Barking, Havering and Redbridge University Hospitals NHS Trust

BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST

QUALITY MANAGEMENT: GOOD MEETING PRACTICE MANUAL

October 2017

Good Governance Institute

TAKING PRIDE IN OUR CARE

Good Governance Institute

The Good Governance Institute exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat - in short, all aspects of being human.

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Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

Barking, Havering and Redbridge University Hospitals NHS Trust

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SECTION 1: Introduction and quality management at Barking, Havering and Redbridge University Hospitals NHS Trust

1.1 What is quality governance?

"The definition of quality in healthcare, enshrined in law, includes three key aspects:

- *patient safety*
- *clinical effectiveness*
- *patient experience*

A high-quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment, and strong leadership are combined to serve patients."

NHS Five Year Forward View, October 2014

Quality governance can be described as the combination of structures and processes at and below board level to deliver trust-wide quality services.

The publication of the NHS Next Stage Review in 2008, led by Lord Darzi, describes three dimensions to quality, all three of which must be present in order to provide a high quality service. The 'Darzi domains' are well recognised and accepted in the NHS as the definition of the main components of quality in England:

- **Dimension 1: clinical effectiveness:** quality care is care that is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes. This requires an understanding of the success rates of different treatments for different conditions, which will include measures such as mortality/ survival rates, complication rates and measures for clinical improvement.

  Clinical effectiveness may also extend to include an individuals wellbeing and ability to live independently.

- **Dimension 2: patient safety and management of risk:** quality care is care that is delivered so as to avoid all avoidable harm and risks to the individual's safety.

- **Dimension 3: patient experience:** quality care is care that looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

This definition of quality has been enshrined in legislation through the Health and Social Care Act 2012, and high quality care can only be achieved if all three of the above components are delivered simultaneously.

The Five Year Forward View (5YFV) bought quality governance to the top of the agenda, with the desire to reduce variations in patient care. The NHS Outcomes Framework was developed in 2010 and is updated on an annual basis by the Department of Health. The framework builds on the definition of quality through setting out five overarching outcomes underpinned by a set of indicators, which capture the breadth of what the NHS should be striving to achieve for patients. The Framework provides an overview of how the NHS is performing and supports in driving transparency, quality improvement, and outcomes measurement across the NHS, developing a culture that is very much focused on outcomes as opposed to process.

The domains set out within the framework are as follows:

Domain	Description	Related quality dimension
Domain 1	**Preventing people from dying prematurely:** this domain captures how successful the NHS is in reducing the number of avoidable deaths.	CLINICAL EFFECTIVENESS
Domain 2	**Enhancing quality of life for people with long-term conditions:** this domain captures how successfully the NHS is supporting people with long-term conditions to live as normal a life as possible.	CLINICAL EFFECTIVENESS
Domain 3	**Helping people to recover from episodes of ill health or following injury:** this domain captures how people recover from ill health or injury and wherever possible how it can be prevented.	CLINICAL EFFECTIVENESS
Domain 4	**Ensuring that people have a positive experience of care:** this domain looks at the importance of providing a positive experience of care for patients, service users, and carers.	PATIENT EXPERIENCE
Domain 5	**Treating and caring for people in a safe environment and protecting them from avoidable harm:** this domain explores patient safety and its importance in terms of quality of care to deliver better health outcomes.	PATIENT SAFETY

1.2 National Institute for Health and Care Excellence (NICE): quality standards

NICE sets out a number of quality standards, which describe the priority areas for quality improvement in health and social care. The standards cover the areas where there is variation in care and each standard contains:

- a set of statements to help health and social care organisations to improve quality
- information on how to measure progress

Quality standards are developed independently, in collaboration with health and social care professionals, practitioners, and service users. They are based on NICE guidance and other NICE-accredited sources.

The NICE quality standards and indicators can be found at the below link:

- https://www.nice.org.uk/standards-and-indicators

1.3 Care quality commission (CQC): fundamental quality standards

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England and holds responsibility for monitoring, inspecting and regulating services to ensure they meet the fundamental standards of quality and safety.

The CQC sets out the fundamental standards below which care must never fall. This includes the statement that:

> *"…providers must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice."*
>
> ***Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17***

All providers of NHS care must have plans in place to ensure that they can meet the standards.

The fundamental standards can be found at the below links:

http://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards

1.4 Demonstrating quality governance

In the NHS, organisations strive to achieve continuous quality improvement. Quality in the NHS is a 'moving target' and as such, what may be considered to be of acceptable quality today may not be acceptable in a year's time. Therefore, in order to embed continuous quality improvement into the organisational culture, NHS bodies should have in place structures and processes that enable quality to be effectively measured and monitored.

Ultimately, the board of a provider organisation is responsible for the quality of care delivered across all services and assume responsibility for embedding a culture of continuous quality improvement and ultimately, for any failures in the quality of care. Key to this is having robust governance arrangements that effectively delegate the responsibility down the organisation to operational levels. Therefore, the delivery of sound quality governance is the responsibility of all staff, with all staff being accountable for the quality of care provision.

An organisation should have the appropriate structures and processes in place to track and report compliance against relevant standards and targets. It must ensure a clear line of sight from the front line of service delivery through to board level on quality and safety. To do that, there must be an explicit means by which to:

- deliver and demonstrate accountability for quality of clinical outcomes
- implement quality improvement activity, including innovation and the delivery of excellence
- measure improvement and compliance with national and professional standards and track performance against national and local targets
- report, record and escalate risks and concerns about quality
- monitor and evaluate actions to reduce risk, improve quality, and sustain improvement

This must be designed to work at all levels of the organisation and be a critical part of the governance system, as it provides assurance that threats to the organisation's strategic objectives are managed. Clinical leaders will be clear about how they assure senior management, and thereby the board, on achievement across this framework and, importantly, how they share information and learn from others both within their own organisation and across the wider health community.

Examples of effective quality governance structures and processes include:

- ensuring required standards are achieved
- investigating and taking action on sub- standard performance
- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best-practice and identifying and managing risks to quality of care. Risk management systems and processes should be incorporated in to everyday practice
- effective use of robust quality information, which should be analysed and challenged
- promotion of a quality-focused culture across the organisation and leadership, skills and knowledge to deliver the quality agenda. An open and fair safety culture should be promoted across the organisation
- clearly defined roles and accountabilities in relation to quality governance
- active engagement with patients, staff, and other key stakeholders on quality
- clearly defined processes, understood by all staff, for escalating and resolving issues and managing quality performance

1.5 Why is quality governance important?

Quality should drive a trust's strategy and robust quality governance structures and processes will facilitate an open and transparent culture within the organisation that enables clinicians and clinical teams to:

- work effectively
- measure and monitor quality
- continuously learn and improve

Strong quality governance systems and processes enable the following:

- delivery of quality care to patients and putting quality at the heart of all that the trust does
- staff understanding their role and responsibility in delivering safe, effective and compassionate care
- a continual strive to improve so that every patient has an outstanding experience of care
- continuously measure quality and patient outcomes to analyse trends and compare the position of the trust against others to drive improvement
- maintain regulatory and registration requirements, as defined by NHS Improvement and the CQC

1.6 Purpose of this guide

An external review to assess how the trust's three quality management groups and the various 'feeder' groups reporting to these were operating in practice recommended that focus be given to improving the standard of meeting practice. This guide has therefore been developed in accordance with this to provide an overview of the core principles that should be adhered to in order to achieve the best possible outcomes from time spent in meetings.

