St George's Healthcare NHS
NHS Trust

QUALITY GOVERNANCE FRAMEWORK

Self- assessment of progress against the report by Deloitte from April 2013

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Contents

Introduction

As part of Monitor's Guide for Applicants (July 2010), aspirant Foundation Trusts (FTs) are required to:

- Provide Board certification that quality governance arrangements are satisfactory, accompanied by a Board memorandum
- Have a quality governance score of 3.5 or below with an overriding rule that none of the four categories of the Quality Governance Framework (QGF) be entirely amber/red rated
- Demonstrate attainment of a quality performance threshold

The QGF assessment is based on four domains:

- Strategy
- Capabilities and Culture
- Processes and Structures
- Measurement

The Trust originally undertook a self-assessment against the QGF which was approved by the Trust Board in October 2012, with a score of 3.5. Part of the FT process requires an independent external assessment of the QGF, which was undertaken by Deloitte in December 2012. At this time Deloitte scored the Trust at 5.0, which was above the level of 3.5 required for Monitor to consider an application. The Trust put in place an action plan to address the issues identified, and Deloitte repeated their assessment in April 2013, when the Trust was assessed as having a score of 3.5 (the level required by Monitor).

The QGF external assessment is considered by the NTDA to be valid for a 1 year period, which the Trust was within when it made its final submissions to the NTDA in December 2013. It is therefore good practice that the Trust refreshes this assessment after one year. It should be noted that the Trust will be required to submit an updated Board Quality Memorandum to Monitor, and it is anticipated that this will be presented to the May Board meeting for approval.

Actions for the Trust Board:

The Trust Board is asked to review the revised score for each domain, and approve this subject to any revisions that may be required. Any of the documentary evidence referred to can be provided to the NTDA/ Monitor if required.

QGF Action Plan: Governance Arrangements

Following the Deloitte assessment and final report, which was received in December 2012, the Trust put in place an action plan to address each recommendation made by Deloitte.

Each action has an executive director lead responsible for its delivery and completion. A monthly progress report against the action plan is presented to the FT Programme Board for review and approval, with exception reporting where any actions are delayed against the expected completion date. As an action is closed, evidence is collected to support this decision.

At the time of the reassessment by Deloitte in April 2013, they confirmed that 10 of the original 21 recommendations had been fully actioned by the Trust and could be considered to be closed.

The QGF action plan and evidence of completed actions was submitted to the NTDA in December 2013 as part of the FT preparation documentation required. The Trust's repeat QGF self-assessment detailed below should be read in conjunction with the action plan, where evidence of the progress made against each recommendation is detailed. (The action plan is included for information as an appendix.)

The changes to the score for each domain is linked to the completion/ progress against each of Deloitte's recommendations for that domain.

QGF RAG RATING COMPARISON SUMMARY

Indicator	Section	Deloitte RAG December 2012	Deloitte RAG April 2013	Trust RAG March 2014
1. Strategy	1A Does quality drive the Trust's strategy?			
	1B Is the Board sufficiently aware of the potential risks to quality?			
2. Capabilities and Culture	2A Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?			
	2B Does the Board promote a quality focussed culture throughout the Trust?			

QGF RAG RATING COMPARISON SUMMARY (continued)

Indicator	Section	Deloitte RAG December 2012	Deloitte RAG April 2013	Trust RAG March 2014
3. Processes and Structures	3A Are there clear roles and responsibilities in relation to quality governance?	0.5	0	0
	3B Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	0.5	0.5	0.5
	3C Does the Board actively engage patients, staff and other key stakeholders on quality?	0	0	0
4. Measurement	4A Is appropriate quality information being analysed and challenged?	0.5	0.5	0.5
	4B Is the Board assured of the robustness of quality information?	1.0	1.0	0.5
	4C Is quality information being used effectively?	0.5	0	0
TOTAL TRUST SCORE:		**5.0**	**3.5**	**3.0**

EVIDENCE TO SUPPORT CHANGES TO THE QGF SCORES

Indicator	Section	Progress and Evidence
1. Strategy	1A Does quality drive the Trust's strategy?	Deloitte identified a requirement for the Trust to ensure the effectiveness of the appraisals system in cascading quality objectives; and to continue to assess the effectiveness of appraisals in this area (QGF action 2). The appraisal documentation now includes a section related to the Trust's objectives, including the quality objectives. EMT has approved incremental progression being linked to performance, which includes performance in support of the quality objectives. The action has been formally closed down as it is now being managed as part of business as usual through the Director of HR. Deloitte identified an action related to all managers having a clear understanding of how key messages should be cascaded to their staff, setting out how activities relate to the broader quality agenda. It was recognised at the time of the reassessment in April 2013 that the Listening into Action programme had started, and that as part of this the Trust should continue to monitor progress against the original recommendation (QGF action 3). The LiA programme has been in place for more than 1 year now and will now continue as part of business as usual, with regular reporting and monitoring. The Trust's self-assessment score continues to be 0.5 in recognition of the fact that both recommendations are issues that will require ongoing attention and monitoring, rather than a more straightforward "task and complete" type of action.
	1.B Is the Board sufficiently aware of the potential risks to quality?	Assessed by Deloitte as being complete in April 2013. There have been no changes since April 2013 to make the Trust consider that its position has changed since April 2013.

