)

#	Priority	Recommendation
18		**Complaints Facilitator – Divisional Governance meeting attendance** The Complaints and PALS Manager has recently aligned the Complaints Facilitators to Divisions to assist with the building of relationships and cooperation of the Division/Directorate staff and to improve the timeliness of responses/investigations. It is proposed that the Complaints Facilitators will attend the Divisional Governance meetings to ensure that key themes, issues, actions and learning from complaints are appropriately discussed. The Complaints Team should evaluate the effectiveness of the Facilitators attending the Divisional Governance meetings to ensure it is the most relevant forum to attend.
19		**Complaints – action plans** The Divisions are heavily reliant on the Complaints Team to write action plans for the complaint outcomes, however these action plans should be compiled by the Divisions. Complaint action plans should be developed by the Divisions to ensure appropriate accountability and ownership.
20		**Complaints – sign off of complaints letters** The Chief Executive undertakes the final signing of the complaints letter. However, Divisional Clinical Director should review and locally sign off all complaints letters for complaints that fall within the remit of the Division. This should not be delegated apart from instances of leave where the assigned deputy can undertake this responsibility.
21		**Head of Quality and Assurance** The Head of Quality Assurance's role is aligned to clinical effectiveness as opposed to quality and assurance. The portfolio includes clinical audit; NICE guidance; patient safety (CAS reports); mortality; Information Governance; and document control. and the Consideration should be given to a change of title to more effectively describe the responsibilities and portfolio of the role.
22		**Clinical Audit – monitoring of action plans** The Quality and Audit team enables the delivery of the clinical audit plan by planning appropriately, taking into account what support is necessary and timescales needed. The team will guide clinicians in the planning and data collection of their audits and compile the audit reports including recommendations. The Divisions should work with the Clinical Audit facilitators to increase local ownership of the development and implementation of clinical audit, and importantly the implementation and learning from resultant actions.

Recommendations (cont.)

#	Priority	Recommendation
23		**Performance reviews – availability of papers** Whilst the Divisions are held to account by the Trust Board and performance meetings occur, papers are frequently issued for the meeting on the previous day and this does not allow time for full review and planning of the meeting/actions. The data pack to enable Divisional performance reviews should be made available to the Divisional triumvirate to allow reasonable time for review and planning for the meeting.
24		**Divisional Governance meeting – attendance** We reviewed the clinical governance meeting minutes for May 2018 and we noted that attendance, particularly medical staff attendance was poor. For example, the Chair was the only doctor present at Medicine's meeting. If meetings are not well attended or are not quorate it is increasingly difficult for committees to consistently apply effective and efficient decision-making. Similarly, there is a risk that certain directorates or specialties are under-represented at meetings and risks are not appropriately identified, discussed and escalated. The Divisions should ensure that meeting dates, identifying expected attendees are communicated to all relevant staff in advance of meetings. Where required attendees are unable to attend a deputy should be nominated to attend the meeting where possible and where relevant make decisions on their behalf. The Division should review job plans to explore whether a common SPA/PA could be arranged for a common time to allow core medical staff to attend Governance meetings, avoiding any conflict with direct clinical care (DCC) timetabling.
25		**Divisional Governance meeting – agenda** We reviewed the meeting agenda for each May 2018 clinical governance meeting. The format of the meetings agendas and meeting papers varied between each Division, for example not all meetings agendas included a standing agenda item to note matters to be disseminated or matters for escalation to the Trust's Quality and Safety Committee and TMB. The Trust should develop a template meeting agenda for Divisional Governance meetings to ensure all key areas are covered. The template can be tailored by the Division to reflect local priorities.

Recommendations (cont.)

