Bradford District Care **NHS**
NHS Foundation Trust

BOARD MEETING

31 March 2016

Paper Title:	BDCFT Quality Strategy 2016 – 2019
Section:	Public
Lead Director:	Andy McElligott, Medical Director
Paper Author:	Debbie Webster, Deputy Director of Quality & Governance
Agenda Item:	**11**
Presented For:	Comment

1. Purpose of this Report:

The purpose of this report is to present the BDCFT Quality Strategy for ratification. The current BDCF Quality Strategy has been in place since August 2014; a full review and re-write of the strategy has been undertaken to ensure that:

- Foundation Trust requirements are met including the requirements of Monitors 'well - led' framework
- The development of the Trust Quality Goals features more prominently
- The Trust's commitment to improving quality is more clearly stated

The Quality Strategy also describes quality governance requirements and processes.

2. Summary of Key Points

The following process for development of the Quality Strategy should be noted:

- Draft submitted to December QSC for comment
- Circulated to all Board members for comment
- Circulated to Trust Wide Involvement Group for comment
- Strategy amended in light of comments from all of the above
- Approved at QSC in March 2016

Once the strategy has been ratified, a summary version will be developed and an implementation / communication plan will be agreed and implemented.

It should be noted that, as agreed, the 2016 / 17 Quality Goals are not set out in the strategy but are referenced within it; this is because the strategy has a three year life span whereas the goals are refreshed annually.

3. Board Consideration

The Board is asked to consider the content of the Quality Strategy and to ratify the document.

4. Financial Implications

None

5. Legal Implications

None

6. Equality Impact Assessment

There are no specific equality implications.

7. Previous Meetings/Committees Where the Report Has Been Considered:

Audit Committee		Quality & Safety Committee	X	Remuneration Committee		FB&I Committee	
Executive Management team		Directors Meeting		Chair of Committee's Meeting		MH Legislation Committee	

8. Risk Issues Identified for Discussion

No specific issues have been identified for discussion

9. Links to Strategic Drivers

Patient Experience	Quality	Value for Money	Relationships
The content of the Quality Strategy inevitably has a focus on the quality quadrant however it has relevance to all four strategic drivers.			

10. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act

11. Recommendations:

It is recommended that the Board ratifies the Quality Strategy.

Quality Strategy
2016 - 19

We are committed to ensuring that a culture of total quality exists throughout our organisation, exemplified by the attitudes and behaviours of every individual and team, regardless of location or function.

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BRADFORD DISTRICT CARE NHS FOUNDATION TRUST
QUALITY STRATEGY 2016 – 2019

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QUALITY STRATEGY 2016 – 2019
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BRADFORD DISTRICT CARE NHS FOUNDATION TRUST
QUALITY STRATEGY 2016 – 2019

INTRODUCTION

National Context

In 2008 Lord Darzi refocused attention on the importance of high quality care, defining such care as safe, effective and personal; this is the working definition used by BDCFT.

The Francis Report (2013), the subsequent Keogh Report (2013) and the Berwick Report (2013) all provided the NHS with significant learning in respect of the need for quality to be at the forefront of all we do, particularly in terms of ensuring transparency and candour and improving support for compassionate caring and committed care and stronger healthcare leadership.

The vision for delivering high quality care for all is explicitly stated in the NHS Constitution which sets out the rights patients can expect from the NHS including quality of care, confidentiality, information and a right to complain if things go wrong.

All Foundation Trusts are required to operate within Monitor's regulatory framework achieving governance and quality thresholds and to maintain compliance with the Care Quality Commission Fundamental Standards.

BDCFT commitment to quality

We are resolute in achieving our aspirations for quality and safety within a challenging climate of tightening resources and competing demands; clearly this strategy cannot 'stand-alone' and takes its place alongside the Integrated Business Plan and the Annual Plan as a key statement that frames the Trust's approach to strategy and operations.

Our previous achievements

2014 / 15 was a particularly important one for the Trust as we continued our journey toward achieving Foundation Trust status on 1st May 2015.

To achieve this success the Trust was subject to intense external scrutiny of our quality governance arrangements. Our achievement stands as testament, to the dedication of every member of staff, to provide the highest possible standards of care to everyone who uses our services.

