Good Governance Institute

Maturity matrix to support the development and improvement of quality and clinical governance in divisions

TO USE THE MATRIX: IDENTIFY WITH A 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. 0 - 6

APRIL 2018

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted and commitment to action	2 EARLY PROGRESS Early progress in development	3 FIRM PROGRESS Progress becomes mainstreamed	4 RESULTS Initial achievements evident	5 MATURITY Results systematically achieved over time	6 EXEMPLAR Others learning from our consistent achievements
IMPLEMENTING BEST PRACTICE E.G. NICE GUIDELINES	No	Knowledge about best practice sits with individuals. Having a structured way to share best practice uniformly is accepted but not developed. The review of new best practice guidelines is often delayed. Clinical guidelines are not routinely updated to reflect best practice until after the clinical guideline has expired	Process in place to ensure new national guidelines come to the attention of divisions and specialties, and that a gap analysis is performed. Process for measuring and monitoring best practice is identified, but not yet implemented systematically. Where best practice is not implemented, this is referenced on the risk register but with limited plans to address gaps	New national best practice is being systematically picked up for adoption by the division/specialty. Evidence of the local situation is collated and evaluated. Multiple examples of best practice being picked up and locally implemented within the last 24 months. Gaps in compliance are routinely captured on the risk register with action plans to close gaps agreed, and implementation monitored	Application of best practice guidelines is systematically monitored and results discussed. Results are shared between specialty and division, and variances with action plans reported upwards. There exists evidence of positive clinical outcomes and experience for patients as a result of the consistent application of national guidelines	Systematic application of best practice locally is routinely reported and learning points shared within and across divisions. The delivery of excellence in care and experience can be consistently demonstrated through ongoing monitoring. There exists evidence that services provided by division/specialty are systematically improving year-on-year	Contribution to the development of national and international standards by being recognised for publishing examples of excellent practice or other peer review recognition. Examples of other organisations learning from this service
CQC REGULATION	No	Division and specialty leadership promote the importance of clinical, quality and regulatory standards more broadly with staff. Staff are aware of CQC quality domains and ratings	Division/specialty has mapped its compliance against all relevant standards and is aware of any gaps. This process has involved staff, and there are dynamic performance measurements in place e.g. clinical audits. Quality dashboards have been developed at both divisional and specialty level, and these are aligned to the CQC quality domains	Compliance mapping is systematic and kept up to date. Action plans have been developed and implementation progress is being managed. Results and issues are shared within the division/specialty. There are action plans in place to improve performance against any gaps in CQC compliance. Trust-wide rolling programme of peer review inspection is in place	Compliance reviews include an external to the division/specialty component. Evidence of inter-division/specialty sharing of improvement points exists. External recognition being achieved, for example CQC 'Good' rating for service concerned	Inter-division working on standards compliance is achieving consistent results for the trust in broad-theme areas e.g. patient safety and patient experience. Year-on-year consistency or improvements can be demonstrated. Results comparisons with other trusts is used as a spur for adopting better compliance against standards	A CQC rating of "Outstanding" in the majority of specialties. Other organisations learn from the work. The trust benchmarks in the upper decile for standards compliance nationally
