BOARD GOVERNANCE, ASSURANCE AND CQC COMPLIANCE ACTION PLAN

(1) Governance and Compliance Structure Actions
(2) Strategy, Policy, System & Process Actions
(3) Team Actions

High = for the majority of the milestone to be achieved within one month
Medium = for the majority of the milestones to be achieved within one to three months
Low = for the majority of the milestones to be achieved within three to six months

	Proposed Action	**Milestone Tasks** *(Key tasks that need to be carried out to implement actions)*	**Priority** Low Medium High	**Responsible/ s Person**	**Exec Lead**	**Colleagues/ teams/ divisions/ depts/ partners to consult / engage**	**Target Date**	**Success Indicator** *(How you can measure / demonstrate that an action is complete)*	**Progress** *(Details of progress to date, useful information, barriers encountered etc) RAG RATE and FILL CELL with colour code (Red/Amber/ Green)*
1	**Governance and Compliance Structure Actions**								
	Review of Committee/ Groups Terms of Reference to ensure responsibilities regarding oversight of risk management, governance and	• Obtain current terms of reference • Review current agreed committee structure (approved at Board March 2013)/ integrated governance framework and	High	CW/GD	AT	Governance leads Committee/ Group/ panel chairs	End of Jan 2014	ToRs in place with clear responsibilities re compliance monitoring and systems governance	

	assurance systems and CQC compliance is appropriately described and that it is a regular agenda item	ensure ToRs are in date, consistent and valid • Share ToRs with committee/group/ panel chairs and discuss and explain integrated governance and quality remit • Ensure appropriate representation from governance, risk, quality, safety team at meetings							
	Ensure fit for purpose Divisional Governance and Quality meetings in place	• Draft Standardise single Terms of Reference and standing agenda items • Consult with key divisional leads to receive feedback • Implement new ToRs and agenda • Ensure high standard minutes taken and stored in appropriate evidence drive • Ensure evidence of actions followed up	Medium	CW/ AW	AT	Divisional and Corporate Leads	End Jan 2014	Standardised Divisional Governance and Quality ToRs Meetings taking place with standing agenda	
	Set up programme of regular divisional and corporate forums	• Alongside review of CQC Assurance Policy, agree model of evidence	Medium	Interim CQC Lead	AT	Governance and assurance team	End Feb 2014	Meeting schedule in place Assurance on	

	where the outcome leads and divisional representatives alongside other key parties (governance and assurance team representation, NED, exec, senior managers [clinical and non-clinical]) "hold court" to hear the evidence of compliance (for assurance purposes), review action plans to address areas of non-compliance and the relevant associated risk registers.	evaluation • Identify team to 'hold court' • Engage divisional leads on proposed new model and rationale • Set up schedule of meetings on rotational basis • Carry out modified '360 degree review' (as per clinical divisions) of Estates and Facilities division • Implement CQC Compliance Assurance review meetings				Identified NED, exec, senior managers [clinical and non-clinical] representatives Divisional and corporate teams		compliance assessed and compliance position clear Action plans to address areas of non-compliance or threats to non-compliance managed Risk registers up to date to reflect risk based on assurance	
	Ensure new committee structure is fully established and that meetings are taking place as per Terms of Reference	• Obtain current ToRs and review • Revise ToRs to ensure they are consistent and meet requirements and clear line of sight from 'Board to ward' • Obtain minutes of last meetings from Chairs • Establish annual cycle showing all	High	GD	AT	Board Committee, Group and Panel Chairs and members Governance Team Report providers as per ToRs	End of Jan 2014	Robust governance committee structure fully established Annual cycle of meetings available Full suite of ToRs in standardised template Effective meetings	