In June 2014 we were one of the first mental health and community trusts to be inspected under the Care Quality Commission's new, more rigorous, inspection regime and were pleased to receive an overall rating of 'Good' for the quality of our services.

In addition to our positive Care Quality Commission inspection outcome, we continued to deliver against our quality priorities in order to support our commitment to providing safe and

effective services which result in a positive experience for patients and service users. We performed better against some areas than others and will continue to strive for improvement in all areas.

Our future aspirations

We will build on our excellent foundation, embedding a culture of total quality exemplified by the attitudes and behaviours of every individual and team, regardless of location or function.

We will continue with a relentless focus on quality improvement, constantly moving toward achieving our vision of becoming one of the country's leading providers of integrated community health services. The way we will achieve this is spelt out in this strategy as follows:

- Part 1 – quality culture & quality improvement
- Part 2 – quality governance; definition, structures & processes

Purpose of the Quality Strategy

The main purposes of this strategy are to

- Confirm the Trust's aspirations, commitment and quality goal processes in relation to delivering the highest quality services
- Confirm the Trust's commitment to a total quality culture throughout the organisation and describe an approach for ensuring continual quality improvement
- Describe the Trust's approach to and processes for ensuring effective quality governance which ensure that the effective approaches are in place from team to board level
- Ensure that the quality aspects of the BDCFT Integrated Business Plan are supported and implemented

Documentation supporting implementation of the Quality Strategy

The following documents will be produced and utilised on an annual basis to support implementation of all aspects of the strategy:

- A communication plan to ensure awareness of the overall strategy purpose and content
- An action plan including all actions required to ensure the strategy is implemented and embedded
- A summary document for staff use which includes the annual Quality Goals and indicators
- A SMART action plan for each Quality Goal with identified and measureable outcomes to ensure that progress is made against each goal throughout the year

PART 1: QUALITY CULTURE AND QUALITY IMPROVEMENT

1. EMBEDDING A CULTURE OF TOTAL QUALITY

A culture of total quality is the product of trust-wide efforts to install, and make permanent, a climate in which we continuously improve our ability to deliver top quality services for all. Such a culture is easier to recognise and feel than it is to describe and building such a culture requires leadership, commitment and hard work.

To support this ambition the trust will continue to invest in appropriate leadership development opportunities for staff, such as 'Engaging Leaders' and 'Moving Forwards'. The result will be a large cohort of supportive leaders who see team performance as all-important and help their teams to remove any barriers which prevent the trust from meeting the needs of its service users.

We will continue to foster a culture of openness and learning (key elements of an effective quality culture) by:
- Taking a pro-active approach to anticipating challenges to quality and safety, not just responding to them as they become evident
- Ensuring consolidation of evidence and information from the multiple sources available
- Conducting open and honest conversations with professionals including those involved in front line services.
- Reflecting on the balance of the picture that emerges, by pursuing deep-dives where appropriate, and by ensuring follow through where issues are identified.
- Learning from our own experience and from that of others

The basis of our culture of total quality is our vision wheel and success will be the knowledge that we consistently and unequivocally deliver against the statements in all 12 segments of the wheel.

1.1 Vision and Values

Our vision is to provide the best possible care to the people of Bradford, Airedale, Wharfedale and Craven and to be recognised as one of the country's leading providers of integrated community health services.