EVIDENCE TO SUPPORT CHANGES TO THE QGF SCORES (continued)

Indicator	Section	Progress and Evidence
2. Capabilities and Culture	2A Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	Deloitte identified a requirement to assess the effectiveness of the changes that had been made at Board level, and in particular the change to the Chief Nurse portfolio to include Director of Operations; the increased accountability of the Clinical Divisions; and the appointment of two new NEDs in January 2013 (QGF action 7). Completion of this action will be demonstrated through the: • Divisional governance review report: action is already underway to recruit to a Chief Nurse and separate Director of Delivery and Improvement role. • Annual Board committee effectiveness review • Executive director appraisals Deloitte identified the need for the membership of QRC to be reviewed to ensure it is fit for purpose and that the effectiveness was assessed (QGF action 8). This action has been completed and is closed. Deloitte identified the need for the Board development programme to reflect the needs of individual members, and as part of this the requirement for the completion of a Board skills audit (QGF action 9). This action has been completed. There is a plan in place to determine the content of the Board development programme from April 2014, again based on the needs of the Board members. On the basis that QGF action 7 is not yet completed, the Trust's self-assessment score continues to be 0.5 at present.
	2B Does the Board promote a quality focussed culture throughout the Trust?	Deloitte identified an action to ensure that the processes and programmes for Board engagement with frontline staff are effective. The April 2013 reassessment defined this more specifically as relating to the 15 Steps Challenge, and the need to assess the impact of changes as a result of this (QGF action 10). The 15 Steps Challenge has now been replaced by Quality Inspections. The action has been closed down on the basis that there are weekly reports to EMT and this is managed as part of business as usual. However, The Trust's self-assessment score continues to be 0.5 in recognition of the fact that effective engagement with frontline staff does require ongoing attention.

EVIDENCE TO SUPPORT CHANGES TO THE QGF SCORES (continued)

Indicator	Section	Progress and Evidence
3. Processes and Structures	3A Are there clear roles and responsibilities in relation to quality governance?	Assessed by Deloitte as being complete in April 2013. There have been no changes since April 2013 to make the Trust consider that its position has changed since April 2013.
	3B Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	Deloitte identified the need to ensure effective mechanisms are in place for all incident reporting that enable staff to learn and share experiences. The reassessment in April 2013 identified a need to demonstrate the positive impact of the improvements that had been put in place, particularly in relation to the feedback mechanisms and learning (QGF action 12). The positive impact of improvements was demonstrated via a report to the Patient Safety Committee in November 2013 in relation to maternity never events and the reduction in moderate levels of harm that occurred to patients. On this basis, this recommendation is considered to be closed. Deloitte identified the need to establish a clear internal audit programme that can directly evidence links to the quality governance agenda, with a focus on bringing together the clinical and internal audit plans to map assurances to the Board (QGF action 13). The internal and clinical audit plans for 2014-15 were mapped as part of the QRC meeting in September 2013, and QRC was assured that there was a sufficient link between the two plans. This action is therefore considered to be complete. These actions have now been closed down as complete. However, The Trust's self-assessment score continues to be 0.5 in recognition of the fact that effective mechanisms to ensure staff learn and share experiences from incident reporting will require ongoing attention.
	3C Does the Board actively engage patients, staff and other key stakeholders on quality?	Deloitte scored the Trust as meeting or exceeding expectations for this domain in April 2013 (i.e. a score of 0), although there was one outstanding recommendation (QGF action 16), which related to the implementation of the Patient and Public Engagement Strategy (as part of the Communications Strategy). The Trust has closed this action on the basis that the Patient Reference Group has been involved in a number of initiatives that have led to quality improvements. The Trust's self-assessment score for this domain is 0, in line with the previous score from Deloitte.

EVIDENCE TO SUPPORT CHANGES TO THE QGF SCORES (continued)

Indicator	Section	Progress and Evidence
4. Measurement	4A Is appropriate quality information being analysed and challenged?	Deloitte identified the need to develop further the use of thematic reviews to monitor overarching issues within Divisions, including adherence to policies. As part of their reassessment in April 2013, Deloitte identified that the pilot was still at the testing phase and needed to move to the implementation phase if considered appropriate (QGF action 18). There has been a significant amount of work undertaken in relation to this over the last year, which has been overseen by the QRC which has received regular reports of progress. A summary report of the pilot exercise which had been undertaken was presented to the QRC in January 2014. The Trust view is that this action has now been completed, but Deloitte will be asked to review the actions undertaken to determine whether they agree that this meets the recommendation that they had made, and therefore can be closed. On this basis, the Trust self-assessment score for this domain continues to be 0.5 at present.
	4B is the Board assured of the robustness of quality information?	Deloitte recommended that the Trust put in place a data quality strategy, supported by a comprehensive programme of data quality review, to be used as a tool to allow the Board to review the progress and the degree of assurance it could obtain relating to the information it received. The reassessment in April 2013 identified that there had been no change to the level of assurance to the Board regarding the quality of data being monitored (QGF action 19). A project plan that would address this action was agreed by Deloitte and has been fully implemented, with regular reporting now to the FPI Committee. On this basis, the action is considered to be complete. The Trust's self-assessment score is now 0.5, which reflects the fact that there needs to be an audit trail from the FPI Committee to support this now being part of business as usual in a sustainable way (which would then warrant a score of 0).
	4C Is quality information being used effectively?	Assessed by Deloitte as being complete in April 2013. There have been no changes since April 2013 to make the Trust consider that its position has changed since April 2013.

Summary

Deloitte's independent assessment in December 2012 gave the Trust a score of 5.0 and identified 21 recommendations that needed to be completed. An action plan was put in place by the Trust to address these areas.

The Deloitte reassessment in April 2013 confirmed that 10 of these actions had been completed, and that the Trust's score had reduced to 3.5, which is the minimum level required for an organisation to be referred to Monitor for FT assessment.

Since April 2013 the Trust has closed a further 8 actions, with 3 actions ongoing. These relate to:

- Evaluation of the effectiveness of the changes at Board level and within the Divisions
- An internal audit programme that is correlated to the clinical audit programme to give the Board comprehensive assurance
- Development of the use of thematic reviews to monitor overarching issues within Divisions including adherence to policies

An action plan remains in place to address these outstanding issues, which is overseen by the FT Programme Board.

The Trust has assessed itself as having a score of 3.0 at present, which remains below the required level for referral to Monitor for assessment. As part of the preparation for Monitor assessment, a full Board quality memorandum with supporting evidence will be presented to the Trust Board in May 2013 for review and approval.