#	Priority	Recommendation
26		**Divisional Clinical Governance meetings** A significant number of documents are presented to clinical governance meetings, for example, one meeting had 15 policy/ guideline documents for ratification and 19 policy/ procedure items 'for information'. There is a risk that the meetings become orientated towards administrative tasks as opposed to the identification and discussion of key risks; mitigation of risk; actions; and lessons learned. An alternative meeting should be dedicated to the ratification of policies to allow the Clinical Governance meetings to function more effectively.
27		**Divisional Governance meeting – agenda** We noted scope to improve the meetings agendas to support the efficient running of the meetings, for example: — the meeting agendas do not state whether the agenda item is for information, action or approval; and — the proposed timings for each agenda item are not recorded on the agenda. To support the smooth running of the meeting and effective time-management: – Divisions should ensure that appropriate time is allocated to each item when setting agendas, with estimated time per item included in each agenda based on the relative importance and complexity of the item. – Items for decision or approval should be clearly marked on agendas to enable members to consider these in advance to ensure the appropriate action is taken.
28		**Divisional Governance meeting – meeting papers** Whilst we identified areas of good practice the quality of meeting papers was not consistent across the Divisions. The presented did not consistently highlight the key issues, themes/ trends, required actions or learning points. The Trust should develop a template Governance report for presentation at Divisional Governance meetings to ensure the key issues and risks are being identified. The template can be tailored by the Division to reflect local priorities.