		meetings, dates and reporting is clear • Put cycle of meetings and ToRs on intranet • Monitor to ensure meetings are conducted in accordance with ToRs							
2	**Strategy, Policy, System & Process Actions**								
	Review the Trust's current provision of Risk Management/ Patient Safety Software (Datix) to gain assurance that the Trust can provide effective and comprehensive governance around incident reporting, claims, complaints and risk management	• Review current Datix provision to ascertain all issues preventing effective Patient Safety Reporting analysis, review and management e.g. space remaining on current server, speed of current server etc in light of reported concerns (see Risk Register and concern re running out of space • Is replacement server for Datix on the IT upgrade plan? • Review status of	High	Interim Head of Risk	PJ	IT Director and team	End of Jan 2014	New Datix server Datix web for Risk	**Update at 9/12/13:- Risk score relating to Datix server and capacity increased on risk register from 15 to 20 by CW given frequency (i.e. likelihood) of problems due to server impacting on usability. 19/12/13: Interim Head of Risk to produce paper for first exec meeting in January (to include the**

		existing Business Case and risk on the Register relating to the need for a new server taking into account a necessary Datix upgrade • Evaluate the benefit of saving older documents on another server as a temporary solution							**business case of Jan 13)**
s	Review and refresh of the Trust's CQC Assurance Process document to ensure it is fit for purpose in light of changes since its inception	• Review Assurance document • Revise document in light of new Trust processes/ structure • Launch document	High	CW/Interim CQC Lead	AT		Wk beg 20th Jan 2014	Up to date CQC Assurance Policy	**Update at 9/12/13:- CVs for Interim resource to lead on CQC sourced. 19/12/13: Interims for CQC Lead and NHSLA/ Policies Lead appointed, commence on 6th Jan 14**
	Ensure all involved understand what is meant by assurance and verifiable evidence of compliance, and how to assess it.	• Provide guidance on definitions of assurance and verifiable evidence • Provide standards required to assess evidence • Provide training and support.	High	CW/GD	AT	Board AMD for clinical standards and audit Divisional and Corporate	End of Jan 2014	Clear understanding of definitions of controls, assurance, verifiable evidence	**Update at 9/12/13:- CQC Compliance maps drafted for all outcomes.**

		• Develop 'CQC Compliance map' to signpost Outcome leads to documents that should be considered for evidence and evaluated for levels of assurance • Provide 'CQC Compliance Map'				Leads			
	Update the Outcome Leads for CQC in light of staff and exec changes	• Identify correct leads • Agree leads with Exec directors • Inform leads and provide interim guidance of role and tools whilst CQC Assurance policy is being updated • check policy re responsibility needing to be in job descriptions for roles	High	ND/CW/interim CQC Lead	MVW	Outcome leads Execs AMD for clinical standards and audit	End Dec 2013	Outcome leads list agreed Outcome leads accept responsibility	**Update at 9/12/13:- List updated with names. Job titles being added prior to circulation to execs/Med director to confirm.** **19/12/13: Outcome leads with Execs for approval- awaiting returns**
	Clear communications of expectations and responsibilities to outcome leads and divisional	• Issue current policy to new leads so they understand the role, explaining the policy will be reviewed and	High	ND/CW/interim CQC Lead	MVW	Outcome leads Execs AMD for clinical	Commence by wk beg 16th Dec and Complete by end Dec	Outcome leads in place with clear understanding of role	**19/12/13: Outcome leads with Execs for approval- awaiting returns**

	CQC leads.	updating to reflect new governance committee structures • Discuss with new leads the requirements of the role • Share with leads the tools with appropriate guidance on how to use • Advise divisions and corporate directorate of leads • Make list available on intranet				standards and audit Divisional and Corporate Leads	2013		
	Re-launch CQC Assurance Process/Policy	• Upload to intranet • Share with divisions and directorates • Send out bulletin • Set up 'road shows'/workshops with outcome leads and relevant others • Mention at onion • Consider use of 'promotional' materials to support e.g. posters, pocket guides, etc	Med	Interim CQC Lead	AT	Outcome leads Execs AMD for clinical standards and audit Divisional and Corporate Leads Clinical Leads Comms	End of Jan 2014	Policy in place	
	Call for all	• Agree tool to be	High	Outcome Leads	MVW	Outcome leads	End Jan	Full complement of	