APPENDIX

QUALITY GOVERNANCE FRAMEWORK ACTION PLAN

DELOITTE QGF REPORT ACTION PLAN: DATE 19th March 2014							
ID and Page No.	**Deloitte Recommendation**	**Risk RAG**	**Lead**	**Executive Lead and Committee responsible for overseeing implementation**	**Trust Action required**	**Progress Update**	**Date for Completion of Action and Progress RAG Rating**
	DOMAIN 1a: STRATEGY						
QGF1 p.11	Clinical Divisions should have explict plans to deliver the Quality Strategy and Clinical Strategy	A/G	Divisional Chairs	Trudi Kemp Business Planning Implementation Goup EMT	Include as part of the Trust business planning process	**January 2013:** Business planning process is ongoing. A review of how each division plans to deliver the quality and clinical strategies will take place as part of the review of business plans in late January/early February 2013. **February 2013:** Business planning process is ongoing. A review of how each division plans to deliver the quality and clinical strategies is taking place as part of the 2nd review of business plans in early March 2013. **March 2013:** Business planning process is ongoing. Draft business plans specifically address issues in Quality and Clinical Strategies. **April 2013:** Divisional business plans are finalised and will be presented to the Board strategy seminar on 25th April. Each has a section in quality	**COMPLETE**

	DOMAIN 1a: WORKFORCE						
QGF2 p.11	**The Trust should ensure the effectiveness of the appraisal system in cascading quality objectives** **QGF Refresh:** The Trust will need to continue to assess the effectiveness of appraisals in this area given the recent changes.	**A/G**		Wendy Brewer Workforce and Education Committee	Review the appraisal documentation to ensure clear links to the Trust quality strategy	**January 2013:** The appraisal documentation will be reviewed to ensure a link to objectives for 2013-14 and to the Trust quality improvement strategy. **February 2013:** Update as above **March 2013:** The appraisal rate was 79% at the end of February and the plan remains to reach 85% by the end of March. Appraisal documentation will be reviewed following approval of the Trust objectives and 2013-14 business plan at the March Board meeting to ensure that the appraisal documentation links to the Trust objectives. NHS Employers are due to publish a Performance Framework in early 2013-14, and the appraisal documentation will also need to reflect this. **April 2013:** The appraisal documentation has been updated to reflect the Trust's objectives, including quality objectives **May 2013:** A paper on incremental progress based on performance was presented to the Workforce Committee on 23rd May, which included a clear link between the Trust and quality objectives to the appraisal process. This is based on adherence to Trust behaviours and meeting personal objectives. The new system will be piloted initially with staff on A4C bands 8-9, and will be a 12-18 month project. **June 2013:** A further paper will be submitted to the Workforce Committee in July for consideration.	**COMPLETE**

QGF2 p.11	Continued					**July 2013:** The paper on incremental progression based on performance has been approved by EMT and will be taken to the Partnership Committee on 18th July for approval. A project group will be set up to oversee the implementation. The first stage of implementation will be that managers will only receive an increment if they have 100% compliance for thier staff appraisals being up to date. The Workforce Committee will oversee progress. On this basis, this action is considered closed and will be monitored as part of business as usual.	
QGF3 p.11	**The Trust should ensure that all managers have a clear understanding of how key messages should be cascaded to their staff, setting out how activities relate to the broader quality agenda** **QGF Refresh:** Listening into Action is a 1 year structured programme that has started recently and as this builds momentum the Trust will need to continue to monitor progress against the above recommendation.	**A/G**	Louise Halfpenny	Peter Jenkinson Workforce and Education Committee	Discuss and agree how messages should be cascaded and ensure this links to the Leadership Framework Implementation of actions that emerge from the LiA events Redo the Pulse Chck after 6 months to assess the effectiveness of those actions	**January 2013:** Meeting has taken place. A communications framework will be developed to co-ordinate with the leadership framework, the proposed board development programme and the Trust values engagement programme. As part of the launch of "Listening into Action", all methods of staff engagement and the effectiveness of each method will be reviewed. **February 2013:** As above **March 2013:** The Trust has now embarked on the Listening into Action programme, which is formally structured to take place over a one year period. A LiA Sponsor Group is in place, chaired by the CEO, which has met three times to date regarding implementation. A pulse survey will be sent out before the end of March and a random group of circa 600 staff will be invited to take place in 'big conversation' events in May. As part of the Communications Strategy the implementation of the Team Brief system wil be reviewed. **April 2013:** LiA Big Conversations under way **May 2013:** as above **June 2013:** First ten teams and quick wins agreed. **July 2013:** A LiA review event is planned for December 2013 **August 2013:** LiA review event confirmed for 13th December 2013	**COMPLETE**

QGF3 p.11	Continued					**September 2013:** The comms implementation plan includes regular staff newsletters and briefings which will be put in place. **October 2013:** Regular staff newsletters and briefings to supplement those already in place will begin in January 2014, in line with the comms implementation plan. **November 2013:** A LiA "quick wins" plan is in place and monitored by the LiA sponsor group to ensure it is progressed. **December 2013:** The LiA 12 month review event was held on 13th December. This completes the first cycle of activity. The LiA programme will continue as part of business as usual, and therefore this action is closed.	**COMPLETE**