Recommendations (cont.)

#	Priority	Recommendation
29		**Divisional Governance meeting – action log** **Action logs** It is good practice to capture action logs as a separate enclosure to clearly document: – Meeting date; – Agenda item and reference number; – Responsible officer; – Due date; – Date complete; – Short status narrative; and – Clear RAG rating to indicate completion status. We noted that an action log was not included on the agenda for all governance meetings If a clear action log is not maintained there is an increased risk that actions will not be assigned to an owner or will not be followed up in a timely manner. Maintaining a clear action log is increasing important where actions span several meetings. An action log should be included as a separate enclosure for each governance meeting. The log should clearly set out the officer responsible for each action and the deadline for completion. The completion status of actions should be monitored.
30		**Review of clinical areas** We visited the clinical areas in Maternity and Emergency Department at DPOW and SGH on 8 & 27 June 2018. We identified areas for development (outlined in Section Three). The Trust should incorporate our findings into the Trust's action plan to ensure appropriate action is taken to address the issues identified.

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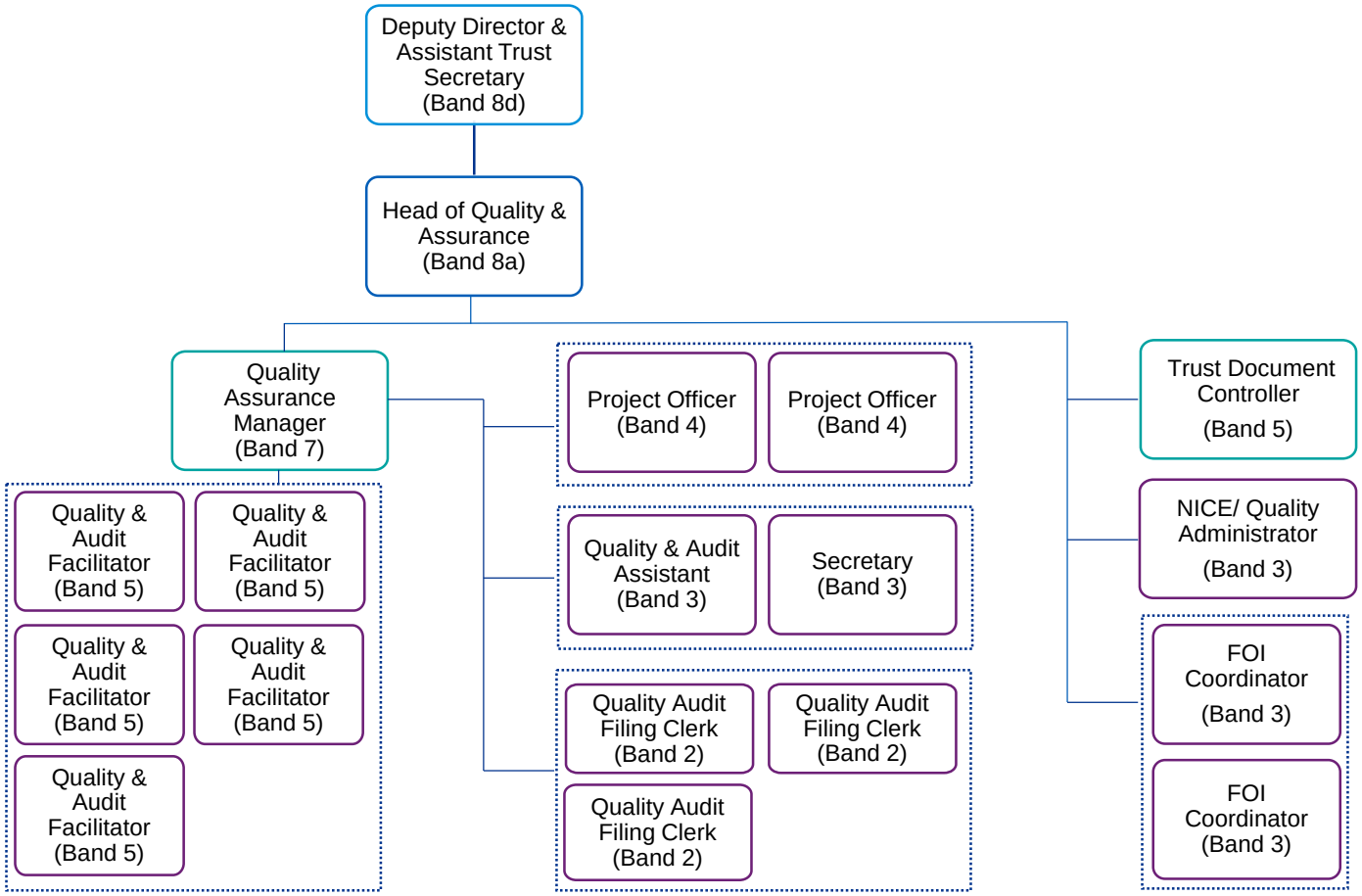
Appendices