The information contained within this guide is applicable for the meetings of the three quality management groups (Patient Safety Group, Clinical Outcomes and Effectiveness Group and Patient Experience and Engagement Group) as well as the various 'feeder' groups reporting to these.

SECTION 2: Quality management at Barking, Havering and Redbridge University Hospitals NHS Trust

2.1 Context

Following a review concluding in 2015, the trust revised its clinical governance structure into a Quality and Safety team, the development of which was supported by the introduction of:

a) a **fit for purpose Quality Assurance Committee (QAC)**, which reports to, and relieves pressure on, the trust board
b) **three quality management groups** (formerly referred to as the 'Darzi' groups):

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

c) the **development of the capability and capacity of the governance activities within the divisions**

The three quality management groups were established in September 2015, with the purpose of ensuring that the three core parameters of quality were addressed by clinical leaders and management teams and to facilitate a more robust standard of reporting in these areas to the trust board.

It is the intention that the three quality management groups reflect the quality requirements for the NHS, as set out below:

- **Patient safety:** the first dimension of quality must be that the trust does no harm to patients. This means ensuring the environment is safe and clean, reducing avoidable harm such as excessive drug errors or rates of healthcare associated infections.
- **Patient experience:** quality of care includes quality of caring. This means how personal delivered care is – the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experiences.
- **Effectiveness of care:** understanding success rates from different treatments for different conditions. Assessing this will include clinical measures such as mortality or survival rates, complication rates and measures of clinical improvement. Just as important is the effectiveness of care from the patient's own perspective, which will be measured through patient-reported outcomes measures (PROMs).

A mature system should comprise a wide range of methodologies, both quantitative and qualitative, for assessing achievement of each of NHS England's dimensions of quality care.

Key examples for each would include:

Clinical effectiveness:

- national and local clinical audit
- local quality improvement initiatives
- Patient Reported Outcome Measures (PROMs)
- implementation of evidence based clinical standards (e.g. NICE Quality Standards and indicators)

Patient safety:

- risk reporting
- incident analysis
- safeguarding
- mortality and morbidity reviews

Patient experience:

- Friends and Family Test
- patient surveys
- complaints
- Patient Reported Experience Measures (PREMs)

2.2 Board sub-committees and management groups

The board has a key role in safeguarding quality and therefore needs to give appropriate scrutiny to clinical outcomes and effectiveness, patient safety and patient experience. An outcome of the *GGI Quality Governance and Assurance Framework (QGAF), Risk and Governance Improvement Programme*, which concluded in May 2015, was the establishment of a simplifed and aligned quality management structure that correctly separated management and governance.

With this in mind, it is important to understand the distinction between a board sub-committee and a management group:

Board sub-committee: the board of directors will delegate a number of its functions to committees, who are responsible for reporting to the board on the critical areas of business (for example, finance, quality etc.) and for escalating risks as appropriate. Each formal committee at BHRUT is chaired by a non-executive director. Unlike management groups, board sub-committees are not responsible for the day-to-day running of the organisation but rather seek assurance that performance and systems are operating to the required standards. NHS boards also have a statutory duty of quality, so increasingly establish a quality committee.

Management group: management groups are accountable for the day-to-day, month on month running of the trust and for providing assurance to the board sub-committees that performance and systems are at the required standards .

As a good governance principle, board sub-committees, such as the Quality Assurance Committee (QAC) at BHRUT, should not have management groups reporting to them. The reason for this is to preserve the added value that derives from the governance/ management divide, which good corporate governance practice emphasises.

Within management, the quality management system may be distributed through various groups that meet regularly, but the reporting line should be to the executive management and then through quality and assurance reports to the board. Any board sub- committee needs a direct line of sight to this system in order that it can provide triangulation and assurance. Management groups actually reporting to the board sub-committee itself, however, frustrate this scrutiny.

Good governance practice includes the programme of work for sub-committees of the board being linked to the board assurance framework, with the board commissioning the assurance function of the sub-committees and linking this to the strategic aims of the organisation. At the same time, a quality management system within management will itself be ensuring that the controls against risks identified in the board assurance framework are being applied, and so will continually be providing management with detail and assurance.

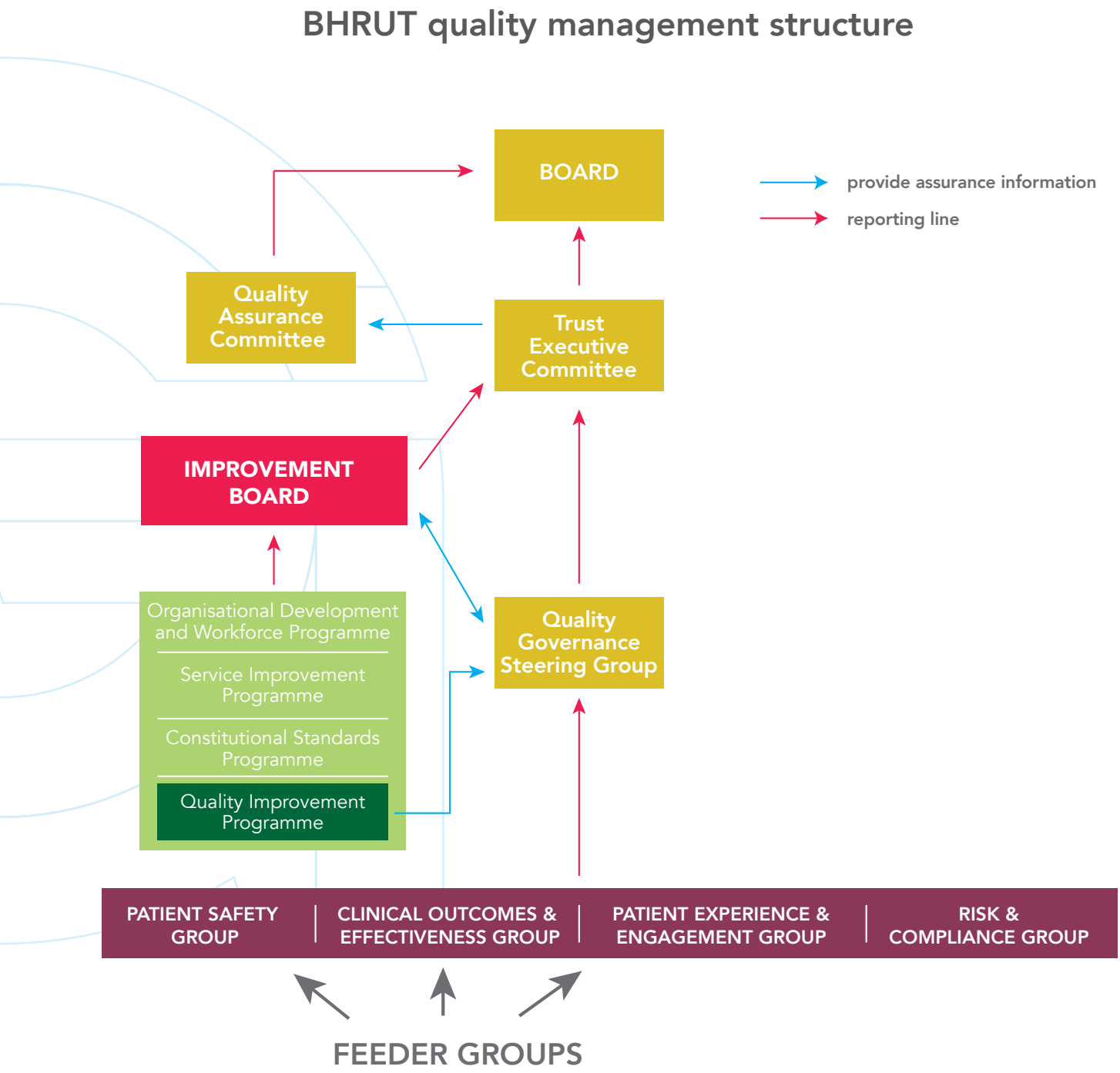
It is important to recognise that a key element of good quality management will be quality assurance, and the board's role, delivered usually through the work programmes of the sub-committees and management groups, will be to be assured that the quality management system is operating reliably and effectively.