	DOMAIN 1b: RISK MANAGEMENT						
QGF4 p.12	The Trust should aim to demonstrate that its approach to risk management, including escalation and the role and responsibilities within the risk management structure, is understood throughout the organisation and embedded.	**A/G**	Christopher Brooks-Daw	Peter Jenkinson QRC	Review as part of risk management strategy refresh	**January 2013:** Risk management processes and structures have been reviewed. A session on visit management will be included in the Board development programme. **February 2013:** To ensure that a clear understanding is held across the Trust, the Risk Management policy will be re-launched with particular attention being drawn to what responsibility lies where. For example, each Division is responsible for governing their own risk register as part of the overall Trust Assurance Framework as well as collating the required evidence/assurance to consider compliance with the CQC standards. This is being supported by sessions being conducted with each of the Divisions on the management of risk within their areas. **March 2013:** Accountability within Risk Management was discussed in the Organisational Risk Committee in March 2013. Each of the Divisions was reminded of their responsibility in managing the risks within their areas. As part of the regular reviews of the respective risk registers, it was highlighted that each of the Divisions is required to ensure that their risk registers reflect an accurate view of the risks within their areas and as such the risks registers are to include all risks relating to the potential impact on quality of the CIPs.	**COMPLETE**

						The Corporate Risk and Assurance Department has met with two of the Divisions and the other two sessions are planned. These meetings are to review each of the risk registers and to discuss the risk portfolio for each division. The other two Divisions will be met with in early April to conduct this review and offer the same assistance. The Risk Management Policy is being re-launched on the intranet and through the regular communications channels, including eG. This will be completed in early April. The process of embedding risk management at Board and Divisional levels will be ongoing as part of business as usual for the Trust. A session on risk management will be included in the May Board Development Session.	

	DOMAIN 1b: CIPS: CLINICAL GOVERNANCE						
QGF5 p.13	CIP Governance: Ensure that the Clinical Governance Committee can demonstrate its effectiveness to provide assurance to the Board that the quality impact of the CIPs have been appropriately considered, assessed and monitored.	A/G		Ros Given-Wilson/ Alison Robertson F&P Committee and QRC Peter Jenkinson Audit Committee	Undertake a review of the effectiveness of the Clinical Governance Group as part of the annual review of the effectiveness of Trust Board sub-committees: F&P Committee and QRC	**January 2013:** See QGF 6 and BGAF 18 re. the Board assurance that the quality impact of CIPs has been appropriately considered, assessed and monitored. This part of the action is completed. The effectiveness of the Clinical Governance Group will be reviewed as part of the annual review of all Board committees and sub-committees by the Department of Corporate Affairs. **February 2013:** As above **March 2013:** The Board Strategy Seminar in April 2013 will focus on an overview of the CIP programme and governance, including how the quality impact assessment of CIPs is proactively managed. The effectiveness review will be conducted during April 2013 and reported to the May CGG meeting. **July 2013:** The terms of reference have been further revised and the effectiveness of the CGG will be reviewed in September against the current ToR	**COMPLETE**
QGF6 p.13	The Trust should ensure that the ongoing impact on quality of its CIPs for 2012-13 is explicitly monitored and that it develops a systematic post-implementation review of CIP schemes	A/G		Ros Given-Wilson/ Alison Robertson QRC	Ensure there is a clear process in place for monitoring the impact of CIPs on quality, and developing a process for post-implementation review of CIP schemes. The need for a post-implementation review will be built into the Service Improvement process.	**January 2013:** The terms of reference for the Clinical Governance meeting have been revised and were presented to the F&P Committee in December 2012. The revised terms of reference were then presented to the Improvement Board and QRC in January 2013. The revised terms of reference will be recirculated to all members of the relevant committees, the PMO, divisional management teams and improvement programme managers for information. Review in April 2013 to ensure this is fully in place. **February 2013:** Review in April 2013 **March 2013:** The terms of reference have been recirculated for information. **July 2013:** The terms of reference for the CGG have bene further revised to ensure they remain up to date and will be approved by the Improvement Board in July.	**COMPLETE**

	DOMAIN 2a: BOARD EFFECTIVENESS						
QGF7 p.15	**The Trust should assess the effectiveness of the changes at Board-level and within the Divisions, with particular reference to the quality agenda, after an appropriate period of time** **QGF Refresh:** The significant change to the portfolio and role of Chief Nurse, the increased accountability of the Divisions, and the appointment of two NEDs with a clinical background has created more focus on quality improvement at Board-level. The Trust is planning to assess the effectiveness of these changes as part of the Board development programme	**A/G**		Peter Jenkinson Trust Board	The effectiveness of the Board Development Programme that has been delivered will be completed in December 2013 and presented to the Trust Board in January 2014. The effectiveness review will include the issues identified by Deloitte.	**January 2013:** Deloitte commissioned to support the Trust in developing a sustainable programme of board evaluation and development, including the divisional management structure. This recommendation to be included in the development of that programme. **February 2013:** It is anticipated that this will be reviewed as part of the QGF re-assessment by Deloitte in April 2013. **March 2013:** Deloitte have been commissioned to provide a Board development programme which includes an assessment of the effectiveness of the programme delivered. This action is complete as arrangements are in place to ensure that this is evaluated by Deloitte as part of the Board development programme and evaluation that have been commissioned. **May 2013:** The evaluation will be completed by Deloitte in January 2014 **June/ July/ August/ September/ October 2013:** As above	**Mar-14**

QGF7 p.15	Continued					**November 2013:** The effectiveness of the changes made will be via: 1. The Divisional governance review which will test accountability and whether the model in place supports this - due to report February 2014 2. Annual Board committee effectiveness review - particularly in relation to the two new NED appointments in January 2013 - due to report March 2014 3. Executive director appraisals: the mid-year appraisals and directors "time out" session have included a reveiw of the effectiveness of the changes. The timescale for completion has therefore been revised to March 2014. **December 2013/ January/ 2014:** As above **February 2014:** The final report of the Divisional governance reveiw will be presented to EMT in March	
QGF8 p.15	The membership of the QRC should be reviewed to ensure that it is appropriate for its purpose and its effectiveness assessed to ensure that the recent changes have led to the desired improvements	**A/G**		Peter Jenkinson QRC	This will be undertaken when the new NED postholder has been appointed, who will chair the QRC	**January 2013:** NED membership of QRC reviewed and updated - Paul Murphy, Peter Kopelman and Judith Hulf now NED members. Other membership to be reviewed as part of annual Terms of Reference review in March 2013. **February 2013:** As above - due to be completed in March 2013. **March 2013:** The terms of reference were reviewed in the March QRC meeting. There will be no speciifc clinical division representation on the QRC, but the divisions will continue to be asked to provide information and give presentations to the QRC as required.	**COMPLETE**