RISK MANAGEMENT	No	Staff are aware of the trust's risk management policy and understand key elements of this e.g. risk assessment, risk escalation, etc. This is included within the induction process. New risks are being entered into the risk register and the division/specialty have started to review these	There exists evidence that risks are being reviewed and calibrated, and action plans agreed. There are examples of appropriate escalation of risks. Risk registers are systematically reviewed at divisional and specialty level, and risk informs quality improvement activity. There are examples of risks being escalated to the corporate risk register. The risk management system is externally tested and recognised, through internal audit	Risk identification is proactive and a key part of annual business planning and quality assurance cycles. SMART action plans are in place for all risks. Division and specialty leadership are fluent in the trust's risk management approach, and understand the trust's risk appetite approach. There are examples of different divisions and specialties collaborating to mitigate risks	No risks overdue for review on the division or speciality risk register. Risks are triangulated between divisions to identify corporate issues. Multiple examples of risk escalation with concomitant actions taken, and of risk score reductions. Divisional and specialty leadership are confident that the risk system is picking up issues they consider important and relevant to better patient care. Staff are aware of the top risks within the division/specialty, and what is being done to mitigate these risks	Internal audit provides positive assurance that risk management is robust and adding value. Staff are involved in peer learning exercises within the trust and externally. There is evidence of consistent risk reduction through the completion of action plans and the lowering of risk scores over the last 24 months. Risk profiling of Cost Improvement Plans (CIPs) shown to be accurate over time	Trust benchmarks within the top decile for achievement of risk management training. Improvements derived from risk management are shared with other organisations and recognised by peers. Contribution by trust to national patient safety learning efforts
PATIENT SAFETY AND MANAGING INCIDENTS	No	Incident reporting is understood by all staff and considered to be valuable. Roles and responsibilities of staff at division and specialty level in relation to incident reporting are clear. There exists evidence of staff reporting incidents of moderate harm and above. A review of incident reports is a standing agenda item at divisional and specialty level clinical governance forums	Evidence of reporting high numbers of no and low harm incidents. With only a few exceptions, incidents are reviewed within policy timescales. Duty of Candour discussions are evidenced. Staff know about 'learning from incidents' events / communications. Serious Incident (SI) investigations are often overdue. Further information requests are frequently received back from commissioners	Quality checking for completion of action plans for incident reports. Feedback is provided to staff on actions arising from incidents. Staff routinely attend patient safety training. Incident reporting is not dominated by one staff group. SI investigations are routinely completed on time, and only occasionally overdue. Further information requests are occasionally received from commissioners. NRLS reporting is in line with the national average	Improvement examples rooted in reported incidents are available. Lessons learnt from incidents are discussed and shared across divisions / specialties. Broader local and national patient safety intelligence is considered. Duty of Candour compliance is tested routinely. No out of date SI investigations exist within the division/specialty. NRLS reporting is in the upper quartile	Staff are systematically involved in peer learning exercises within the trust and externally. Examples of harm reduction are demonstrable. Examples of patient/carer involvement with patient safety initiatives are available within the last 12 months. There are no breaches of internal SI deadlines in the past 24 months. NRLS reporting has been in the upper quartile for the last 12 months	In the upper quartile of NRLS reporters. Examples of harm reduction achievements are externally shared. Staff routinely participate in broader local and national learning around patient safety. Peer recognition exists around patient safety initiatives