Our vision wheel, designed by service users and staff, sets out what we will deliver; it puts 'you and your care' at the centre of everything, adjacent to our guiding values of respect, openness, improvement, excellence and together.
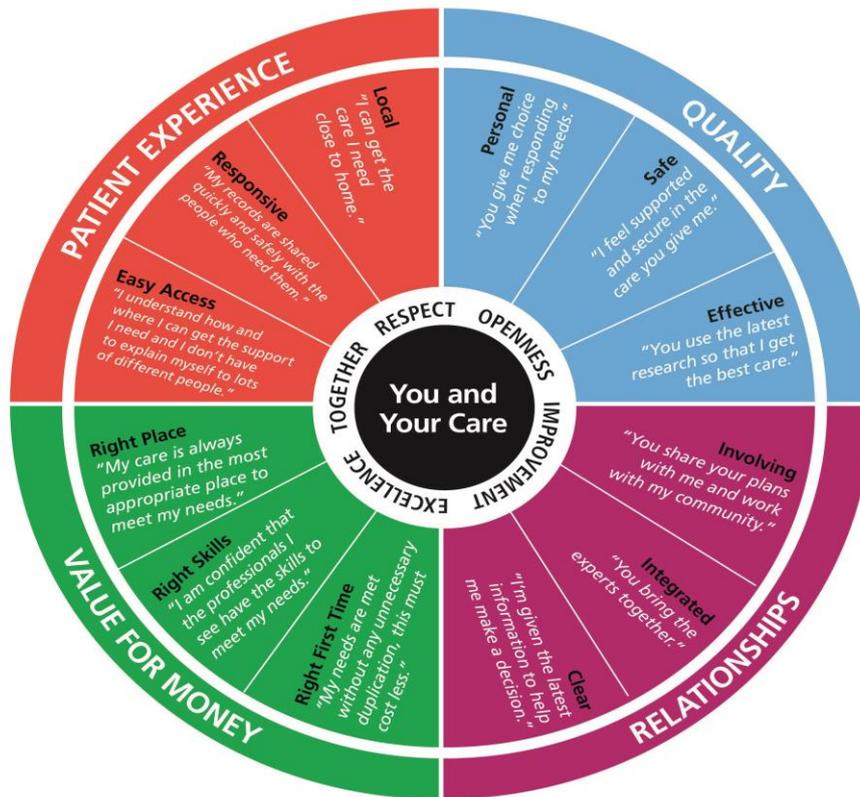
1.2 Quality Ambition

The key principle underpinning this strategy is the Bradford District Care Foundation Trust definition of quality; **'Everything we do is based upon personal, safe and effective interventions'**; as identified in the Department of Health document 'High Quality Care for All - Measuring Quality Improvement'.

Our approach to quality improvement is underpinned by a principle of 'pushing boundaries' and not simply maintaining adequate, or even good, performance; this approach is supported by the challenging quality goals which we pursue on an annual basis.

1.3 Quality Priorities

The three quality priorities for the trust which build on the quality definition are:
- Improving patient **safe**ty
- Improving **effective**ness
- Meeting **personal** need

1.4 BDCFT Quality & Safety Framework

The Trust Quality and Safety Framework builds upon the three quality priorities and supports the trust's Total Quality Culture ensuring that a proactive, open approach to identifying quality issues and learning from a range of information is taken.

Use of the framework as an aide to agenda setting ensures that key issues are routinely addressed across the organisation from operational quality and safety meetings to the business of the Quality and Safety Committee.

BDCFT QUALITY & SAFETY FRAMEWORK		
Good Governance		
Personal	**Effective**	**Safe**
Service user and carer involvement	Staffing • **Numbers & skills** (inc. leadership capacity) • **Fit and proper persons employed (inc. training & development)** • Engagement & morale	**Premises & equipment**
Service user and carer experience including: • **Complaints** and PALS data • Compliments • Feedback • **Dignity and respect**	**Meeting nutritional needs**	**Safe care and treatment** • Serious incident reviews • **Duty of candour** • Incident reporting including alerts • Risk registers
Person-centred care • **Consent** • Care Planning / CPA • Access to services • Self care	Clinical audit	**Safeguarding against abuse**
Equality, diversity & human rights	NICE guidance	Medicines management
	Research and Development	Infection prevention
	Working with other providers	
Standing Items: • Impact on quality from; service changes; commissioner requirements, new standards, resource constraints, • Quality Goals • Issues to escalate to QSC / share with other quality & safety groups		
This framework is utilised as the basis for the agenda of each locality governance meeting; the items identified in bold text relate to the CQC fundamental standards.		

2. ANNUAL QUALITY GOALS

Each year we develop a demanding set of quality goals; these goals are not 'static'; they will be consulted upon and refreshed annually, this is likely to include some goals being 'carried forward ' to the following year and new goals being identified.