	DOMAIN 2a: BOARD DEVELOPMENT						
QGF9 p.16	**Ensure that the revised Board development programme reflects the needs of Board members, as individuals and as a collective, to support the delivery of quality governance QGF Refresh:** The Board has yet to complete a skills audit against the skills and competencies expected to support the delivery of quality governance although this is being progressed.	**A/G**		Peter Jenkinson Trust Board	The skills audit will be conducted as part of the 1:1 mentorship during June 2013 and the findings will be presented to the Trust Board in July 2013	**January 2013:** Deloitte commissioned to support the trust in developing a sustainable programme of board evaluation and development, including the divisional management structure. Draft Board development programme to be presented to the Trust Board on 12th February. **February 2013:** The Board Development Programme is currently being finalised to ensure that it reflects the needs of all Board members M**arch 2013:** Detailed Board development plan to July 2013 agreed with Deloitte. Full Board development programme commissoned from Deloitte through to March 2014. Draft contract issued and due to be signed imminently. Content includes issues related to quality (both clinical and data), and a Board individual member self-assessment which will be used by Deloitte to plan more specific development. **May 2013:** Timescale for delivery of the skills audit report agreed with Deloitte as July 2013 Board meeting **June 2013:** Skills audit completed. Results will inform future board development and succession planning. Report with proposals to be received from Deloitte by 11th July. **July 2013:** Awaiting the completed report from Deloitte	**COMPLETE**
QGF9 p.16						**August 2013:** Board skills audit report received from Deloitte. The topics identified by Board members from the audit are already planned as part of the Board Development Programme. The particular comments made in relation to each topic will be shared with the lead director for each session, to ensure that these issues are covered within the session. On this basis, the action is considered to be closed.	

	DOMAIN 2b: BOARD ENGAGEMENT						
QGF10 p.17	**The Trust should ensure its processes and programmes for Board engagement with frontline staff are effective QGF Refresh:** The Board has implemented the 15 Steps Challenge as a tool for structured visits, following a period of pilots; however, this is still relatively new and so the effectiveness and impact of these changes need to be assessed for the recommendation to be fully addressed.	**A/G**	Sal Maughan	Peter Jenkinson Trust Board	The 15 Step Challenge will be reviewed after 3 months at the end of June regarding its effectiveness and impact	**January 2013:** Divisional presentations to board and sub-committees reviewed. NED involvement in 15 Step Challenge, in process of being implemented. **February 2013:** The Listening into Action programme will include Board to Ward communication. **March 2013:** The Trust has embarked on the Listening into Action programme, which is formally structured to take place over a one year period. A LiA Sponsor Group is in place, chaired by the CEO, which has met three times to date regarding implementation. A pulse survey will be sent out before the end of March and a random group of circa 600 staff will be invited to take place in 'big conversation' events in May. The Communications Strategy has been approved by the Executive Management Team. The 15 Step Challenge is being implemented by the Trust. A structure is now in place to ensure that this recommendation is delivered. Implementation will be ongoing as part of business as usual for the Trust, and will be overseen by the Listening into Action group chaired by the CEO. This will also be included as part of the Board development programme that has been commissioned from Deloitte.	**COMPLETE**

QGF10 p.17	Continued					**May 2013:** The effectiveness of the initiative will be reviewed in June **June 2013:** The review of the 15 Step Challenge is on track for completion in June and will be reported to EMT in July. **July 2013:** The report will be presented to EMT in August 2013 **August 2013:** A 15 Step Challenge report was presented to EMT on 5th August. A meeting has been arranged for 19th August to agree how to integrate the 15 Step Challenge with the programme of mock CQC inspections.	
QGF10 p.17	Continued					**September 2013:** The 15 Step Challenge process and CQC preparation have been combined as a new Quality Inspection process which will be launched on 1st October. The launch event includes a briefing and training information. A programme of ongoing visits is in place. A look-back exercise has been completed to review the visits undertaken in July 2013 and reported to the September Patient Experience Committee. The effectiveness of the programme of visits that has been put in place is demonstrated by the improvement in the CQC report for the Trust from the original visit in January 2013 to the repeat visit in August 2013. On the basis that the effectiveness of the programme has been demonstrated through the CQC reports, this action is considered to be closed. The ongoing effectiveness of the new Quality Inspection visits will be managed as business as usual and reported to the Patient Experience Committee (and through this to the QRC).	

