QGAF ACTION PLAN
Updated 7/11/2013: Colour code:- Blue = Des Holden, Pink = Fiona Allsop, Green = Gillian Francis-Musanu, Yellow = Paul Simpson

Questions	What we said	Score	Actions	Action Owners	Rag Rating	Timescale
1A: Does quality drive the trust's strategy?	**Strategy:** • To be described • To be communicated Lack of understanding of quality strategy. Ward/department level awareness could be improved.	0.5	Defining the strategy and defining what the key objectives are for quality governance and to be communicated to all staff. Determining what we want to achieve and how to achieve it. Quality programme of work -small number of quality (patient experience, safety and clinical effectiveness) goals that are achievable and are time framed. Communication of quality goals and development of sequential quality goals at divisions, speciality, ward level as well as community services.	MW/AM DH DH DH GF-M Each divisional senior team		31/12/2013 01/01/2014 01/01/2014 31/12/013
1B: Is the board sufficiently aware of potential risks to quality?	Poor/ Fit for purpose Risk Register Lack of engagement from Board when risks escalated. Poor risk management at management board Not everyone is engaged enough to take ownership of Trust risks. Culture of under reporting because of fear of criticism/ creating a lot of work. Limited assessment and understanding at Board level of current and future risks to quality. No feedback from incidents.	1	Review and clarify process in which Risk register is assessed and interactively discussed with divisions. Setup interactive Risk Committee as subcommittee of the Board if not of the board the Safety and Quality Committee. Assuring themselves (Board) that the divisions are prioritising and managing risks appropriately. Standardised approach to risk assessing and scoring. Communication of Risk management from Board to ward Process to be created to review incidents, NPSA alerts, NICE guidance and disseminate learning within the Trust A clear accountable process evidencing appropriate actions.	FA FA PS FA GF-M FA FA		31/01/2014 30/12/2013 28/02/2014 31/01/2014 31/12/2013 31/01/2014 31/01/2014

2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	Nursing "advocates" not valued – big problem. There is lack of challenge around quality issues from Board. Improving but still can be challenging. No confidence, lack of engagement of board and lack of board's ability knowledge and skills. Does the board comprise of the appropriate mix of skills and capabilities in relation to delivering quality governance. What skills does the NED's provide to the quality agenda?	0.5	Ability for the Board to articulate a consistent top three quality related priorities. Ability of the Board to give specific examples of their impact on improving quality. Evidence that the Board members have had training on quality governance. Process for assessing the training needs of new and existing board members. Develop Divisional speciality goals and plan	MW/AM PS PS PS DH Divisional Team member		19/12/2013 19/12/2013 06/12/2013 06/12/2013 31/01/2014
2B: Does the Board promote a quality focused culture throughout the trust?	Poor feedback from Board to ward. At board level yes, sometimes lost further down the line. Patchy, I am not clear. When will quality count and when it won't. Financial constraints seem to take most priority. Talk about what we want to aspire too but don't feel we are supported enough to achieve it. Constant trade-off between Quality and Cost Just Fix it.	0.5	Evidence of active leadership from Board to ward. Structured walk rounds by board members. Evidence of listening to patients and using their feedback in improvement planning, service monitoring and design Understanding, communicating and evidencing how reporting and learning from incidents improves patient safety and experience. Training and development plans by divisions and wards linking back to ward and speciality objectives. Two way street- division back to board Mechanism to provide feedback to divisions. ED/NED Buddy by Division	DH PS PS+DH DH GF-M DH PS		- 19/12/2013 31/12/2013 31/03/2014 31/12/2013 19/12/2013