Relevant to the three quality management groups, at this trust, the Quality Assurance Committee (QAC) and the Audit Committee will have roles in delivering this assurance to the board. This is described in Section 2.3.

2.3 Quality management structure at BHRUT

The redesigned quality management reporting structure at BHRUT is set out below:

Figure 1: Redesigned quality management structure at BHRUT



The three quality management groups - Patient Safety Group, Clinical Outcomes and Effectiveness Group and Patient Experience and Engagement Group - have been constituted under the authority of the board reporting to the Quality Governance Steering Group (QGSG), which in turn reports directly to the Trust Executive Committee (TEC), the principle executive group of the trust.

The three quality management groups are thus accountable to the QGSG and constituted to advise the group with regard to, for example,

- achievements exceptions
- themes and trends associated with patient experience
- any failings in regard to meeting the required healthcare or health and safety standards
- any arising quality issues

In addition, the trust's various 'feeder groups' report to the three quality management groups, and therefore also report through the management/ operational arm, as opposed to through the assurance arm.

The Chairs of the three quality management groups are members of the QGSG, and therefore are the critical link between the groups and the QGSG. The Patient Safety Group, Clinical Outcomes and Effectiveness Group and Patient Experience and Engagement Group at the highest level, are a key element of the trust's quality management machinery, and support the TEC to provide the quality-related assurances that lie within the board assurance framework.

The QGSG had a direct operational link upwards to the TEC, which is the executive body of the organisation accountable to the trust board, with responsibility for overseeing the delivery of the strategy and for the quality, financial, and operational management of the trust. The link between the quality management groups, QGSG and TEC therefore ensures that quality remains within the realm of management. The QAC is then constituted as the sub-committee responsible for assuring the trust board that all aspects of the quality and safety agenda are being met through the efficient application of a quality management system, and for scrutinising quality assurance and specific risks on behalf of the board – i.e. QAC has the role of ensuring that all the above is working.

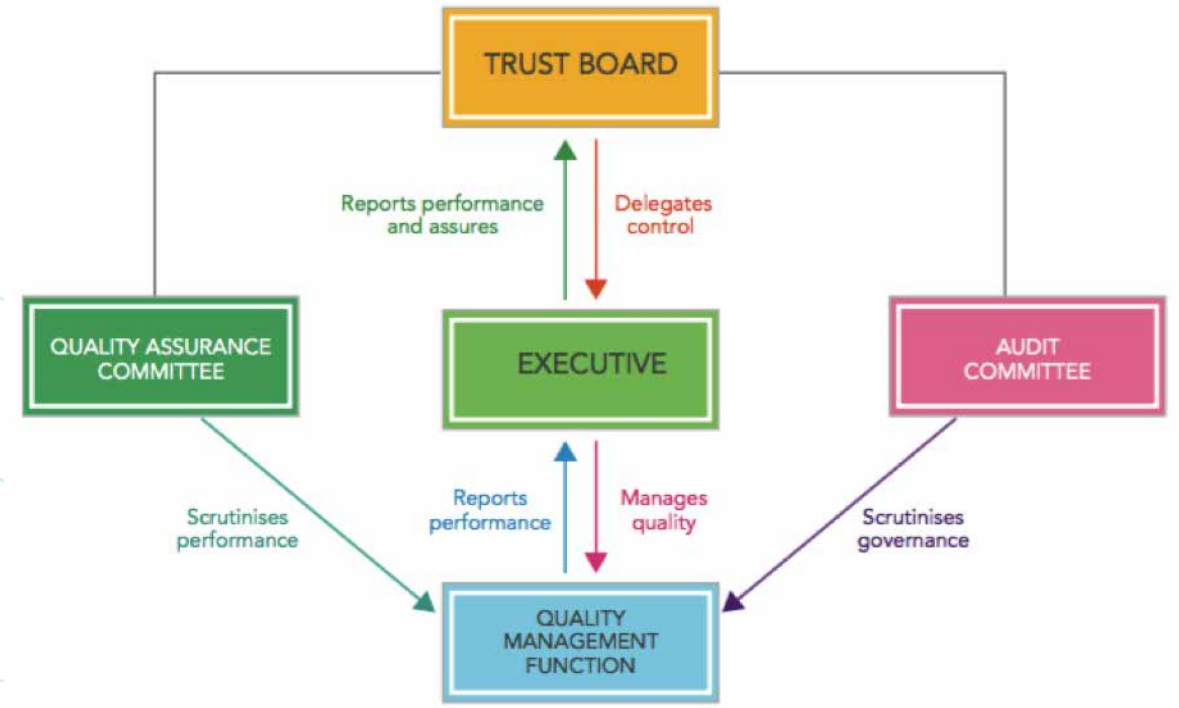
2.4 Quality assurance: roles at each level of the organisation

The board has a key role in safeguarding quality and therefore needs to give appropriate scrutiny to effectiveness, patient safety, and patient experience.

The QAC provides assurance to the board that the management mechanisms relating to patient safety, patient experience, and clinical outcomes and effectiveness are operating correctly. The trust's Audit Committee will also have a role in this.

The below chart sets out the quality assurance structure, describing the relationship between the quality management function and the relevant board sub-committees.

Figure 2: Quality assurance: roles at each level of the organisation



Role of the board

Quality governance refers to the board's leadership on quality and their ability to:

- understand the quality of services provided
- identify and manage risks to quality
- act against poor performance
- implement plans to drive continuous improvement

In an environment of tighter public finances and the need to make significant efficiency savings, it is crucial that all NHS boards are able to identify and manage risks to the quality of their services in the same way they would their financial position.

Ultimately, the BHRUT trust board is responsible for the quality of care delivered across all services and assumes responsibility for embedding a culture of continuous quality improvement and ultimately, for any failures in the quality of care.