	DOMAIN 3a: BOARD EFFECTIVENESS						
QGF11 p.19	The Trust needs to ensure that roles and responsibilities for quality governance at Board level are clearly defined and demonstrate ownership of the quality agenda to the organisation and drive the necessary improvements through the divisional structures	**A/G**	Christopher Brooks-Daw	Peter Jenkinson QRC	Complete a review of the job descriptions for the Chief Nurse/ Director of Operations, Medical Director and Director of Corporate Affairs to ensure that roles and responsibilities are clearly defined	**January 2013:** The review of job descriptions is under way **February 2013:** As above - due to be completed in March 2013. **March 2013:** Review of job descriptions completed by the Interim Head of Risk, with recommendations for changes to be made. Meeting to be convened in April 2013 to agree how the proposal should be taken forward.	**COMPLETE**
	DOMAIN 3b: RISK MANAGEMENT						
QGF12 p.20	**Ensure that there are effective feedback mechanisms in place for all incident reporting that enables staff to learn and share experiences** **QGF Refresh:** Whilst the Trust has improved processes for identifying and monitoring incidents and risks as part of the relaunch of the Risk Management policy, the positive impact of these improvements need to be demonstrated, particularly in relation to feedback mechanisms and learning from experiences.	**A/G**	Sal Maughan	Peter Jenkinson QRC	Review the adverse incident and SI policies to ensure feedback mechanisms are included Regular monitoring of impact through QRC via metrics such as the number of serious incidents (safety) and number of incidents reported (culture)	**January 2013:** The SI and Adverse Incident Policies describe the reporting and governance arrangements for sharing findings and lessons learnt from incidents. Periodic reports on Incidents (including SIs in the thematic reviews) are presented across the governance structures at strategic and Divisional levels. These reports identify trends and themes. All findings from SI reports are presented at each Patient Safety Committee as well as at the respective Divisional Governance Committees. Patient safety initiatives have been based on findings from the above reports and the agenda for the Patient Safety weeks are influenced identified areas for improvement and concerns. The implementation of the Safety Dashboard was informed by lessons learned from incidents. Patient safety messages are communicated across the Trust in the Patient Safety Newsletter which the Head of Patient Safety uses to spread safety initiatives and learning. Risk Business is the equivalent of this, used specifically in Maternity Services. Patient Safety Forum is in place to provide feedback to staff. The SI policy includes the Trust feedback mechanisms to staff	**COMPLETE**

QGF12 p.20	Continued					**May 2013:** On the basis that the improvements to processes and the relaunch of the Risk Policy occurred in January, the methodology to assess the positive impact of the changes will be agreed in September, and the assessment and report completed for November. **June/ July/ 2013:** As above **August 2013:** Risk management presentation given to QRC seminar **September 2013:** The methodology to demonstrate the positive impact of the improvements made will be to take 2 case studies: reported incidents for patient ID and medicines safety. The case studies will demonstrate how the incident reporting mechanism has been used to improve quality. The report will be taken to QRC in November 2013. O**ctober 2013:** Work is underway for the case studies to be presented to QRC in November.	
QGF12 p.20	Continued					**November 2013:** The positive impact of improvements can be demonstrated through for example the reduction in maternity never events and the reduction in the proportion of moderate levels of harm that have occurred to patients, as detailed in the report to PSC on 20th November 2013. This demonstrates the positive imapct of these changes as required. On this basis, this action is considered to be closed.	

	DOMAIN 3b: GOVERNANCE						
QGF13 p.21	**The Trust needs to establish a clear internal audit programme that can directly evidence links to the quality governance agenda. This audit programme should be correlated to the coverage of the clinical audit programme to give the Board comprehensive assurance** **QGF Refresh:** The focus needs to be on bringing together the clinical and internal audit plans to map the assurances to the Board	**A/G**		Peter Jenkinson Audit Committee	Include the clinical audit programme as part of the annual Audit Committee workplan review - to be presented for consideration at the same time as the internal audit plan for 2014-15.	**January 2013:** The draft audit programme for 2013-14 is under discussion and due to be presented to the Audit Committee in March 2013. **February 2013: T**he draft programme will be presented to EMT in March 2013 and to the Audit and Assurance Committee for approval on the 27th March. **March 2013:** Draft audit plan submitted to March Audit Committee meeting for review and approval. Approved in Audit Committee meeting on 27th March - plan includes audits that are specifically related to quality governance. **May 2013:** No action required until 2014 **October 2013:** Paper taken to QRC in September 2013 to outline the proposed method to ensure that the internal audit and clinical audit programmes for 2014 are clearly linked. **November 2013:** The Director of Corporate Affairs will agree a timescale with internal audit for the presentation and approval of the combined audit plan to Audit Committee and QRC. **December 2013:** The draft internal audit plan will go to Audit Committee in January 2014; EMT in February; and Audit Committee for final approval in March. The clinical audit plan will also go to EMT in February and Audit Committee in March, so that both are approved together to ensure they are complementary.	**COMPLETE**

QGF13 p.21	Continued					**January 2014:** Internal audit have met with clinical audit to ensure that the proposed audit plans for 2014-15 are aligned. Proposed plan for 2014-15 presented to the Audit Committee meeting. **February 2014:** Draft audit plan for 2014-15 presented to EMT on 3rd March **March 2014:** The QRC mapped the internal and clinical audit plans for 2014-15 in its September meeting and was assured that there is sufficient and appropriate linkage between the two. The internal audit plan will be approved by the Audit Committee in the March meeting. The QRC review of the clinical audit plan was used to inform tha development of the internal audit plan for 2014-15. On this basis, this action is considered to be closed.	
QGF14 p.21	The Trust should review the effectiveness of its whistleblowing policy, particularly given the extent of financial savings required over the coming years that may impact on quality, to ensure that staff are clear on the practical use of the policy	**A/G**		Peter Jenkinson Audit Committee	Already in place	Whistleblowing incidents reviewed as standing item at Audit Committee	**COMPLETE**