	divisions/services to undertake an urgent Provider Compliance Assessments using the CQC PCA tool	used • Share with Outcome Leads • Set deadline and explain urgency • Monitor returns and evidence • Prepare report on findings • Add to risk register as appropriate		with governance team	JA	Execs AMD for clinical standards and audit Divisional and Corporate Leads Clinical Leads	2014	robust PCAs completed	
	Ensure 'fit for purpose' divisional and corporate dept risk registers and BAF are in place, which captures all risks, including those related to governance, assurance and CQC outcomes compliance.	• Ensure risk register report is fit for purpose • Obtain current risk registers • Governance team to support identification of risks through relevant forums • Set up and run risk register workshops with divisions and corporate departments • Deliver risk management training	High	Interim Head of Risk	AT	Divisional Risk Leads Outcome Leads Committees/ Groups All relevant staff	End Jan 2014	Risk registers in place across all areas Effective BAF tool in place	**Update at 9/12/13:- Risk Assessment form determined as not fit for purpose. Being redrafted. Only 280 risks open on entire risk register- to be reviewed early week beg 9/12/13. 19/12/13: Risk registers being split out to Directors for review. New risk register assessment form shared with Divisional**

									risk leads for immediate use (as per Execs 18/12/13)
	Review Risk Management Strategy and Policy and associated systems and processes support Risk Management	• Review functionality of current Datix versions • Liaise with IT re the need to roll out Datix Web for risk registers (server implications) • Review current Risk Management training (induction, regular programme of training, training for Board) • Consider trust-wide staffing structure and reporting lines to deliver robust risk management • Review BAF • Recommend new BAF template and risk register template as necessary • Liaise with Board and divisional leads responsible for risk/governance regarding templates	High	CW/Interim Head of Risk	AT	Divisional Risk Leads Outcome Leads Committees/ Groups All relevant staff Training and Development dept	End Jan 2014	Risk Management Strategy and Policy in place Training programme in place	**Update at 9/12/13:- Datix functionality poor due to server capacity- urgent attention required. Interim Head of Risk to pursue this week. 19/12/13: as per other action- paper to go to execs in Jan re Datix server. Risk management training at induction reviewed and not fit for purpose. Meeting to be arranged for early new year to discuss required changes with T&D**

		• Implement policy/strategy and templates • Organise soft and hard launch							
	Ensure systems and processes to ensure NHSLA standards and policy management systems and processes are robust	• Agree that the NHSLA standards will continue to be an expected standard and tool used by the Trust (irrespective on the use by the NHSLA for calculating CNST payments) • Undertake a review of current compliance against level one regarding policies in place for the 50 applicable policy areas • Triangulate against T&D training offered and that required as stated in policy and drill down to understand any gaps (i.e. why a policy says training will be delivered and the training available does not meet need) • Ensure training	High	Interim NHSLA standards/policy compliance and assurance lead	AT	Divisional Risk Leads Outcome Leads Committees/ Groups All relevant staff	End Feb 2014	Policies in place System for policy management in place and operational Audit of policies scheduled Training available as per policy requirements	**Update at 9/12/13:- CVs for potential interim NHSLA standards obtained- to interview this week. 19/12/13: interim starts on 6th Jan. Confirmation that Trust has previously agreed to continue with NHSLA standards (as per MVW)**