Key to this is having robust governance arrangements, as displayed in **Figure 1** and **Figure 2**, that delegate the responsibility down the organisation to operational levels

Role of the Quality Assurance Committee (QAC)

Established to help the board develop and understand service quality issues.

Objective of the QAC: provides an independent and objective review of all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. The committee aims to ensure that the board mainstreams consideration of services and clinical issues over time. The QAC is responsible for providing the trust board with assurance on all aspects of quality of clinical care and regulatory standards of quality and safety.

Examples of the primary duties and responsibilities of the QAC:

- oversee an effective system for safety within the trust, with a particular focus on patient safety, staff safety, wider health and safety requirements
- oversee an effective system for delivering a high quality experience for all patients and users, particularly focusing on involvement and engagement for the purposes of learning and making improvement
- oversee an effective system for monitoring clinical outcomes and clinical effectiveness. This would typically focus on ensuring that patients receive the best possible outcomes of care across the trust
- assure and monitor the trust's maintenance of compliance with the CQC registration requirements through assurance of the systems of control. Obtain assurance that improvement reviews are implemented
- to assure the board that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality and care services
- oversee and assure the board on statutory and mandatory requirements, relating to quality of care
- to assure the board that where there are issues that may jeopardise the trust's ability for the provision and delivery of excellent quality care and services, that these are being managed in a controlled and timely way
- gain assurance over the full range of quality performance via, for example, the quality report, quality dashboard etc.

Role of the audit committee

A sub-committee of the board comprising non-executives directors and sometimes advisors, but not the Chair or Vice Chair. The audit committee assures the board that all the governance systems and processes, including the clinical ones, are working. The audit committee has a strong working relationship with the internal auditors, and may invite executive colleagues to attend and participate in meetings.

In the spirit of scrutinising all governance systems and processes, the audit committees would also examine systems for patient safety, complaints, information governance, clinical quality and clinical audit.

Objective: the audit committee is accountable to the board and has non-executive responsibility for oversight of, and advice to, the board on matters relating to effective corporate governance and financial reporting. The committee seeks assurance that financial reporting and internal control principles are applied and advises the board on the robustness of internal controls.

In addition, the audit committee must consider the clinical objectives and risks in the assurance framework and report to the board on controls and assurances in relation to these.

Examples of the primary duties and responsibilities of the audit commitee:

- provides the board with an independent and objective review of financial and corporate governance, assurance processes, internal controls and risk management across the whole of the trust's clinical and non-clinical activities, both generally and in support of the Annual Governance Statement
- monitors corporate governance, which includes aspects such as compliance with the constitution, codes of conduct, standing financial instructions, and maintenance of register of interests. The committee also obtains assurance as to the trust's systems of quality governance and oversees the work programmes for external and internal audit, receiving assurance of their independence
- examines systems for patient safety, complaints, information governance, clinical quality and clinical audit, ensuring that clinical audit is material. Clinical audit should be used as a tool in strategic management as part of the broader quality improvement programme

SECTION 3: Key elements of good meeting practice

The following section of this manual sets out the key elements of good meetings practice, which should be adhered to by all groups within the quality management function at the trust.

Section four of this manual then proceeds to set out a number of templates for use by the trust's quality management and 'feeder' groups.

Adhering to the guidance set out in this section of the manual and using the templates provided will support in strengthening the quality management function at BHRUT.

3.1. Quality and distribution of papers

The quality of meeting papers is of the utmost importance, serving as the key source of information in advance of a meeting. In this way, the standard of papers have a material impact on the quality of discussion, debate and decision-making at meetings.

How effectively a meeting runs is predicted, in part, by the **timely distribution** of papers to members of the group. Lead authors of papers are responsible for ensuring that submitted papers **summarise key points** in sufficient detail to **enable an informed discussion.**

Recognition should be given to the limited time that those attending meetings often have available. Each agenda item and supporting paper should therefore be **précised** to provide **clarity on context and purpose** together with the **key issues and risks** arising from the paper and **expectations in terms of decisions.**

Inclusion of an **executive summary** can be a very effective means of ensuring members are appropriately sighted on the context, purpose and expectation of the paper.

The use of **graphs, tables** and **bullet points** can support lead authors in adopting a style of report that **makes clear required actions to address any issue** (e.g. who, what, when, how etc.), as opposed to descriptive reports that simply describe the issue.

It is important that when writing a paper, attention is given to each of the sections (where appropriate) detailed in the checklist included on the following page.

Cover sheet

The cover page provides the reader with a clear overview of the key elements contained within the paper. It should be succinct whilst containing the below information:

a) The name and date of meeting at which paper is being presented

b) The status of the item:

i) is it a new item?
ii) or an item that has been previously considered at this meeting?

c) The name of the report author

d) The name of the Lead Officer (if different from the above)

e) The action for the meeting. Is the paper to:

i) note for assurance
ii) approve
iii) endorse
iii) or does it require a decision?

f) The forums where the paper has been previously considered and the dates of these meetings

g) Short executive summary:

- provide a brief summary of your report, summarising the main points of the underlying paper, and drawing out the key recommendation/s. The executive summary needs to standalone. It must give members of the group a brief yet clear outline of purpose, implications, risks, and mitigation.

Include:

- *Why has this report been brought to this meeting?*
- *What are the 3 -5 key headlines?*
- *What are the actions required?*

h) The implications of the findings of the paper on, for example:

i) patient safety
ii) financial
iii) legal/ regulatory
iv) equality (if an Equality Impact Assessment (EIA) is not required, there may nevertheless be an equality impact. For example, your paper may provide information to support the trust to meet its commitments to equality. This must be summarised here. If there is no impact on equality, diversity, or inclusion this also should be stated)

i) The **equality impact** (noting whether an equality impact assessment has been completed / is not applicable) - if the paper relates to a new or amended policy, procedure or protocol; a change to service provision or the development of a strategy, you are required to conduct an EIA using the "Equality Impact - Policy Service, Strategy, Procedure - Guidance and forms" on the HR Section of the trust intranet.

j) The range of consultation and communication - how you have consulted/plan to consult with key stakeholders, and how you will communicate internally and externally

k) The date the report is due for review

Report structure

When writing a report, the below should be considered/included:

a)	Title of paper
b)	Table of contents
c)	**Executive summary:** this should be a concise headline summary of the paper / report, which enables the reader to understand the essence of the paper without having to read the whole document / finer detail. An executive summary should include: i) the scope and objective of the paper (purpose) ii) the key findings / results iii) any particular issues of note / concern iv) the key actions required v) whether the paper / report is being presented for assurance / approval / decision
d)	**Brief introduction, background and context:** detail on the nature / function of the report
e)	**Discussion / analysis:** may include key risks and mitigations; resource consideration etc.
f)	**Success criteria**
g)	**Conclusion / summary**
h)	**Recommendations**
i)	**Actions:** what is the paper asking from the board / sub-committee of the board
j)	**References**
k)	**Appendices**

3.2 Guidance for completion of reports

1. Executive summary

The executive summary is regarded as the most important section of any business report. It should always be written last, when authors have finished the main body and recommendation of their report.