3A: Are there clear roles and accountabilities in relation to quality governance?	Probably not enough focus at divisional level. No clear leadership. Staff not aware of responsibilities to quality governance. No, the restructure needs to be clarified outside the Executive Team. Not understood at ward level.	0.5	Define Chief and Clinical leads responsibilities. Define divisional Board responsibilities. Mechanism to review how divisions are covering the quality agenda and taking appropriate action and escalating when necessary Review MBQR. Redraft division JD for risk and sign off. Clarity of Roles and Responsibility between Divisional Risk manager and central function –SOP. Review SI process in particular sign off and action plans and ensuring lessons learned are disseminated.	DH DH DH DH FA FA DH		01/01/2014 01/01/2014 14/02/2014 Complete Complete 31/01/2014 31/12/2013
3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	More work at divisional level is required. No clear leadership about many gaps in how we manage quality. Lack of response to the processes, reduces motivation to use them after several unsuccessful attempts to do so. Lots of action plans but often too large to manage and no drive to action. Getting better, further work required on escalation of concerns. I don't feel processes are clearly defined. I don't think people would feel safe and supported to whistle blow.	1	Clearly defined processes to be written and communicated to staff for management of quality performance. Clearly defined processes to be written and communicated or clarified through divisional boards for management of quality performance. Wide dissemination of lessons learned-forum or process to be agreed. Process for escalating, resolving and management of poor quality performance. How are Divisional boards supported to manage poor or need to improve quality performance?	DH DH GF-M DH DH		01/01/2014 01/01/2014 31/12/2013 28/02/2014 28/02/2014
3C: Does the board actively engage patients, staff and other key stakeholders on quality?	No structured process to action patient opinion.	0.5	No patient representative in most meetings.	DH		31/12/2013

stakeholders on quality?	No patient representative in most meetings.		Clinical feedback – improved responsiveness to clinical demands in relation to quality.	DH		31/12/2013
	More work and focus required at both trust and divisional levels.		Build effective communication to staff, patients and stakeholders.	GF-M		31/12/2013
	Are stakeholders engaged? What happens to their feedback?		Development required about how the Trust informs patients and carers how their feedback is used to improve patient safety, experience and services.	GF-M + DH		
	Communication could improve.					
4A: Is appropriate quality information being analysed and challenged?	Dashboards don't appear to be linked to outcomes. Not read quality account	0.5	Triangulation of information from complaints, complements, pals, patient surveys, friends and family test, your care matters.	DH		15/01/2014
	No idea of board knowledge experience. Do they challenge scrutinise the reports they receive, so they seek assurance.		Benchmarking of performance against national quality standards and peer organisations.	DH		31/12/2013
	Clinical governance was not involved in the processes that now drive our quality.		Assurance process required that systems providing quality information are more detailed for review at sub committees and divisional level.	DH		01/02/2014
	Process is reactive rather than the division's pro-actively managing information.		Evidence of measuring the right things i.e. outcomes	PS		28/02/2014
4B: Is the board assured of the robustness of the quality information?	Rare for us to follow up on action plans.	1	Determine how the Board is seeking assurance of the robustness of information?	PS		17/01/2014
	Concerns about resources and process to fully validate data we report externally-regular and ad-hoc.		How is the robustness of quality information challenged where appropriate?	DH		-
	Too many vague actions plans and how do we monitor action plans.		How does the Board test the quality information presented to them for reliability, robustness and scrutiny?	PS		17/01/2014
			Has the Board determined what information is required to be assured of quality?	DH		Feb-14
			Improvement required on feedback from lessons learned.	GF-M		31/12/2013

4C: Is quality information used effectively?	Have not had a good upstream process. We should feed the information to staff more.	0.5	Quality data should be part of staff meetings.	GF-M		31/12/2013
	External benchmarking not produced systematically for major meetings.		Need to ensure follow up of actions plans and lessons learned across the organisation.	DH		Feb-14
	Lots of information on lots of systems. Needs pulling together to credit full picture.		Develop quality information further.	DH		Feb-14
	It needs to establish outcomes. Without clarity of purpose information will not inform stakeholders.		Move to measure outcomes.	DH		Mar-14
	Dashboard- ward staff may not access due to workload.		Actively engage staff to use quality information impacting on their area of work.	GF-M		31/12/2013
	Do we feedback lessons learned to clinical staff or just to managers?		Systematic process for following up issues that have been challenged.	DH		Dec-13
			Determine how quality information has made differences to staff area of work ultimately impacting on patient care.	DH		Jan-14
			Quality information to be used as a driver for improvement within the organisation.	DH		Feb-14