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PATIENT AND CARER FEEDBACK	No	Staff understand the 'Friends and Family Test', the role of PALS and the local complaints process. The division/specialty has considered these as part of a broader range of potential feedback mechanisms for patient and carer feedback. Complaints are responded to, but response time often falls outside the time period agreed with the complainants	Patient and carer groups within the division/specialty have been identified. Positive and negative patient stories are considered at division/specialty governance meetings. Patient and carer feedback is given the same profile as other elements of quality in division/specialty reporting and discussion. More than 50% of complaints are responded to within the agreed timeframe	Division / specialty complaints and PALS reviews look at content as well as process performance/uptake metrics. There is a consistent approach to advertising feedback mechanisms to patients and carers, and staff are confident to solicit patient and carer involvement in local initiatives e.g. patient forums, surveys, focus groups etc. More than 90% of complaints are responded to within the agreed timeframe	There are examples of improvements achieved that were initiated as a result of patient or carer feedback. Broad themes identified from patient and carer feedback are included in division/specialty improvement plans. Feedback concerns are shared across divisions and specialties. When asked, front line staff can recall examples	Improvement plans are systematically checked against, and generated by, patient and carer feedback mechanisms. Improvements in examples of patient experience are demonstrable over the past 24 months. Patient feedback meaningfully contributes to other elements of quality management, e.g. the risk registers	Patient and carer feedback initiatives have been recognised externally. Patient and carer advocates use the work of the division/specialty to suggest improvement mechanisms to other organisations
IMPROVEMENT, IMPLEMENTATION AND LESSONS LEARNED	No	Staff understand that systematic improvement processes are part of business as usual. Division/specialty leadership have considered how to use assurance and other governance mechanisms as the basis for the local improvement plans. The skills for implementing improvement are recognised and form part of overall staff evaluations/recruitment strategies	Quantifiable action plans are part of the approach to compliance and quality management. Success criteria is included within action and improvement plans. Selected staff have received training in improvement techniques. Management forums have time set aside to consider improvement approaches	Regular staff forums have time set aside for sharing improvement work, lessons learnt and changes to practice. Staff understand routes by which they can surface improvement ideas. When ideas have been offered, there is feedback to advise on the adoption or otherwise of such ideas. There are multiple examples of practice changing as a result of improvement plans, and lessons learned. These transcend single divisions/specialties	Staff feedback confirms that improvement work is valued, and recognised as everyday within the division/specialty. Improvements, including CIPs, have a track-record of delivering intended results. Quantifiable dividends from improvement work are identifiable. Several care pathways have developed as a result of specific improvement interventions. Improvement science capacity has been developed locally through training and/or recruitment	There is a consistent track-record of tangible results and multiple examples of learning between divisions and specialties. Improvement initiatives that derive from learning from outside the organisation have been delivered. Future plans are developed on the expectation of continuing improvement work, and this extends beyond financially-related benefits to issues such as improvement to patient experience, harm reduction, etc	External peers have recognised and copied improvement approaches from the division/specialty. Improvement work has been written up and shared at external events or by publication. Other organisations have recognised the contribution of work undertaken by us in their own improvement work
CLINICAL AUDIT	No	Clinical and non-clinical staff recognise the value of clinical audit, and appropriate time has been quantified for involvement in this. The division/specialty has developed an annual plan for supporting clinical audit activity and there is a division/specialty forum established for sharing results and learning points	Specialties have a clinical audit programme which is coordinated by the division, and the division has an overall clinical audit plan as part of its improvement work. The clinical audit plan includes a balance between national and local audits. Clinical audit activity is rooted in areas where risk, or improvement potential, has been demonstrated	There is evidence of action being taken to improve clinical practice at ward/team level in response to clinical audit results. Some cross-specialty clinical audits are undertaken, with joint improvement plans in place. The division actively steers clinical audit activity as part of its improvement work	There are quantifiable examples of benefits as a result of clinical audit activity, such as improved compliance, better use of resources, care pathway modification, etc. There are examples of inter-division/specialty learning. There is a tangible connection between clinical audit and other clinical governance mechanisms, for example clinical audit appears as a consistent action plan item within risk registers and SI action plans	Quantifiable benefits from the clinical audit plan is systematic over a period of at least 24 months. Where audits are comparative, there is a forum where the results are discussed and benchmarking takes place. Lessons are sought from higher-performers. Clinical audit is used as a dynamic measurement of performance to support overall compliance assurance and improvement programmes	There are examples where improvements that have used clinical audit have been adopted by others. There is full compliance with all mandatory national audits. Peer-review publications authored by division/specialty staff have used clinical audit, or the equivalent for scientific conference presentations. There have been contributions to the national development of clinical audit, for example by involvement with HQIP
MORTALITY	No	Case note reviews for patients who have died are undertaken on an ad hoc basis. The multidisciplinary team (MDT) is not routinely involved in case note reviews, which is sometimes undertaken by individuals	Case note reviews are standardised and follow agreed best practice. More than 50% of deaths in the division's care are reviewed, and review is usually undertaken by a team rather than an individual	All patient deaths are reviewed by the MDT at a dedicated session. The division receives summary data from the trust which they review with the aim of abstracting issues relevant to the division. Nationally recognised measures are used to measure the quality of care and preventability e.g. Hogan scale, NCEPOD standard	We can identify changes in practice that are routed back to case reviews. There are action plans to pick up issues identified by mortality reviews (reviews from within the division and for the trust overall)	There have been reductions in mortality over the last 24 months as measured by HSMR and SHMI	Our HSMR and SHMI is 90 or less. The work on mortality at the trust has influenced care and pathway design in other organisations