1.1 What is an executive summary?

An executive summary is a short document or section of a document, produced for business purposes, that summarises a longer report or proposal, or a group of related reports, in such a way that readers quickly become acquainted with the contents of the body of a report without having to read it all. People who read only the executive summary should understand the essence of the document without the fine details. It contains a brief statement of the problem or proposal covered in the major document(s), background information, concise analysis and main recommendations/conclusions. It is intended as an aid to decision making by managers and is possibly the most important part of any business paper. It is essential that the executive summary is short and to the point.

1.2 Structure of the executive summary

A typical executive summary will:

- be as short as possible (approximately 5% maximum of the length of the main report) - maximum of two sides of A4 for large reports
- be written in language appropriate for the target audience and refrain from jargon
- consist of short and concise paragraphs
- start with a summary
- be written in the same order as the main report
- only include material present in the main report
- make recommendations
- provide a justification
- have a conclusion
- be able to be read separately from the main report

1.3 An executive summary is not...

It is essential that authors do not confuse an executive summary with an abstract.

An abstract is usually shorter and is intended to provide a neutral overview or orientation rather than being a condensed version of the full document. Abstracts are extensively used in academic research where the concept of the executive summary would be meaningless.

The executive summary is not background and not an introduction and should not include any new information that is not covered in the main body of the report. It should not be copied and used as a conclusion (the conclusion of a report is there to wrap-up the main points – an executive summary highlights them).

2. Main body of the report

The main body of the report needs to be a summary of the key parts of the whole proposal. If there are any Appendices attached to the report, reference to those Appendices must be included within the narrative in this section by either highlighting, emboldening, or placing in (brackets) in order that the reader can relate to what each Appendix refers to.

Data in the main report should be clear and not buried among words.

One or two pages of narrative that has a facing page with key data/tables on each subject could be used. This helps the author when writing reports that include narrative as well as data, and it is also helpful for the reader. Appendices are then just an opportunity to expand on the relevant data boxes.

3. Quality impact

If there are any quality implications that have been considered or need to be considered, they need to be referenced within this section. If there are no quality implications, this paragraph does not require including within the report.

4. Financial impact

If there are any financial implications that have been considered or need to be considered, they need to be referenced within this section. If there are no financial implications, this paragraph does not require including within the report.

5. Risks and mitigating actions

Any risk implications in relation to what is discussed within the report should be considered and included within this section together with the mitigating actions in place.

6. Conclusion and next steps

This would be used to summarise the report and should be clear and to the point, highlighting if there are any next steps required.

7. Recommendations

Recommendations need to be succinct and fluent and the purpose is to make it clear what you are asking of the board. Ideally, no more than one or two paragraphs in total.

8. Appendices

It is the author's responsibility to ensure that any Appendices are not embedded within the main body of the report as this looks untidy and unprofessional.

3.3 Style guide for reports

1. (Sub Heading) font style and size

To ensure that all reports look professional, one font style and font size should be used. The trust would like to use 'Arial' font. The main headings of the report are required to be font size 12 and everything else font size 11.

The use of underscoring should be limited (highlighting narrative to draw attention to the reader is seen more user friendly when embolden is used).

2. Numbering

All headings should be referenced by a number and sub-numbering should be used as below.

3. Spacing (sub-numbering)

Single spacing should be used throughout for narrative reports, with one clear line space between paragraphs and headings.

4. Alignment

Reports should be left aligned as standard and justified.

5. Tables

Any tables should include an appropriate heading and be referenced within the narrative for the reader's ease of reference.

6. Acronym

If acronyms are used, the full title or description needs to be included first with the shortened acronym following and highlighted in brackets i.e. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). If the author wishes to use the acronym again once it has been referenced and included within (brackets) this would be done without the use of any brackets, i.e. BHRUT.

7. Page numbering

All pages are required to be numbered at the bottom of every page.

8. Transparency/openness

The Health and Social Care Act (2012) requires openness and transparency, which the trust fully supports. Authors are, however, asked to be mindful of the appropriate language used when writing reports.

The following key questions should be considered when writing a paper:

1. Is the purpose of the paper clear (e.g. is it for assurance, decision, noting etc.)?
2. Who is the target audience and is the paper appropriate for them?
3. Is the paper an appropriate length for the meeting?
4. Is the paper presented in a way that is easy to understand and digest?
5. Does the paper cover the critical issues?
6. How will the paper be presented in the meeting?
7. How is the paper helping to provide assurance?

3.4 Terms of Reference: key elements

The Terms of Reference (ToR) for any meeting should be the principle document that describes a meeting's purpose, role ,and responsibilities. The ToR should include information on the following:

- **title** of the meeting
- **date the Terms of Reference was approved and the approving body**
- **constitution**
- **the purpose of the group:** what is the group expected to achieve?
- **membership:** which staff will make up the committee/group? This should include roles
- **attendance:** for those staff or stakeholders who are not full members, the conditions necessary for them to be in attendance (for example, members unable to attend must send a deputy who is briefed and able to make decisions on their behalf; there must be at least one representative from each division; members are expected to attend a minimum of 85% of meetings in person.
- **communication:** for example, notice of each meeting, including the agenda and supporting papers, to be made available to each member of the group one week prior to the date of the meeting. Expectations regarding submitting papers / agenda items should be made clear. For example, agenda items should be submitted at least two weeks before the date of the meeting.

- **quorum:** the number of members required to be in attendance to ensure that decisions taken are valid
- **the frequency of meetings:** how often the group will meet?
- **agenda and notes / action points:** who will be providing administrative support to the group
- **authority:** the authority that the group has been delegated
- **duties**: this will vary depending on the group – decision making duties; advisory duties; monitoring duties
- **accountability:** who is the group accountable to?
- **reporting responsibilities:** to include how the group reports up; publication of minutes
- **review of Terms of Reference:** when the Terms of Reference is scheduled for review.

3.5. Membership

In terms of group membership:

- it is good practice for membership to be reviewed annually, or as appropriate
- within the Terms of Reference for the meeting, the make-up of a meeting as well as the necessary attendance to ensure it is quorate should be specified
- when a member cannot attend, apologies should be given and if possible a suitable replacement agreed with the Chair
- members are expected to make every effort to attend all meetings and it is expected that they shall attend the majority of meetings
- an attendance register should be taken at each meeting and maintained on record

3.6. Agenda development

When developing the agenda, consideration should be given to the overall desired outcome of the meeting. Specifically, the following points should be considered:

- agendas should be created to reflect the annual work plan of the meeting, and can be pre-populated with items from the annual work plan
- agendas should be of an appropriate length for the time allocation of the meeting
- agenda items should be regularly scrutinised to ensure that they remain relevant
- it is the role of the meeting support to ensure that all items carried forward from previous meeting minutes and / or action logs are included within the relevant agenda
- utilising other communication channels for agenda items that are for information only could assist with streamlining the agenda, especially when agendas are particularly busy
- particularly challenging items should be placed earlier on in the agenda to ensure that priority is given to these items
- the inclusion of indicative timings on the agenda, whilst helpful when planning to ensure time is sufficient, can create added pressure and may result in discussions being inappropriately cut short – it may be appropriate during the course of a meeting to extend the time for a particular discussion item to enable a successful conclusion / decision to be agreed

3.7. Minutes

The proceedings of the meeting should be drawn up in to minutes, which should closely resemble the agenda of the meeting and include information such as location and time of the meeting, membership, apologies and those in attendance.

