Maturity Matrix to support the Development and Improvement of Quality and Clinical Governance at site level of a group model

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To use the matrix, identify and circle the level you believe your organisation has reached and then draw an arrow to the right to the level you intend to reach in the next 12 months. Generally, organisations/teams will only progress one level per year.

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PROGRESS LEVELS ▶ / KEY ELEMENTS ▼	0	1 BASIC	2 EARLY PROGRESS	3 FIRM PROGRESS	4 RESULTS	5 MATURITY	6 EXEMPLAR
Leadership and Strategic Delivery ▶	No	The trust board has reviewed and agreed a commitment to the delivery of safe, high quality and harm free care in the site plan. The governance structure clarifies site leadership responsibilities for the management of risk, quality and safety.	The site leadership has debated its appetite for risk in the context of risks to the quality and safety of services. The board has defined its Quality and Safety plans and time-limited outcomes, based on the overarching quality strategy. Site-specific specialisms have been incorporated into plans. Priorities have been agreed as in line with the system and group strategy.	There is a clear plan for leadership support and development, supported by training and development plans and succession planning. Budget is available and infrastructure exists to support it.	The site is able to evidence how it consistently and effectively supports the development of its clinical leadership teams.	The site is achieving its strategic objectives and has reviewed and tested and adjusted its strategic direction in the light of changing circumstances. Benefits are felt from plans that have been realised. Other sites adopt your practices.	The site enables group to influence national and international practice and is recognised for publishing and sharing examples of best practice. Data and evidence supports this. Peer reviews are undertaken and the learning embedded.
Enabling Learning and Sharing: ▶ The relationship between the group and the sites		The trust board has set out their expectations of all sites/services and divisions, with regard to quality and safety and clarified tolerances for escalation. The information flows between specialities, directorates and divisions are described. Inclusivity – the importance of the inequalities agenda is recognised.	Divisions have identified plans in line with the trust's strategic direction and have described their reporting processes upwards. Clinical leaders have mechanisms for liaising and sharing learning with colleagues across divisions as well as between divisions and site leadership. There are forums for check and challenge outside business- style meetings, e.g. workshops.	There is a central system for monitoring outstanding actions or exceptions from all reported action plans and follow up with divisions. The escalation system is reviewed and tested at intervals. Workforce capacity and capability for quality governance has been assessed and a development plan is in place.	There are working mechanisms for supporting divisions and front-line staff in managing risk and issues locally. There is a routine good attendance at clinical governance meetings at all levels, with all divisions being well represented at trust wide and senior meetings. Teams actively learn from failure without resistance. Culture of frankness, candour and respect enables constructive challenge.	Performance is consistently improving across services. Strategic objectives are on track. A consistently good level of recruitment to clinical positions is sustained. Staff surveys indicate good visibility of the senior team and consistent good attendance at routine and ad hoc communications and briefing sessions.	The site is regarded as an exemplar in internal communications and in clinical service provision. Other sites, trusts or clinical bodies visit to observe practice.
Staff Engagement ▶		The leadership understand and articulate the values and expertise of all its staff and their importance in safe, high-quality care and decision-making processes. This has been promoted in documentation, such as inductions and appraisals. The leadership has involved staff in developing its clinical improvement strategy, plans and time-limited outcomes.	Staff are clear on their roles and responsibilities with regard to clinical governance and achieving improved outcomes. Staff are able to articulate the purpose and values of the organisation.	Staff are empowered to identify and make improvements. The organisation is open and responsive to staff concerns, contributions and feedback. Reward and celebration are built into the staff engagement approach. There are examples of staff initiated quality programmes coming to fruition.	Evidence from staff surveys demonstrates that staff feel involved in and take ownership of clinical governance. Feedback from Freedom to Speak Up processes are reported and drive improvement. Appropriate forums exist for staff to learn from quality improvement initiatives and for staff to receive structured feedback. Rewards and celebration is built in and wide spread. There are site excellence visits.	Progress has been made in those areas identified as needing improvement from staff surveys and other engagement mechanisms. Staff report confidence in the effectiveness of the organisation to receive constructive scrutiny, deliver improvement, and staff's ability to affect these processes. Staff feel acknowledged and rewarded for their contributions.	The trust is regarded as a centre of best practice for staff involvement and engagement in service improvement. Staff survey results show year on year improvement.