Achievement of these goals will require significant effort, supported where necessary by extra resource, and will take the Trust a long way to realising our vision of being one of the country's leading providers of integrated, community healthcare services. The goals are co-produced with governors, other stakeholders and operational services and are designed to address any areas for improvement identified through the consultation process which is illustrated as follows:

Quality Priorities / Goals consultation process

Feedback from events throughout the year e.g.

Camper Van feedback

Service user & carer engagement events

Use of a 'quality question'; what would make a difference to you?

Quality Priority Survey

- Web site
- Staff
- Service users & carers
- Governors (& contacts)
- Members
- Commissioners
- Partners

Analysis of key themes to Council of Governors task & finish group to identify draft quality goals

Draft quality goals to Trust Wide Involvement Group (TWIG) and the Quality & Safety Committee for discussion

Council of Governors task & finish group further develops draft quality goals & indicators

Approval of final quality goals via the Senior Management Team and ratification via Trust Board

Each quality goal will be underpinned by a small number of measurable indicators identified by the operational services which will be held accountable for their delivery. In addition, SMART action plans will be developed to support achievement of the goals / targets.

Performance against Quality Goals will be routinely reported to and monitored by:
- the Quality and Safety Committee which will seek assurances on behalf of the Board
- the Locality Performance Meeting which will hold services to account for their performance

3. CONTINUOUS QUALITY IMPROVEMENT

The trust has in place a number of high level initiatives which support continuous quality improvement and which will be further progressed throughout 2016 – 2019; these are summarised as follows:

3.1 Quality Governance Improvement Plan

The Monitor 'Well Led Framework' sets out best practice in relation to governance arrangements including those for quality governance.

The Trust's Quality Governance Improvement Plan provides a set of actions to help support full compliance with this framework; the plan is monitored routinely by the Quality and Safety Committee which is charged with seeking assurance that actions are implemented and leading to improvements.

3.2 Forward to Excellence

The senior management team meets, regularly, to consider a key area of quality; this often includes an external speaker to ensure that learning can be shared. As a result of each session, a small number of objectives are identified to ensure that learning is used to improve services / quality.

3.3 Change Programme

The Trust's change programme is a series of transformational projects which will bring about organisation-wide change. The projects are designed to ensure that best practice is achieved and the quality of our services improved as a result.

3.4 Quality Report

Our Quality Report sets out a number of quality indicators to drive improvement; these include a number of aspirational, or 'stretch', indicators where the trust has set a target of 100% or zero tolerance. These indicators are encompassed within the Quality and Safety Committee dashboard to ensure ownership and scrutiny at the highest level within the organisation, the indicators are refreshed annually and published externally.

3.5 Commissioning for Quality and Innovation (CQUIN)

Each year we agree a set of CQUIN improvement targets with commissioners; these are a range of nationally and locally agreed targets with the prime purpose of improving quality.

3.6 Quality Impact Assessment

All cost improvement plans (CIPs), transformational projects and business-cases within the trust have a quality impact assessment completed. The purpose of this assessment (completed by a panel of clinicians and managers) is to ensure that a project will not have a negative impact upon quality or safety. Where potential risks are identified, indicators are agreed and monitored to ensure that the Trust is aware of any negative impact on quality at

the earliest stage possible. The quality impact assessment for each plan is reviewed at least 6-monthly to ensure the content remains applicable.

3.7 Electronic Risk Registers

Risk registers are live, dynamic, electronic documents accessible to view risks that threaten areas of work at any time. Real-time progress can be viewed on identified actions in place to mitigate the risks ensuring risks are being managed in a timely manner. This process provides assurance and contributes to the quality agenda by building a safety culture. This culture enhances the safer delivery of care and services, improving the patients experience and the environment for all overall.

3.8 15 Steps Quality Challenge

BDCFT runs a full programme of 15 Steps Quality Challenges, this methodology for assessment of patient experience and service improvement aims to offer meaningful patient and carer engagement that facilitates empowerment and fosters a positive equal relationship in the review of services. Each team visit results in structured feedback to the service to support improvements to quality, safety and service user experience.