Appendix one

Quality Assurance and Clinical Audit team

The Quality Assurance and Clinical Audit Team is managed by the Head of Quality and Assurance. Areas of responsibility include Clinical Audit; NICE guidance; patient safety (CAS reports); mortality; Information Governance; and document control.

Quality Assurance and Clinical Audit team structure



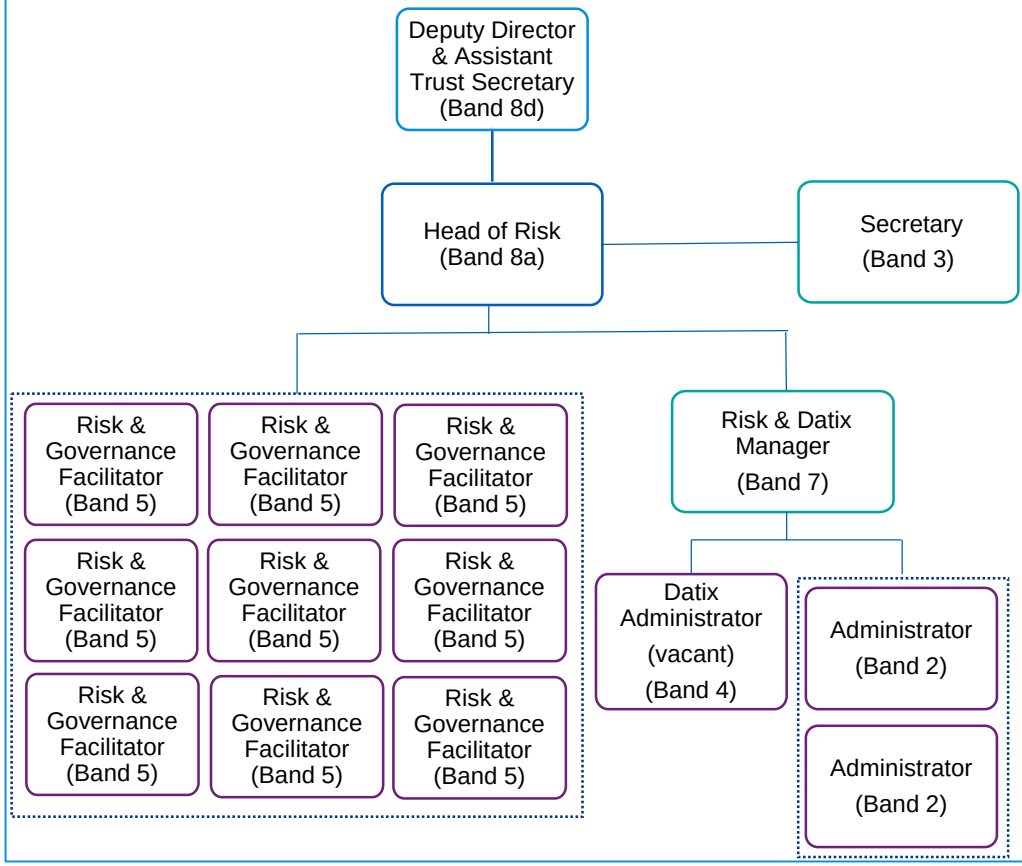
Appendix two

Risk and Governance team

In 2012 the Trust centralised the Risk and Governance Facilitators (RGF) into the Directorate of Governance and Assurance, managed by the Head of Risk. This was to offer support to the Divisions and develop a common approach.

In order to enhance the Divisional ownership a longer term decentralised model should be considered for the future.

Risk and Governance team structure



Appendix three

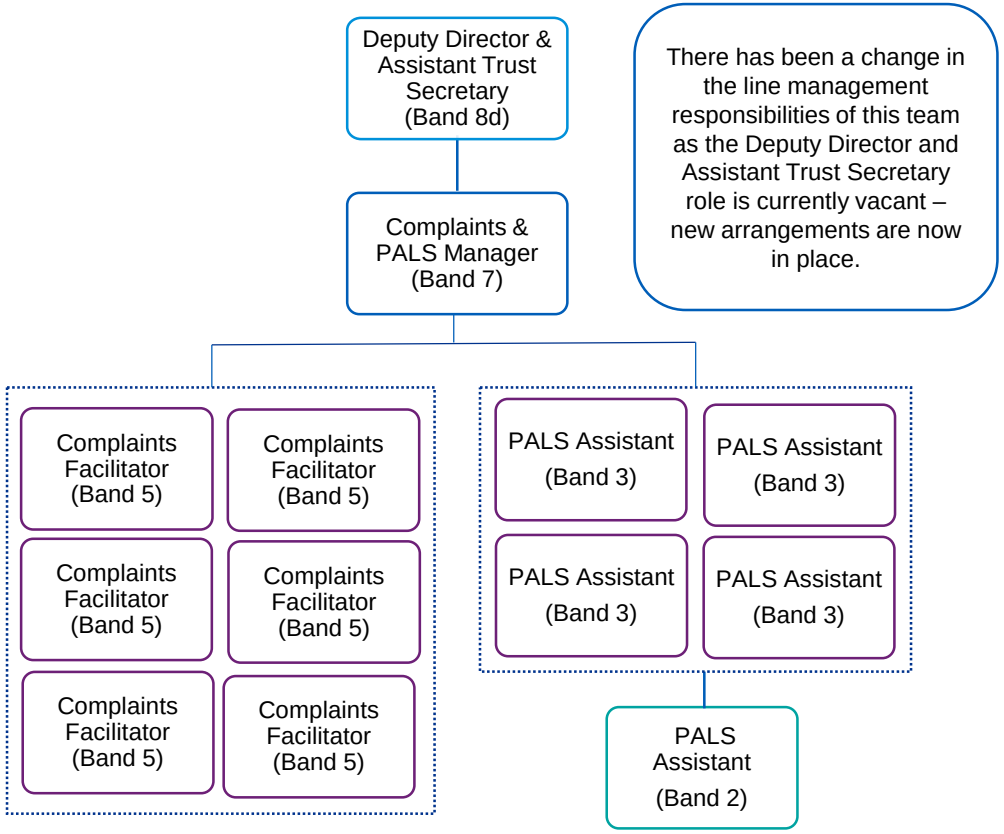
Complaints team

The complaints function has now moved to the Chief Nurse's Directorate.