	DOMAIN 3c: PATIENT INVOLVEMENT						
QGF15 p.22	Clarify the role of patient representatives and how the Trust can gain benefit in improving quality from their engagement	G	Sam Ridge	Peter Jenkinson FT Programme Board	Review and discuss this as an agenda item at the next Patient Reference Group meeting	**January 2013:** The next meeting of the Patient Reference Group is in February 2013 **February 2013:** Agreed at the PIC meeting the week of 25th February that the terms of reference for both PIC and PSC will be amended to include a clear statement of the roles of patient representatives in both meetings. The terms of reference will be updated for the next meetings in April 2013. **March 2013:** The terms of reference for PIC and PSC have been updated and will be tabled for review and approval at the April meetings. The PIC terms of reference include a clause to clarify the role of the patient representatives. There is ongoing discussion at the Patient Reference Group about this, e.g. in relation to Place Assessments. This will be taken forward as part of business as usual.	**COMPLETE**
QGF16 p.22	**Review the effectiveness of the Patient and Public Engagement approach and its delivery through frontline staff and monitoring by the Board** **QGF Refresh:** The implementation of the Communications Strategy will include a review of the effectiveness of the Patient and Public Engagement Strategy to be clear as to whether this is effectively delivered, monitored or implemented within the organisation. This will enable the Board to demonstrate whether engagement with patients and public has supported delivery of quality improvements.	G	Louise Halfpenny	Peter Jenkinson Trust Board	Develop a PPE plan which is approved by EMT. This will include the means by which the effectiveness of Trust engagament will be determined.	**May 2013:** PPE plan under development **June 2013:** Public / patient involvement now agreed for service improvement, PLACE assessments, 15 Step Challenge and mock CQC inspections, as well as strengthening role of patient representatives in formal committees and development of the Trust PPI database. On this basis, the first part of this action is considered to be complete. Review of effectiveness will be undertaken in October 2013. **September 2013:** The Trust is able to demonstrate that engagement with patients and the public has supported the delivery of quality improvements through the regular reporting by patients at the Patient Reference Group of initiatives they have been involved in and the benefits that these have brought. This is reported to the Patient Safety Committee. On this basis, this action is considered to be closed and is now part of business as usual.	**COMPLETE**

	DOMAIN 4a: PERFORMANCE AND INFORMATION						
QGF17 p.24	The Trust should include prior year data for quality indicators to allow trend analysis, benchmarking and comparison of performance trajectories	A/G	Kaye Glover	Steve Bolam F&P Committee	Prior year data to be incorporated for reported quality indicators.	**January 2013:** Trust already reports prior data across a number of metrics by exception. Wherever possible and worthwhile the Trust includes prior year performance to contextualise current performance **February 2013:** With the planned restructure of the Perfomance Department, the Trust will review the ability to extend this further	COMPLETE
QGF18 p.24	**Develop further the use of thematic reviews to monitor overarching issues within Divisions including adherence to policies** **QGF Refresh:** The pilot is still at the testing phase and members of the QRC have expressed concern about the pace of implementation.	A/G	Yvonne Connelly	Alison Robertson Patient Experience Committee	Pilot underway led by the Head of Patient Safety with the Division of Medicine and Cardiovascular	**January 2013:** Planning meeting held the week of 12th January 2013. Key areas of initial focus have been identified, e.g. communication and handover. Overarching action plans will be developed by March and implementation will be monitored as part of the pilot. **February 2013:** Further meeting with the Divisional Governance Manager to agree the approach - an implementation plan will be piloted in one clinical area initially. and this is currently being agreed. The aim is to begin the pilot in March. **March 2013:** Meeting held with care group lead to obtain clinical agreement. Pilot to proceed and the findings will be reported to the June QRC meeting. **April 2013:** Priority themes for actions have been agreed by the renal and acute medicine care groups with the implementation plan. Observations of key processes in the 2 pilot ward areas have been carried out. Proposals for systems to monitor the themes at ward level are currently being developed. **May 2013:** Progress report presented to the QRC. A range of initiatives have been trialled on Buckland Ward and will be followed up to determine how practical they are to use. These include a ward round checklist , a medical notes bookmark with inbuilt prompts and a proforma for the ward round notes.	Dec-13

QGF18 p.24	Continued					**June 2013:** Pilot projects in place on Buckland and Rodney Smith wards. Focus on incorporating safety checks into ward round processes for medical staff. Junior doctors have been particularly helpful in the development of practical and effective tools and continue to use a proforma for new patients and stickers with safety checks for every patient which can then be added to the notes. Further checklists and stickers have been developed to trial with nursing teams and these are being incorporated into handover/ intentional rounds. **July 2013:** A ward-based dashboard is under development that will give wards a snapshot of key quality measures (e.g. workforce, Friends and Family test feedback) and trends to enable monitoring as to whether the specific actions/initiatives are impacting on quality as expected. A meeting has taken place with the medical consultants on Buckland Ward to agree actions to ensure the project is sustainable. A similar meeting will be undertaken with the consultant for Rodney Smith. **August 2013:** Trialling of patient stickers for safety checks has been implemented with the new junior doctors. The project us due to be discussed at the Divisional Governance meeting the week of 26th August.	

QGF18 p.24	Continued					**September 2013**: Buckland Ward have now taken over the management of the project re. carrying out checks during ward rounds and use of stickers/ pro formas. Progress will be reported to QRC. Work ongoing with Rodney Smith to implement a trial. Data is now being analysed to review whether the project is having an impact at ward level, and will be reported to QRC. **October 2013:** The informatics team has provided a second tranche of data which is designed to measure whether the pilot is having an effect on the reliability of systems on the two medical wards where the pilot is in place. This is currently being evaluated. The medical safety checks appear to be working well on Rodney Smith Ward. A Safety Facilitator has been recruited to support the pilot along with the Head of Patient Safety. A system for telephone nursing handover is currently being trialled between the AMU and Rodney Smith to improve the quality of information sharing between the wards. Buckland and Rodney Smith wards will combine the safety checks with their intentional rounding processes in November. This will then be evaluated at the beginning of December. **November/ December 2013:** As above ongoing actions. A formal report will be presented to QRC in January 2014 with an evaluation of the pilot and future recommendations.	
QGF18 p.24	Continued					**January 2014:** Summary of pilot presented to QRC meeting in January. Action agreed that there will be a discussion with the medical director re. the future of the pilot. **February 2014:** Update as above	