3.9 Board Walkabouts

BDCFT implements an annual programme of Quality and Safety Walkabouts whereby a pairing of a Non-Executive Director and Executive Director visits services with the primary objective of talking to groups of staff about quality and safety issues. The Trust encourages open and honest discussion during the visits and the service receives a letter within one working month of the visit, detailing discussions and any agreed actions (where required) which are implemented to support improvement.

3.10 Learning and Sharing

A key element of good governance is to ensure learning from good practice, incidents, complaints, audits and external reports etc. BDCFT is committed to improving quality through this approach. Regular quality and safety learning forums and robust governance arrangements ensure that opportunities for learning and sharing are maximised.

3.11 Meeting Care Quality Commission (CQC) Requirements

The board receives an annual assurance report in relation to how well the Trust is performing against CQC requirements. The CQC introduced their new fundamental standards in April 2015 and the Trust has reviewed its processes to ensure effective assurance reporting against the revised standards. The Trust is committed to achieving a rating of 'Good' or 'Outstanding' across all five themes of 'safe', 'caring', 'responsive', 'effective' and 'well-led' within the CQC inspection regime. A process of self-assessment against these themes (including action-planning to meet gaps in compliance) is being introduced and embedded to ensure that operational and support services are meeting these quality requirements. The outcomes of this work will feed into the annual board assurance report on the CQC fundamental standards.

3.12 Staff Training and Development

The Trust is committed to ensuring that staff receive the training and development required to support the delivery of high quality services. In addition to mandatory training courses and clinical training required by specific professions (i.e. continuing professional development) the following quality and safety related training is provided:

- Clinical audit
- Risk management
- Complaints
- Customer care

- Clinical supervision
- Health & safety
- Equality & diversity
- Engaging Leaders Programme

4. WORKING IN PARTNERSHIP

We work with a range of stakeholders to ensure that our work on quality improvement meets their needs and has maximum impact for the wider community. We engage with service users, carers, staff and external partners wherever possible. We do this as follows:

4.1 Service User and Carer Involvement

a) Service Level

Service users and carers will be involved in quality & safety governance activity across all service areas at whatever level is appropriate to the individual and the area concerned. Practical examples of involvement are as follows:

- Membership of the Locality Quality & Safety Group
- Membership of any sub-group of the Locality Quality & Safety Group
- Attendance at team quality and safety meetings
- Linkage to and from the Trust Wide Involvement Group / Partners in Audit Network etc.
- Attendance of PALs Officers / involvement leads and / or advocates at Locality Quality & Safety Group to put forward the views of service users
- Use of comments cards / feedback systems (including both positive and negative views) which then feed into the Locality Quality & Safety Group.
- Use of established groups to explore specific quality and safety issues
- Carers in Action Group
- Relevant volunteering groups

b) Friends and Family Test (FFT)

The Trust implements the FFT across all services; this provides service users with an opportunity to provide feedback to the trust about the way the services they have used were delivered. The trust routinely reviews and collates the information and ensures it is fed back to services to share success and support improvement.

c) Trust-wide level

The following are examples of how service users and carers are / will be involved in the service governance work at a trust- wide level:

- Representatives attendance at the Quality & Safety Committee
- Attendance at existing service user and carer forums to put forward views
- Attendance at workshops held to examine and develop quality and safety issues
- Membership of groups addressing specific governance issues, for example the Partners in Audit Network

4.2 Staff Involvement

a) Service Area level

Quality is everybody's business and staff have a personal responsibility to support good service governance. It is important that staff teams within service areas have an understanding of governance issues that affect them in the workplace. Specific approaches and opportunities to involve staff in service governance work include:

- Discussion in staff team meetings to inform team quality and safety action planning; this will ensure that the issues being addressed are 'owned' by the team.
- Membership of the Locality Quality & Safety Group
- Membership of a sub-group of the Locality Quality & Safety Group
- Involvement in a specific piece of work (e.g. an audit, complaints investigation)

It should be noted that corporate services which are not directly providing care delivery have their own governance structures in place to ensure that their work is managed safely and effectively. This work will naturally underpin the Trust's approach to quality governance.

b) Trust-wide level

The ways in which staff are involved at a trust-wide level are summarised as follows:

- Operational deputy directors are in attendance at the Quality and Safety Committee
- Attendance at workshops and forums held to examine and develop quality and safety issues
- Membership of groups addressing specific quality and safety issues, for example the Audit Steering Group or the Safeguarding Group.
- Involvement in specific project work to support the quality and safety agenda

4.3 Governors

We are committed to ensuring that our Council of Governors is engaged in the quality agenda across the Trust and has the information available to enable it to hold the non-executive directors to account on the quality of the services we provide. Governors have a responsibility to listen to and escalate any quality issues or concerns identified by Trust

members and the wider public. The governors also have a defined role in developing our quality goals each year; these will be set out in the annual Quality Report.