Line management of the Complaints and PALS manager has recently changed. This now sits with a Quality Matron who has patient experience as part of her specialist role.

Complaints team structure

The Trust's Complaints and PALS Manager is currently supported by six Complaints Facilitators (4.96 WTE) and five PALS Assistants (3.1 WTE):



Appendix four

Scope of work

Scope

Clinical and Quality Governance Arrangements

We have undertaken the following work to assess the Trust's Clinical and Quality Governance arrangements:

- Reviewed the Trust's Quality Governance structures and information flows up and down the Trust's governance structure to provide assurance and to take actions when issues are identified.
- Held structured interviews with key individuals in the Trust's Quality Governance structure to understand and review the accountability structure and clarity of roles and responsibilities.
- Considered the effectiveness and resource allocation of the current Quality Governance structure and its suitability to the current needs of the organisation.
- Held structured interviews with key individuals in the Trust's Divisional teams to understand and review the accountability structure and clarity of roles and responsibilities.
- Reviewed the degree to which the clinical and quality governance structures and processes are arranged and resourced within the Divisions, identifying current allocation and future need.
- Observed of the Trust's Quality and Safety Committee to gain insight into how individuals interact with each other and with the information provided. We will consider the following:
  - The effectiveness of the Committee and the level and type of interaction of each member/attendee;
  - The appropriateness of the papers being presented to the Committee and how these are used to ultimately provide assurance; and
  - The quality of the data presented to the Committee to enable them to make decisions effectively.
- We visited selected clinical areas to assess progress made with CQC actions as detailed on the Trust's Quality Improvement Plan.
- We used our recent Internal Audit reviews to inform on how the Divisional meetings are run and the coverage of the governance agenda. We will not duplicate any recent work previously undertaken.

Appendix five

Staff involvement

We undertook interviews with key stakeholders to inform this work, including:

Stakeholder	Job role
Dr Peter Reading	Chief Executive
Kate Wood	Acting Medical Director
Tara Filby	Chief Nurse
Shaun Stacey	Chief Operating Officer
Wendy Booth	Director of Governance & Assurance
Kathryn Helley	Deputy Director – Improving Together
Kelly Burcham	Head of Risk
Jeremey Daws	Head of Quality Assurance
Mr Werner Mueller	Consultant Gynaecologist and Clinical Governance Lead
Dr Steven Griffin	Divisional Medical Director - CSS
Tracey Broom	General Manager - CSS
Ruth Kent	Head of Radiology
Lorraine Turner	General Manager – Surgery and Critical Care
Jenn Orton	Head of Nursing – Surgery and Critical Care

Stakeholder	Job role
Simon Buckley	Governance Lead – Medicine
David Broomhead	Divisional Medical Director - Community and Therapy Services
Karen Fanthorpe	General Manager - Community and Therapy Services
Dawn Daly	Head of Nursing - Community and Therapy Services
Mr Manohar	Divisional Medical Director - Family Services
Ashy Shanker	General Manager - Family Services
Dotty Watkins	Head of Nursing – Family Services
Dr Stuart Baugh	Divisional Medical Director – Medicine
Pete Bowker	General Manager - Manager
Chrystal Fox	Interim Head of Nursing – Medicine
Jane Warner	Operational Matron – Family Services
Gemma Mazingham	Complaints and PALS Manager
Colleen Grey	Governance Midwife
Gemma Logan-McRae	Patient Safety Midwife

Appendix five

Staff involvement (continued)

Stakeholder	Job role
Carol Gray	Quality Matron
Sara Wood	Quality Matron
Joanne Loughborough	Quality Matron
Rachel Greenbeck	Quality Matron
Jo Mountfield	Consultant Obstetrician (University Hospital Southampton)
Claire Pacey	NHSI Improvement Director
Jackie France	Head of Patient Administration
Sascha Wells-Munro	NHSI Maternity Improvement Advisor