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Patient Experience	No	The site understands the importance of involving patients, carers and families in governance and decision-making processes and service development plans and this has been promoted in documentation. There is a senior level group responsible for reviewing practice and performance on complaints management and learning.	The board has involved patients, carers and stakeholders in developing its Quality and Safety Strategy and time limited outcomes. There is a patient and public involvement plan in place that goes beyond board representation.	Mechanisms are in place to ensure that patient feedback is routinely collected. Patients are carers are engaged and feel confident providing their feedback to the organisation. The board has defined its patient and public involvement strategy, plans and time limited outcomes. Patient feedback pollinates over quality management disciplines.	Patient experience and complaints targets are being met. Patients report confidence in the responsiveness and effectiveness of the service experienced. Performance against service user involvement standards and outcomes is recorded and improving.	Development and improvement programmes routinely engage patients and this is demonstrably driving improvement across the trust. There is a site/service-wide programme to support and develop patient leadership. There is equity of access to these programmes. The site/service can demonstrate that it learns from the triangulation of patient experience data with other quality measures and across services. Tangible benefits are evidenced.	Lessons on engagement and improvement are shared beyond the site/service.
Risk Management and Assurance Systems	No	The site has set out its commitment to the management of all risks to clinical quality and safety. A clear system for risk management is in place. There are metrics in place designed to provide assurance on compliance with national guidelines and applicable guidance, standards and targets. There is a board sub-committee charged with securing assurance on clinical quality and safety.	Risk systems are aligned to board priorities and expectations of clinical effectiveness. There is a described and communicated system from front line to the board, which allows for the identification of risks to clinical and care quality, the monitoring of risk management actions and the escalation of issues that cannot be managed locally.	Challenge on clinical issues debated at the assurance committee and board is informed and constructive. Potential internal and external system failures affecting clinical quality and safety are identified in risk registers and mitigated appropriately.	Issues are systematically identified and addressed without regulatory input. There are no surprises or resistance when data is requested, inspected or challenged. The risk management system, including effectiveness of related committees and groups, is monitored and any identified adjustments are implemented. There is quality testing of waste reduction programmes. Few risk scores need change or challenge.	National clinical standards and targets are consistently achieved. Divisional systems for tracking compliance and monitoring actions plans are in place and functioning. Risk scores are reducing. Information emerging through the risk system triangulates with other data from governance reporting.	The organisation provides benchmark data externally and welcomes comparison and inspection. Other organisations visit the trust to learn about our best practice approaches.

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Patient Safety	No	There is a trust-wide commitment to patient safety characterised by the existence of clear roles and responsibilities at group, site and divisional levels. There is a trust-wide incident and investigation policy and procedure and governance forums at all levels discuss reported incidents and risks. This includes the means of sharing learning from incidents across the trust. There is a clear and communicated procedure for Disclosure (whistleblowing) and for Duty of Candour.	Maintaining and improving safety is a key priority for divisional leaders and staff. Incident reporting levels increase. Clinical safety targets are set out for all divisions. The investigation process is in place and staff are trained to support it. Staff learn from incidents.	Results of incident reporting and recommendations from investigations are debated at board or board sub-committee level. More moderate and low harm incidents are observed with fewer serious level incidents. Ownership of investigation and learning is evidenced at divisional and local levels. Engagement with partners about implementing PSIRF. Surfacing of PSIRF framework understood and leadership are able to articulate this to staff. There is testing of the reporting culture and the understanding of the Duty of Candour processes. Compliance issues are identified and escalated according to risk or incident grading. Patient safety is triangulated against other data, e.g. feedback from patients.	Active listening and learning from safety challenges. Forum and system for evidencing that learning has taken place and led to change. Positive reporting challenged on high level of low harm incidents being reported.	There is routine report of evidence of the effectiveness of activity to mitigate risk and to learn from incidents and other governance information. Patients and families are involved in safety initiatives. Fewer compliance issues emerge from risk and incident reporting. Benchmarking against patient safety partners identifies where the trust is an outlier.	The trust demonstrates sustained evidence of improvement in safety priorities and targets.
Clinical Effectiveness	No	Key elements of clinical effectiveness are identified including safety, effectiveness, clinical audit and patient experience. There is a trust audit plan which reflects national as well as local priorities.	Leadership has clarity on how it is assured of clinical effectiveness from across the site/service, evidenced by divisional and speciality plans. The site is able to assure the group of this. System for receiving external reports and publications and a system to undertake a gap analysis to identify risks and good practice and then share it.	Divisions and specialities include discussion, analysis and sharing of effectiveness in their governance structures and processes.	Performance against clinical standards is recorded, reviewed and improving, including achieving results and/or evidences of changed practice in identified focus areas. There are mechanisms to allow sharing of effectiveness information between divisions and specialities.	The site/service consistently performs highly against clinical standards. Innovative approaches have been assessed for effectiveness and sustainability and are being mainstreamed in service delivery. There is evidence that this has improved relevant metrics. The organisation can demonstrate that it learns from the triangulation of clinical audit findings with other quality measures within and between services.	The trust can demonstrate an evidence base of achieving sustained results in clinical effectiveness and is recognised as a source of sustained best practice.

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Use of Information: Reporting and Monitoring	No	The reporting routes across the trust are clearly set out and supported by information systems. Staff understand their role in managing and maintaining data quality in information systems.	Staff (and board members) are all levels are empowered through training to properly understand and utilise, interrogate and challenge data appearing in dashboards and reports. Data is accessible and transparent. The different kinds of information are drawn together.	Systems are aligned and allow for the easy sharing of information and data. Outcome data is routinely used to guide operational decision-making processes. Risks and movements in performance are evident and understood by the board and used to drive improvement. There is visibility of HIVE information.	The site has confidence in the quality of its data and is able to present one version of the truth across the group.	The organisation is able to utilise its reporting to escalate and address issues at an early stage and consistently uses data to drive improvement. The organisation has appropriate and well attended forums for staff to share and learn from previous work and incidents encountered. Information is tailored to the audience which reduces information overload. It is well presented, proportionate and pitched at the right audience. There are examples of HIVE driving changes to care pathways and to sustainability.	Data collected drives improvement across all areas of the organisation. Lessons learned and best practice are benchmarked and shared across the group.

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