On completion, minutes should be submitted to the chair of the meeting for review. They should then be submitted for agreement at the next meeting, where they will be signed off as an accurate record by the chair of the meeting. Usually, the minutes from a previous meeting will not be discussed by members during the following meeting, except in terms of accuracy or where the chair deems it appropriate.

Should any amendments be required, these will be agreed during the meeting and the relevant amendments made.

It is good practice for minutes to be circulated within five working days of the meeting to all members.

3.8. Action log

Action logs are a key component of effective management – they identify how important tasks and objectives can be achieved and by when, and implementation of these tasks can be tracked and monitored over time.

Meetings can be supported in keeping on track of actions by maintaining and updating an action log. Action logs support in ensuring that tasks are owned and delivered to time, and should be included at the end of the minutes.

Actions should be **SMART**:

a) **Specific:** what exactly needs to happen?

b) **Measurable:** what indicator or evidence will be used to assess progress and completion?

c) **Assignable:** who will do it? Name or job title of relevant individual. Actions should not be assigned to teams

d) **Realistic:** what can realistically be achieved given available resources?

e) **Time-bound:** when will the results be achieved?

The action log must contain the following mandatory information:

a) **Date** of meeting where the action was discussed and the item number (as included within the minutes)
b) **Description of the action**
c) **Named lead individual:** the individual that the action is assigned to and who has responsibility for implementation. This should include the name and job title of the individual
d) **Target closure date:** date that the action is planned to be completed by: the deadline by which the action should be fully implemented, and influenced by the priority of the action. High priority actions should be addressed as quickly as possible as they represent a high risk. This date should be influenced by the priority of the action
e) **Current position:** narrative describing the status of the action/ progress/ current position
f) **Status of the action:** open or closed?
g) **RAG rated**, dependent on the status of the action:

- **Red:** there are significant issues with the delivery of this action, which require escalation. Corrective action is required to meet the objectives and this cannot be solely handled by the lead individual/ project team.
- **Amber:** an issue has a negative effect on the delivery of this action, but can be dealt with by the lead individual. Steps are in place to resolve the problem, which should be monitored.
- **Green:** the action is on track to be delivered to time.

Meeting administration: summary of expected standards

1. Draft agenda for each meeting agreed with the chair of the meeting and circulated to members at least 10 working days before the deadline for papers wherever possible.
2. Once the draft agenda has been agreed by the chair, additional items should only be added with the agreement of the chair.
3. Final agenda and papers distributed to members at least five working days before the meeting date (where possible).
4. No papers to be received/circulated late or tabled without prior agreement of the chair of the meeting.
5. Draft minutes and action log to be provided to the chair of the meeting within five working days of the date of the meeting.
6. Draft minutes and action log to be circulated to all members within seven working days of the date of the meeting.
7. An annual cycle of business will be in place for every meeting of the quality management groups and, where applicable, 'feeder' groups. These will be approved by the relevant meeting and then reviewed by the group, and re-circulated to all members at least quarterly.

3.9. Chairing

The chair of a meeting plays a pivotal role in ensuring the meeting operates effectively and fulfils its mandate, as set out in the meeting Terms of Reference. A good chair should:

- steer the meeting, ensuring each agenda item is kept to time
- effectively summarise the discussion following each agenda item
- ensure that actions and outcomes are clearly captured

Where the group is seeking assurance on a particular issue, sufficient time should be allowed to debate and discuss any areas of concern prior to reaching an agreed decision.

An expectation of the chair should be that all members of the group have read the submitted papers and therefore, agenda time should not be taken up by the presentation of papers.

Chairs should not direct the meeting, but should be comfortable in allowing debate, whilst utilising their facilitation skills to steer discussions appropriately and ensure that the meeting remains on track and to time. The chair should not be viewed by members of the group to overly influence the outcome of debates during the course of the meeting.

The chair should create an environment where all members feel comfortable to contribute to discussions. Members should feel as though they have had an opportunity to contribute to discussions and the chair should ensure less forceful members of the group are included by actively seeking their opinion. Similarly, where a member of the group appears to disengage from discussion, the chair should seek to re-engage them through, for example, a question or asking their opinion. This helps to instil the point that it is unacceptable for members to disengage.

Key duties of the chair:

- ensure relevant escalation rates are adhered to with regards to any material matters that have come to the attention of the group
- ensure that all significant risks are appropriately discussed and escalated, in line with the trust's Risk Management Policy
- encourage and create a culture where there is healthy debate
- review the minutes of the meeting, ensuring that they are an accurate reflection of the meeting
- ensure equal opportunity for participation and that no-one becomes isolated in expressing their view

3.10. Content and cycle of business

Meeting agendas should be developed with standing items agreed. Additional items can be added as necessary, as agreed with the chair.

One individual should be assigned administrative duties, for example, taking the minutes and working closely with the chair to plan the agenda.

The cycle of business for the group should also be agreed. This describes the schedule of work for the group throughout the year. It should be realistic, relevant and owned by the group.

In the case of the trust's quality management groups, the cycle of business between the Board Assurance Framework, the QGSG, three quality management groups and various 'feeder' groups must be aligned.

At the most practical level, the three quality management groups should be providing many of the assurances itemised on the Board Assurance Framework.

3.11. Meeting etiquette

Behaviours determine the actions of the organisation and are a vital element of good governance. Some behaviours are expected and prescribed, others reflect experience, styles and etiquettes adopted or learnt.

The chair of the meeting should encourage a culture where there is healthy debate and ensure that all members are given an equal opportunity to participate, with no-one becoming isolated in expressing their views. In addition, the chair should review the minutes of the meeting, ensuring that they are an accurate reflection of the discussions.

Duties of members and attendees:

Below are set out the primary duties of those attending meetings of the trust's quality management and 'feeder' groups:

- prepare and submit papers to time
- attend all meetings, be punctual and actively engage in, and contribute to, discussions to ensure that decisions have a multidisciplinary perspective
- if unable to attend a meeting, send apologies prior to the meeting and, if appropriate, seek the approval of the chair to send a deputy to attend
- read all papers and materials in advance of the meeting and be prepared to discuss them
- ensure agendas are sensible in terms of time allowance per item
- assume papers are read by members prior to the meeting and present only key points. This will ensure the best utilisation of time and ensure there is adequate time for discussion
- be honest, open and constructive
- show determination, tolerance and sensitivity – rigorous and challenging questioning, tempered by respect
- respect one another as possessing individual and corporate skills, knowledge and responsibilities. Be courteous and respect freedom to speak, disagree or remain silent
- support the chair and colleagues in maximising the scope and variety of viewpoints heard
- challenge constructively
- disseminate learning and action points arising from the meeting to appropriate staff
- when matters are discussed in confidence during the meeting, to maintain such confidences

- declare any conflicts of interest/potential conflicts of interest in accordance with trust policies and procedures and, at the beginning of each meeting, declare any conflicts of interest in respect of specific agenda items (even if a declaration has previously been made in accordance with trust policies and procedures)
- ensure no-one becomes isolated
- take decisions and abide by them
- make the most of time

Members should not:

- act as 'stoppers' or 'blockers'
- regard any arrangements as un-manageable or unchallengeable
- adopt territorial attitudes
- give offence or take offence
- regard papers presented as being 'rubberstamped' without discussion or agreement
- act in an attacking or dismissive manner
- become obsessed by detail and lose the strategic picture
- breach confidentiality

Alongside this, it is important that a meeting etiquette is developed which clearly sets out expected standards of behaviour. The development of a meeting etiquette will support a collective understanding regarding the process of the meeting and clarity of expectations.