		needs analysis takes place and training is made available as required • Prioritise the review and update of key policies • Inform policy leads of need to update policies • Ensure means for monitoring implementation is clearly understood and communicated and that all responsible are sighted on requirements • Plan to audit implementation of policies at appropriate time: ensure it is in the business planner for integrated governance							
	Set up shared CQC drive with divisions and ensure verifiable evidence of compliance is regularly provided for each service and location across the Trust,	• Identify who should have access to drive e.g. outcome leads, board sec, minute takers for committees etc, div risk leads, • Speak to IT to arrange access	High	ND	AT	IT Divisional and corporate leads Board Secretary	End Jan 2014	Drives with access available	

	saved by outcome	• Communicate doc quality standards for saving info, by outcome, by service, by location							
	Ensure Statement of Purpose and registered locations are accurate and that updates are appropriately managed	• Identify who is responsible for Statement of Purpose and updating it • Clarify who is the nominated person for the Trust • Check process for updating- is there a policy or documented procedure; What are the governance arrangements for notifications to update. • Review Trust's Statement of Purpose and registered locations, services and activities, to ensure accuracy • Ensure regular updating by person responsible • Sign off arrangements with Board are clear • Clarify who	Med	Interim CQC Lead	AT	Execs Service Leads	End Feb 2014	Up to date statement of purpose and list registered locations and services with CQC	**16/12/13: CQC registration re registered activities and locations are identified as not being accurate. Interim CQC lead to review urgently early January**

		submits notifications /updates to CQC							
	Plan and implement a programme of “mock CQC inspections”.	• Identify team for mock inspections • Prioritise areas of greatest concerns based on triangulation of soft and hard intelligence available • Identify or develop documentation/ inspector guides • System for feedback of findings in place	Medium	Interim CQC lead	MVW JA	Divisional and Corporate Leads Board	End Feb 2014	Programme in place	
	Set up a system where every relevant Board and Committee paper is routinely saved as evidence against each of the CQC outcomes.	• Check that the Board/Committee paper cover sheet requires the author to identify which outcome/s the paper should be saved against. • Discuss with Board Sec, who should lead on this requirement and save the documents accordingly	High	GD	AT	Board Sec Report Writers of papers for formal committees/ groups/ panels	End Jan 2014	New cover sheet for papers Papers saved into correct evidence folder	
	Verify whether action plan for previous Internal Audit of CQC	• Obtain report • Review implementation of	High	Interim CQC Lead	MVW JA	Action leads as required	End Jan 2014	All actions completed	

	Compliance has been implemented.	action plan • Ensure leads implement any outstanding actions asap, if still relevant							
	Ensure Internal Audit Plan allocates sufficient audit time to CQC and governance.	• Speak to finance lead with responsibility for relationship with internal audit • Obtain Internal Audit Plan and assess days allocated in light of risks in relation to governance and compliance with registration with the CQC (and associated requirements)	Medium	CW/GD	AT	Head of Internal Audit (IA) Lead for relationship with IA	End Feb 2014	IA plan reflects areas requiring audit in integrated governance	
	Ensure Policy Management System is in place and managed appropriately	• Evaluate current position regarding out of date or policies requiring review • Identify lead for policy management • Review and revise policy on policies in light of committee structure changes, especially regarding	High	Interim NHSLA standards/policy compliance and assurance lead with team administrator	AT	Policy authors Ratifying and approving forum chairs	End Jan 2014	Robust system in place	

		ratification, consultation and approval of policy documents • Ensure it is clearly communicated							
	Ensure the integrated governance teams have the key strategies, policies and governance procedures within sphere of responsibility fully up to date e.g. SI/incidents management policy; Being Open Policy; risk management; clinical audit; complaints; PALS; legal; risk; NICE, NCEPOD, Quality Standards; Central Alerting System (CAS); BAF; Datix	• Review all policies and ensure continued relevance, including being in date • Review procedural/process and ensure in line with national frameworks e.g. serious incident management • Refine processes ensure fit for purpose, lean and reduce risk of error	High	CW with all team	AT	Integrated Governance Team Divisional and Corporate leads	End Jan 2014	All policies and system in place and well managed	
	Review Serious Incident Management and ensure it is compliant with the National Framework (2010; 2013) and links appropriately to the contractual	• Review previous policy and procedures • Attend meeting with the CCG regarding the reports and engagement with them regarding 72hr/7day/45 day	High	MLW/PS/CW	AT	MVW JA AMDs Divisional Directors Clinical Leads Divisional Risk	End Jan 2014	Revised Incident (including SIs) Management Policy in place Effective system in place	**Update at 9/12/13:- Positive meeting with CCG held. 19/12/13: New interim SI process in draft form for initial review**