4.4 Involvement of External Partners

There are a number of existing meetings and opportunities to engage in governance work with external partners including Clinical Commissioning Groups (CCGs). These include:

- Quality & Performance Group (CCG lead)
- Quality Forum (across Airedale & Bradford)
- Quality and Safety sub-group (CCG lead)
- Health Care Safety Group (West Yorkshire-wide)
- Attendance of partners at BDCFT quality and safety groups
- Local informal arrangements for sharing good practice and learning from one another.

In addition, operational services in particular continually work in partnership with commissioners and other organisations to develop new and innovative approaches to service delivery.

PART 2: QUALITY GOVERNANCE

1. DEFINITION OF QUALITY GOVERNANCE

Monitor defines quality governance as:

The combination of structures and processes at and below board level to lead on trust-wide quality performance including:

- ensuring required standards are achieved
- investigating and taking action on sub-standard performance
- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best-practice and
- identifying and managing risks to quality of care.

The Monitor well-led framework (which encompasses quality governance requirements) is available for further information at Appendix 1 of this strategy.

Effective quality governance arrangements will not only ensure that existing quality issues are examined and addressed, they will also provide the opportunity for staff at all levels to generate and implement new ideas to drive innovation and development.

In summary, it is through effective quality governance processes that the Trust can drive quality improvement and seek and obtain assurance that high quality services are being delivered.

2. QUALITY GOVERNANCE SYSTEMS AND PROCESSES

The key systems and processes for ensuring effective quality sit within the remit of the medical and nursing directorates and include:

- Risk management
- Serious incident management
- Clinical audit
- Complaints and litigation management
- Clinical policy work
- Quality governance at locality level
- Quality performance monitoring

Each of the above functions is responsible for ensuring that their specific area of work delivers against agreed objectives. They are also responsible for providing appropriate data, information, support and advice at all levels of the organisation.

The work of each of these functions is underpinned by a strategy or policy document which provides further detail; these documents are included in the 'references' section of this strategy.

There are other teams or functions that also support quality improvement and it is important that close links are made across the various departments to ensure that integrated governance is the day to day business of the Trust.

The diagram at Appendix 2 illustrates the way in which all of these functions come together and report into the Quality & Safety Committee.

3. SPECIFIC ACCOUNTABILITIES AND RESPONSIBILITIES

3.1 Trust Board

The board has overall accountability for quality and for meeting any quality governance requirements. The board delegates responsibilities to and seeks assurance from four committees (see section 3.2).

The board receives routine quality information via a monthly dashboard; this includes escalation of issues by exception (such as 'never events'), and on a routine basis (such as serious incidents and complaints). Where it is necessary to bring issues to the notice of the board outside of scheduled meetings, this will be conducted via email by the Chief Executive or Deputy Chief Executive.

The Chief Executive has overall accountability for the organisational approach to quality improvement and governance

The Medical Director and Director of Nursing have responsibilities in relation to quality governance arrangements and the delivery of high quality services.

The executive and non-executive directors are responsible for ensuring they are adequately equipped (in terms of leadership, knowledge, skills and values) to support maintenance and improvement of the quality of service provision.

The way in which quality governance arrangements are managed by the board is illustrated in Appendix 3.

3.2 Committees

All committees of the board have responsibilities for quality and quality governance; these responsibilities vary dependent on the role and function of each committee.