A **meeting etiquette template**, developed by the Good Governance Institute, is included within **Section 4**.

SECTION 4: Tools and templates for use by the trust's quality management and 'feeder' groups

The following templates are provided within this section of the manual for use by the trust's quality management and 'feeder' groups:

- front cover sheet
- standard report template
- divisional feedback template
- Terms of Reference
- action log
- meeting etiquette
- maturity matrix to support the implementation of good meeting practice
- identifying the purpose of a group: SIPOC (supplier, input, process, output, customers)

4.1 Front cover sheet template

Title of meeting:	Date:	Agenda Item:

PAPER TITLE

Status:	☐ New item	☐ Previously considered	
Action:	☐ Note for assurance (i.e. for information and to evidence action taken and progress/status)	☐ Approve (i.e. approve actions or recommendations outlined in the report)	☐ Endorse (i.e. agree the suggested course of action; more details still to be provided for further approval)

Executive Summary:

This section is to provide a brief summary of your report summarising the main points of the underlying paper, and drawing out the key recommendation/s. The Executive Summary needs to standalone. It must give members of the group a brief yet clear outline of purpose, implications, risks and mitigation.

Include:

- Why has this report been brought to this meeting?
- What are the 3 -5 key headlines?
- What are the actions required?

Decision:	***The [name of meeting] is asked to……***		
Implications:			
Patient safety:	Maximum two sentences		
Financial:	Maximum two sentences		
Legal/Regulatory:	Maximum two sentences		
Equality impact Check this box if you have completed an Equality Impact Assessment (EIA) ☐ Check this box if the EIA is not applicable ☐	If the paper relates to a new or amended policy, procedure or protocol; a change to service provision or the development of a strategy, you are required to conduct an Equality Impact Assessment using the "Equality Impact - Policy Service, Strategy, Procedure - Guidance and forms" on the HR Section of the Trust intranet. You must check the box to the right to confirm that this is complete and include a summary of the outcome here. If an EIA is not required, there may nevertheless be an equality implication; for example, your paper may provide information to support the Trust to meet its commitments to equality. This can also be summarised here.		
Consultation and communication	How you have/plan to consult with key stakeholders and how you will communicate internally and externally. Maximum two sentences.		
Author	Name	Job title	Ext
Lead officer (if different)	Name	Job title	Ext
Review date(s)	*Enter a date*		

4.2 Standard report template

PAPER TITLE

1 EXECUTIVE SUMMARY / PURPOSE OF THIS REPORT

1.1

1.2

2 BACKGROUND AND CONTEXT

2.1

2.2

3 [ENTER SECTION HEADING]

3.1

3.2

4 [ENTER SECTION HEADING]

4.1

4.2

5 KEY RISKS AND MITIGATIONS IN PLACE

5.1

5.3

6 RESOURCE CONSIDERATIONS

6.1

6.2

7 LEARNING POINTS

7.1

7.2

8. CONCLUSIONS AND NEXT STEPS

8.1

8.2

9 ACTION REQUIRED FROM THE GROUP

9.1 The Group is asked to:

a)

b)

10. APPENDICES

4.3 Divisional feedback template

[NAME OF GROUP]

DIVISIONAL FEEDBACK

We would welcome your feedback about any work that you are doing regarding patient experience and plan to do with patient partners

DATE	
DIVISION / AREA	
Top positive change implemented	
Top challenge for Division	
Exception Report	

4.4 Terms of Reference template

Title:	*[Enter name of group]*
Date approved and approving body:	*Reviewed on [enter date] at the [enter name of approving body].*
Constitution:	
Purpose:	*The purpose of the [enter name of group] is to….*
Membership:	*[List roles]*
Communication:	*A notice of each meeting, including an agenda and supporting papers, will be available for each member of the [enter group] two weeks prior to the date of the meeting.* *Agenda items should be submitted at least three weeks before the date of the meeting, to the [enter name of Chair].*
Quorum:	*A quorum shall consist of at least one third of the membership.*
Frequency of meetings:	*[Monthly]*
Agenda and notes/ action points:	*Support to the [name of group] will be provided by …….*
Attendance at meetings:	*Members unable to attend must send a deputy who is briefed and able to make decisions on their behalf.* *There must be at least one representative from each Division at each meeting.* *Members are expected to attend a minimum of 85% of meetings in person.*
Duties – decision making:	

Duties – advisory	
Duties – monitoring (includes healthcare standards that the group monitors)	
Accountability:	*The [name of group] is accountable to the .....*
Sub-committees	*The following groups are sub-committees / groups of the [enter name of group], which will maintain an overview of their activities, either by receiving minutes, or reports from them:* • *[Group 1]* • *[Group 2]* • *[Group 3].....*
Reporting responsibilities:	*Approved minutes submitted to.....*
Review:	*The Terms of Reference for the [enter name of group] were reviewed and considered at the [enter name of group] on [enter date]. The Terms of Reference were formally reviewed at the [enter name of group] on [enter date].* *Terms of Reference will be reviewed on [enter date].*

4.5 Action log template

TITLE OF MEETING
ACTION LOG FOR MATTERS ARISING FROM MEETINGS

Meeting Date	Item No.	Action	Lead individual (including job title)	Target closure date	Current position	RAG rate (Red/Orange/Green)

4.6 Meeting etiquette

Meeting etiquette

1. We will adopt the following:

- **Mutual trust and respect; honesty**
- **Commitment to:**
  - attending, reading briefings, and clarifying any points of detail with the relevant author before the meeting, arriving on time and participating wholeheartedly. Tell our offices we are not to be disturbed
  - taking decisions, and abiding by them
  - being honest, open and constructive
- **Determination, tolerance and sensitivity:**
  - rigorous and challenging questioning, tempered by respect
  - demanding and persistent rather than attacking, crushing or dismissive
- **Group support:**
  - support each other. Be courteous and respect freedom to speak, disagree or remain silent
  - listen carefully to all ideas and comments and be tolerant to other points of view
  - regard challenge as a test of the robustness of arguments
  - sensitive to colleagues' need for support when challenging or being challenged
  - the group ensures no one becomes isolated in expressing their views. All ideas treated with respect
  - respect one another as possessing individual and corporate skills, knowledge and responsibilities
- **Confidentiality**
  - candid not secret. No gossip, or gossip is shared and aired
- **Making the most of time:**
  - support the chair, colleagues and guests in making best use of time to maximise scope and variety of viewpoints heard
  - time is well used and individual points are relevant and short

2. We will not:

- refer to past systems or mistakes as being responsible for today's situation
- act as 'stoppers' or 'blockers'
- regard any arrangements as unchangeable or unchallengeable
- adopt territorial attitudes – any member of the team has the right to challenge/question another
- avoid giving offence – be ready to apologise
- avoid taking offence – stay open to discussion
- regard papers presented as being 'rubberstamped' without discussion and agreement
- act in an attacking, crushing or dismissive manner
- become obsessed by detail and lose the strategic picture
- breach confidentiality – will be candid not secret

3. At the end of each meeting

We will allow time for review of performance against the above standards at the end of each meeting. For example:

- Did we use our resources well?
- Who else should have been here?
- What decisions were taken?
- Are all members clear on their responsibilities?