	Duty of Candour	reports • Review SI review meetings and ensure fit for purpose/timely/ appropriate attendance • Review significant incident management and supporting procedures • Implement robust systems management for SIs				Leads			**by SJ/MVW/JA**
	Ensure Being Open process and contractual Duty of Candour meet the requirements as laid out for the NHS(NPSA Being Open Framework and alert 2009; NHS Standard Contract 2013/14 SC35) are aligned	• Review current policy and procedure • Carry out gap analysis between current position and alert/framework requirements • Identify where evidence of Being Open is currently held • Set up robust system of recording as per SC35 • Review training arrangements and put in place appropriate training	High	CW/PS	AT	MVW JA AMDs Divisional Directors Clinical Leads Divisional Risk Leads T&D dept	End Jan2014	Revised Being Open Policy in place Effective system in place Training on DoC/Being Open in place as per national framework	**19/12/13: CPD training allocation of £39k for Duty of Candour (DoC) training has been reallocated for complaints training. Funding needs to be found for Being Open/DoC training**

	Ensure Governance and Risk KPIs are in place and monitored regularly (e.g. for risk management, SI management, Being Open/Duty of Candour, clinical audit)	• Review current position • Draft KPIs in light of revised policies • Consult on KPIs • Speak to performance/IT regarding adding to overall quality scorecard • Discuss use of Qlikview for data from Datix and SI management database • Set up systems for feeding timely and accurate information into appropriate scorecards/reports	Medium	CW	AT	MVW JA AMDs Divisional Directors Clinical Leads Divisional Risk Leads IT/Performance leads Integrated Governance teams	End March 2014	KPIs in place and regularly monitored	
	Ensure action plans across all elements of governance and quality improvement (e.g. from SIs, incidents, complaints, PALS, legal affairs, audits, surveys, inspections, reviews, etc) are tracked, monitored and reviewed for completion, impact, and	• Scope out current means of consistently tracking the implementation and completion of all action plans in the Trust • Look at options available for action plan tracking in the Trust • Recommend model/system • Implement agree model/system • Review method of	Medium	CW LL	AT	MVW JA AMDs Divisional Directors Clinical Leads Divisional Risk Leads IT/systems leads comms	End March 2014	Action Plan tracking system in place Lessons learned shared consistently	

	relevance, **and that lessons learned are shared across the Trust**	sharing lessons learned • Consider need for quality governance newsletters							
	Ensure robust Integrated Governance and Quality Reporting	• Review current report formats, content/data, triangulation of information, scheduling, author, etc for governance and risk papers • Review in light of Terms of Reference and standing agenda items of committees, groups, panels, meetings • Determine appropriate model for reports in light of all influencing factors (e.g. national guidance, Trust position, team structure, data available, etc) • Consult on proposed best model (if different to current) • Implement agreed model	Medium	CW and all governance/ quality leads	AT	Board Divisional Directors Clinical Leads Divisional Risk Leads	Feb 2014	Clear reporting requirements in place	
	Ensure plans and decisions are in	• Board Secretary and AD for	Ongoing	GD and CW	AT	Leads for risk summit actions	ongoing		