All committees routinely undertake the following:

- Reviewing the allocated aspects of the corporate risk register to ensure those risks are managed appropriately
- Seeking and receiving assurance in relation to compliance with CQC requirements
- Receiving, scrutinising and responding to a performance dashboard tailored to the purpose of the committee (with the exception of the Audit Committee)
- Providing assurance on quality and performance issues to the board

The Quality and Safety Committee is the principle committee in terms of monitoring and seeking assurance on clinical and service quality issues including the trust's quality governance processes. Where required the committee will request 'deep dive' reports into areas where further assurance is required.

The Quality and Safety Committee dashboard includes indicators set beneath each of the quality priorities allowing measurement of specific quality and safety issues.

The Mental Health Legislation Committee has a specific responsibility to oversee appropriate implementation of the Mental Health Act, Mental Capacity Act and Care Programme Approach and receives assurance on related issues through a quarterly dashboard, routine reports and 'deep dives' where required.

All committees are accountable to the board and escalate any quality and safety concerns through a routine reporting process.

3.3 Localities

Each 'operational' locality has a Quality & Safety Group (QSG) in place which is responsible for ensuring that the locality has in place robust quality governance arrangements which address the key elements of quality and safety in line with the trust framework; this framework includes the CQC fundamental standards to ensure that these are routinely considered and discussed at locality level.

Each QSG has agreed terms of reference in place which clearly set out how the group will meet the following expectations:

- The Trust Quality & Safety Framework forms the agenda
- A lead clinician or manager acts as chair
- Clinical staff, managers and service users / carers will be represented
- Corporate quality and governance team members attend as required
- Meetings take place at least six times per year
- A clear record of discussions, actions and progress against actions are maintained
- Assurance reports to QSC are provided at least twice a year
- Relevant sub-groups or task and finish groups are maintained

Within all localities (including corporate and other 'non-operational' localities), it is expected that services will address key aspects of quality as a part of their regular management and team meetings. This will ensuring that key aspects of the Quality and Safety Framework are addressed with a focus on making improvements through learning from incidents, complaints etc.

Localities are also held to account for their quality performance through routine Locality Performance Meetings which are chaired by the Chief Executive and provide the opportunity for the scrutiny of locality-level performance against key indicators, including quality indicators.

Deputy Directors have a specific responsibility for ensuring effective arrangement for quality and safety monitoring and improvement are in place within their respective locality.

Heads of service and service managers support the implementation of systems and processes to actively promote safe, effective and personal care. They have a responsibility to ensure that any exceptions or risks within these systems and processes are communicated and dealt with effectively both up and down the lines of accountability. They are also key agents of change in ensuring effective structures exist to support the dissemination of learning and good practice examples. Assurance against these accountabilities is provided by them to Deputy Directors.

The team manager's role is to locally implement systems and processes to actively promote the delivery of safe, effective and personal care in their area. They have responsibility to ensure that information is passed appropriately to their service manager with regard to any risk or exceptions which relate to the governance framework. They ensure that learning and positive practice is highlighted and relevant service delivery adjusted accordingly. Assurance against these accountabilities is provided to the service managers.

3.4 Professions

Each professional group within the Trust (e.g. psychology, nursing, medical practitioners, allied health professions, social workers) has in place a governance structure which allows specific professional issues to be addressed (and escalated to the Professional Council where appropriate). These groups also ensure that any wider learning feeds back in to service area quality and safety governance groups as appropriate.

Professional leads have a responsibility to ensure that the colleagues they represent are aware of and work to the principles of the Quality and Safety Framework. They are responsible for ensuring that both lessons learned and good practice examples are shared and acted upon and for reporting any risks or exceptions through the most appropriate channels.

3.5 Corporate Roles

Corporate leads support the key elements of the Quality and Safety Framework. These lead roles span the areas of safeguarding, equality, human rights, patient experience, research and development, care planning, risk, audit, policy development, serious incidents, complaints and claims.

3.6 All Staff

All staff have a responsibility to ensure that safe, effective and personal care is delivered in an environment of continuous improvement within their service area, the level of responsibility and accountability in line with the expectations of their grade.