4.7 Maturity matrix to support the implementation of good meeting practice

There are some essential elements critical to securing the best outcomes from the time spent in meetings. The Good Governance Institute (GGI) have produced a maturity matrix to support the implementation of good meeting practice, which can be used to track improvements in the standard of meetings over a developmental period. The key elements included within the matrix against which progress can be measured are as follows:

- *structure*
- *engagement*
- *recording and action plans*
- *content and cycle of business*
- *communication*

The horizontal axis of the matrix include six levels of maturity:

- **basic:** principle accepted and commitment to action
- **early progress:** early progress in development
- **firm progress:** progress becomes mainstreamed
- **results:** initial achievement evident
- **maturity:** results systematically achieved over time
- **exemplar:** others learning from consistent achievements

In order to assess the current standard of practice against each of the key elements described, evidenced examples need to be given to match the activities within each progress box. The rate of progress is incremental, and it is not possible to progress to the next level of maturity unless all criteria from the previous box has been fulfilled and can be evidenced.
To use the matrices, Members should identify the level they believe they have achieved and can evidence, as well as identifying the level they intend to reach within a given timeframe (for example, six months or a year). Those involved in the process should also identify the steps they will take to achieve the intended level of maturity and how they will evidence this.

Maturity matrix to support the implementation of good meeting practice: definitions

- **BAF:** Board Assurance Framework
- **CCG:** Clinical Commissioning Group
- **CQC:** Care Quality Commission
- **HQIP:** Healthcare Quality Improvement Partnership

Good Governance Institute

A maturity matrix to support the implementation of good meeting practice

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

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4.8 Identifying the purpose of a group: SIPOC (supplier, input, process, output)

4.8.1 What is SIPOC and when to use it?

On assessing the operation and effectiveness of a group, the SIPOC process management framework, a tool from the Six Sigma improvement methodology, offers a useful guideline. Using the SIPOC analysis requires consideration of the following for the group in question:

SUPPLIERS	INPUT	PROCESS	OUTPUT	CUSTOMERS

The tool clarifies who inputs in to the process, what specifications are placed on the inputs, who the true customers of the inputs are, and what the requirements of the process are. Taking a board sub-committee for example, their 'customers' could be understood as the board, and internal and external auditors, while the 'outputs' would include committee reports and papers. Similarly, for the trusts three quality management groups (Patient Safety, Patient Experience and Clinical Outcomes and Effectiveness Group), the customer could be considered as the Quality Governance Steering Group whilst the outputs would be group reports and papers.

In this way, the SIPOC framework can be used to understand and test assurances and create a common understanding of where improvements and clarifications are required.

The SIPOC tool can also be used when commencing a process management or improvement activity in order to get a high-level understanding of the scope of the process first. It provides a high level view of the "as is" state of a process and a structured way for a team to gain consensus on what a process involves. The tool is widely promoted in the Lean and Six Sigma approaches to quality management in healthcare systems to facilitate continuous improvement and eliminate waste in order to ultimately improve patient experience.

The SIPOC tool can be used by a team in order to identify all relevant elements of a process improvement project before work begins. It is particularly useful when it is not clear:

- who supplies inputs to the process
- what specifications are placed on the inputs
- who the true customers of the process are
- what the requirements of the customers are

4.8.2 Elements of a SIPOC

- **S (supplier):** entity that provides input(s) to a process. This could be internal or external to the organisation that performs the process.
- **I (input):** material or information that is required by the process in order to produce the output.
- **P (process):** steps or activities carried out to convert inputs to one or more outputs – i.e. a high level flow chart of about five core activities that form the process.
- **O (output):** one or more outcomes or physical products emerging from a process – products, services or technology that the process produces.
- **C (customer):** the main users of the output(s) of a process.

Each item listed under the 'input' and 'process' poses a potential source of variation in the overall output. Once all possible sources of variation have been defined, it is possible to start measuring them to:

- determine the significant sources and
- develop plans to control or reduce the variations in them

A simple SIPOC diagram may be helpful in revealing the areas that need to be measured and controlled in order to ensure quality outputs.

4.8.3 How to use the process map

1. Create an area that will allow the team to post additions to the SIPOC diagram e.g. flip charts with headings (S-I-P-O-C) written on each, or headings written on post-it notes posted to a wall

2. Begin with the process. Map the process in to four or five high-level steps.

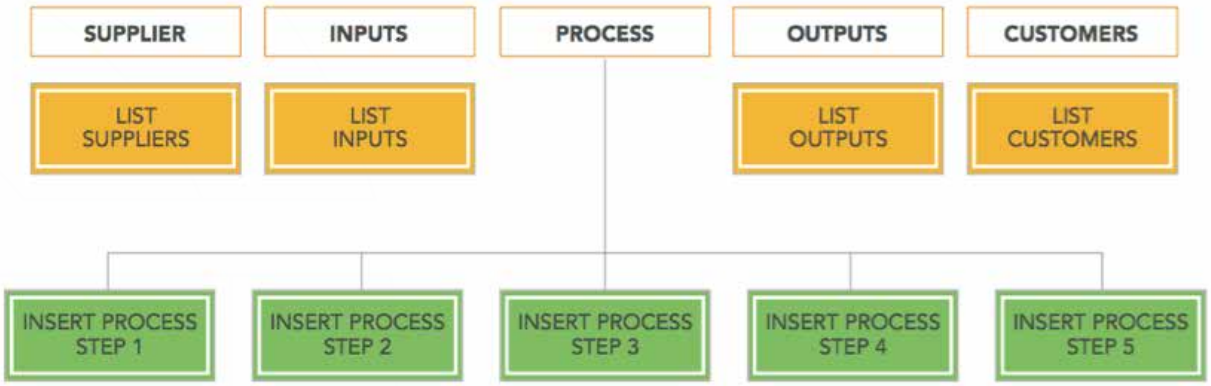
3. Identify the outputs of this process

4. Identify the customers that will receive the outputs of this process

5. Identify the inputs required for the process to function properly

6. Identify the suppliers of the inputs that are required by the process.

4.8.4 Template SIPOC



4.8.5 Beyond SIPOC

A SIPOC diagram can be the springboard to other critical activities in process improvement, each building to the next step. In particular, it can be used as the starting point for:

a) identifying sources of variation
b) metric identification
c) determining a relationship between the variables
d) generate improvement opportunities and projects
e) create a control plan

SIPOC sources:
https://www.isixsigma.com/tools-templates/sipoc-copis/sipoc-beyond-process-mapping/
https://www.isixsigma.com/tools-templates/sipoc-copis/sipoc-diagram/

Barking, Havering and
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NHS Trust