	line with risk summit action plan re governance in order to ensure duplication or differing approaches that may lead to confusion	integrated governance and quality to liaise frequently and agree responsibilities for actions				and this action plan			
	Ensure NICE, NCEPOD, and Quality Standards management is robust	• Review the relevant policies • Devise flowchart of process for each • Define and communicate divisional responsibilities • Identify KPIs to include timeliness of responses • Ensure action plans are monitored • Obtain Terms of Reference of NICE Implementation Review Group from Board Secretary • Identify which Group/Committees NCEPOD and Quality Standards are supposed to be monitored through and determine if they are in place	High	Interim NICE Lead/ AMD for clinical standards and audits	MVW JA	MVW JA AMDs Divisional Directors Clinical Leads Divisional Risk Leads	End Jan 2014	Compliance monitoring systems in place	**19/12/13- Resource for a 3rd interim not available- review of workload to take place week beginning 6th Jan when the two interims start to see how actions required can be re-allocated. Meeting arranged with Anna Wood for 2nd wk Jan to further discuss actions required and plan next steps.**

		• Set up or input into the set up of the appropriate monitoring and scrutiny groups • Establish the current position regarding the establishment of the NICE Implementation Group as per new governance committee structure							
	Ensure ongoing additions to this action/work plan are added and tracked through to implementation as identified	• Set up regular weekly CQC Compliance monitoring meeting • Review action plan and associated risk register and update on an ongoing basis	Ongoing	CW, SJ, JA, MVW, AT, GD Leads	AT	All action leads	ongoing		**19/12/13:** Weekly meetings to start on 8th Jan 2014
3	**Team Actions**								
	Review integrated governance staffing structure and ensure fit for purpose	• Define the function of the directorate (including what comes into its remit e.g. risk, audit, incidents, Datix, complaints, legal, etc) • Benchmark structure against	Medium	CW	JA MVW	Execs HR Staffside Other senior managers Finance	End March 2014	Job descriptions in place Consultation Structure appointed to	**19/12/13: Job descriptions of divisional risk leads requested**

		other similar sized/challenged organisations and FTs, including against guidance available regarding requirements for quality governance, for example • Obtain all relevant job descriptions (including those of devolved/divisionally based roles, system administrators) • Map against functionality required of directorate of Integrated Governance and Quality (patient safety, experience, effectiveness) • Liaise with Finance about budget • Agree budget (business case as required) • Draft consultation document • Write job descriptions and take through AfC process • Engage with							

		staffside as per management of chance policy requirements • Launch consultation • Appoint to structure							
	Ensure the governance and risk (including clinical audit) function is appropriately resourced to be able to deliver its responsibilities	• Resource the team/functions appropriately with skilled and experienced interims whilst the integrated governance, quality, assurance and compliance functions/team are restructured • Identify short-term resource required to support compliance/ governance improvement plan • Obtain agreement to source • Source experienced Interim managers/ project leads asap • Obtain current structure • Scope out current responsibilities/work load • Assess against job	High	CW	MVW JA	AT, JA, MVW	End Jan 2014	Interim support in place Clear understanding of function, roles and responsibilities of team/s	**19/12/13: On CEO approval two interims appointed to specifically support the delivery of the action plan- in place from 6th Jan 14**

		descriptions and define difference between the two (i.e. what are band 6 and band 5 picking up since senior staff have left) • Obtain budget/ establishment information for pay • RCA into clinical audit structure and posts in place vs substantive posts							

MVW= Mike Van der Watt, Medical Director
JA= Jackie Ardley, Chief Nurse
AT= Antony Tiernan, Director of Communications and Corporate Affairs
CW= Caroline White, Interim AD
AW= Anna Wood, Associate Medical Director
GD = Georgia Denegri, Board Secretary
PS = Pooja Sharma, Risk and Patient Safety Manager (Serious Incident Coordinator)
ND= Nilofer Dawoodani, Assurance Coordinator
KDS= Karin Dawson-Smith, Clinical Audit Manager
MLW= Millie Leigh-Wood, Interim Risk Lead (from 9th Dec)
PJ= Paul Jenkins