	DOMAIN 4b: PERFORMANCE AND INFORMATION						
QGF19 p.24	**The Trust should put in place a Data Quality Strategy, with clear SMART objectives, supported by a comprehensive programme of data quality review. This should be used as a tool to allow the Board to review the progress and the degree of assurance that it can obtain relating to the information it receives. The Board should incorporate clear data quality metrics within its reporting.** **QGF Refresh:** A Data Quality Group is to be introduced to meet on a quarterly basis. Initial work will be to identify the core set of data quality indicators that the Divisions and Finance & Performance Committee should review on a regular basis. There has been no change to the level of assurance to the Board regarding the quality of data being monitored.	**A/R**	Tom Dewar	Steve Bolam F&P Committee	Produce and implement a Data Quality Policy.	**January 2013:** A Data Quality Policy is currently under development and planned for ratification in February 2013. This policy will detail the responsibilities, processes and protocols which will serve to both improve data quality and provide assurance to the Board. **February 2013:** A Data Quality Policy is currently under development and will be presented to EMT and then to the Policy Ratification Group meeting in March 2013. This policy will detail the responsibilities, processes and protocols which will serve to both improve data quality and provide assurance to the Board. **March 2013:** Data Quality Policy approved by Policy Ratification Group on 21st March **May 2013:** The inaugural meeting of the Data Quality Group is being scheduled for the last week of June / first week of July. The aim will be to agree the groups ToR and recommend (to the Finance & Performance Committee) the Trusts data quality priorities for 2013 - 14. **June 2013:** Data Quality Group inaugural meeting scheduled for 11th July, with main points on agenda to agree ToR and recommend data items for prioritisation in 2013-14. **August 2013 :** Data Quality Group established and has met. Feedback provided to F&P Committee in July. Data Quality Strategy to go to next F&P	**COMPLETE**

QGF19 p.24	Continued					**September 2013:** Planning is underway for the data quality Board development session on 8th October **October 2013:** The data quality strategy and implementation plan will be approved by the Data Quality Group on 22nd November and will then go to Finance, Performance & Investment Committee for approval. Internal audit review of data quality in maternity pathways completed and will be reported to Audit Committee in November. **November 2013:** Data Quality Group met on the 22nd November. The Data Quality Strategy and plan were discussed, and the top priorities agreed. A paper to be presented at the December FP&I committee (which will include the final version of Data Quality Strategy). **December 2013** : FPI Committee has reviewed the top 5 data quality priorities and action plan and received the final version of the data quality strategy at the meeting on the 18th December. FPI Committee is assured that the Trust is making progress and has plans to improve data quality in the top 5 areas identified and that there are reliable governance mechanisms in place to manage, monitor and report on the actions being taken and the progress being made	**COMPLETE**
QGF19 p.24	Continued					**January 2014:** Data Quality Group meetings are now scheduled quarterly from March 2014. A report on progress against the data quality top priorities went to FPI Committee in January 2014; FPI requested future updates quarterly authored by the Data Quality Group. The next update to FPI will be in March/April 2014. **February 2014:** Data Quality Group has approved final version of Data Quality Strategy. The next update to FPI Committee will be in April and every three months thereafter. Specific proxy metrics for each of the top 5 priorities will be taken to FPI in April. Data quality issues will be raised with Divisions by exception. On this basis this action is considered to be closed, as all the actions identified by Deloitte are now complete.	**COMPLETE**

	DOMAIN 4c: PERFORMANCE AND INFORMATION						
QGF20 p.26	The Trust needs to review the effectiveness of its quality performance information reported to the Board. This should include methods for triangulating performance data with more subjective information reported directly from staff and patients and incorporating the active monitoring of the Quality Accounts priorities through to services	**A/G**	Tom Dewar	Steve Bolam F&P Committee	Incorporate new National Quality Dashboard in performance monitoring processes.	**January 2013:** We are currently awaiting the release of the new National Quality Dashboard. This is expected to be used by Monitor, the CQC, the NCB and CCGs to assess our quality of care (relative to others). The Head of Information is on the 'first-wave' list of those nationally who will be given access. Board and Division performance scorecards are being reviewed for 2013/14. This will take into account the metrics being used in the National Quality Dashboard, alongside the longer set being used locally. **February 2013:** as above **March 2013:** We now have access to the National Quality Dashboard. Head of Information and Performance Development Manager meeting in first week of April to review this (and other benchmarking sources) and make recommendations for use in performance monitoring in 2013-14. An exemplar quality report has been requested from Deloitte to use to help inform this piece of work	**COMPLETE**

QGF20 p.26 (cont.)						**April 2013:** Use of national quality dashboard for month 1 reporting to be reviewed. Approach will be as follows: • Flag in performance reporting where we are a national outlier wherever benchmarked sources are available The NQD to be used for this purpose for: 30d readmissions, A&E 4hrs, RTT(adm), SIs, bed occupancy, amenable mortality o Other benchmark sources – Dr Foster, Audit Commission etc. – could be used for some of the other metrics we monitor (e.g. DNA rates, risk adjusted mortality, LOS) • Adopt the SPC-style monitoring approach – as used by NQD – to identify significant deviations from normal variation (spikes or trends). Incorporate this into scorecards / performance management reporting. • Use benchmark information to inform performance (RAG) thresholds. • Train Principal & Senior Information Analysts on benchmarking sources, making them the gateway to their wider use in the Trust. **July 2013: R**egular monthly meetings have been established between the Chief Nurse/Director of Operations and a member of the information team to review the National Quality Dashboard. A summary report will be included in the Trust Board quality report from July.	
QGF21 p.26	The Trust should review its use of benchmarking (internal and external) data year on year analysis in relation to quality indicators to improve the management information to the Board and services	**A/G**	Tom Dewar	Steve Bolam F&P Committee	Review use of benchmark information.	**January 2013:** The Head of Information has produced a paper making recommendations on the Trusts approach to and use of benchmarking information. This is currently with the Finance Director and others for feedback. Recommendations will be agreed in Q4 2012/13 for implementation from Q1 2013/14. **February 2013:** As above **March 2013:** Head of Information and Performance Development Manager meeting in first week of April to review benchmarking sources and make recommendations for use in performance monitoring in 2013-14.	**COMPLETE**