Quality is everybody's business; as such all staff are required to promote and sustain the delivery of high quality services. This includes the requirement to:

a) Comply with Trust policies and procedures
b) Work professionally and in line with professional codes of conduct
c) Follow safe working practices
d) Provide safe clinical practice

e) Report concerns regarding poor practice
f) Engage in relevant quality initiatives

All staff with a management responsibility should provide leadership in improving quality; such responsibilities include:

- Ensuring appropriate induction, training and appraisal for staff
- Optimising opportunities to improve quality
- Involving staff, service users and carers in decision making and quality initiatives
- Reporting and addressing any issues which may impact upon the delivery of quality services.

4. QUALITY GOVERNANCE ANNUAL ASSESSMENT

The Monitor well-led framework sets out best practice in relation to governance arrangements including those for quality governance. All Foundation Trusts must meet the requirements of this framework and will be formally assessed by an external organisation every three years. BDCFT will undertake an annual assessment against these requirements and the process for achieving this will be developed during 2016.

A key element of the quality governance work during 2016 will be further development in relation to the functioning of the Quality and Safety Committee. The Trust commissioned an external review of the committee's effectiveness during the latter part of 2015 and although the findings of the review were largely positive there were some specific recommendations for improvement. The Trust developed a clear implementation plan for each recommendation.

5. CONCLUSION

The provision of a top quality service is the 'raison d'être' of the Trust. To ensure we deliver on this imperative, we will embed a 'total quality culture' throughout the organisation, underpinned by a system of excellent quality governance. This strategy describes how we are making this vision a reality, the further steps we intend to take and the measures we will use to judge our success.

MONITOR WELL-LED FRAMEWORK

Compliance with the requirements of the Monitor well-led framework is essential for Foundation Trusts; the framework provides an important basis upon which to assess and build the approach to quality governance. The framework content is as follows:

Key:
Board's role =
Governance domains =
Key questions =

2. Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

3. Does the board have the skills and capability to lead the organisation?

4. Does the board shape an open, transparent and quality-focused culture?

1. Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?

5. Does the board support continuous learning and development across the organisation?

Strategy and planning

Capability and culture

Board's leadership role:
- strategy and planning
- accountability
- shape culture
- risk and performance oversight – quality, operational and financial performance

10. Is the board assured of the robustness of information?

6. Are there clear roles and accountabilities in relation to board governance (including quality governance)?

Measurement

Process and structures

7. Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?

9. Is appropriate information on organisational and operational performance being analysed and challenged?

8. Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?

Trust Board

Quality and Safety Committee

Service User & Carer Involvement

Medicines Management Group

Research & Development Group

Serious Incident and Complaints Forum

Locality Governance Groups (Link to relevant sub groups)

Team/Unit Service Governance Meetings

Additional issues reported to QSC (not groups)
Equality Delivery System
CQC Outcomes
Clinical Policy Development
Reviews/Inquires
Complaints
Care Co-ordination
Risk & Incident Management
Performance Dashboard
CQUINs
Allocated sections of the Corporate Risk Register
Quality Impact Assessment
Quality Governance

Clinical Audit Steering Group

NICE Guidance Monitoring Group

Infection Control Sub Committee

Safeguarding Forum

Resilience Group

Assurance on Quality and Safety

V1 20 February 2016

QUALITY GOVERNANCE; ORGANISATIONAL STRUCTURE

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                        │   TRUST BOARD    │
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Audit Committee	Mental Health Legislation Committee	Quality and Safety Committee	Finance Business & Investment Committee	Executive Management Team
Integrated governance Risk management and internal control (clinical and non-clinical)	In relation to mental health legislation compliance: Systems and structures Policies and procedures Education and training Care Programme Approach	Risk & incident management Clinical policies Infection Control Safeguarding Service user / carer involvement and experience Clinical audit NICE Medicines management Professional issues Research and development Complaints, compliments and PALs Single equality scheme Resilience	Financial risks Strategy and investment Quality impact of cost improvement plans	Direction and support in terms of quality initiatives Ensuring that appropriate systems (in relation to quality) are in place and functioning appropriately

ASSOCIATED BDCFT DOCUMENTATION

Involving You Strategy

Clinical audit policy

Professional strategies

Risk management strategy

Incident management strategy

Management of serious incidents policy

Complaints policy

Safeguarding policies

Quality impact assessment procedure

Responding to and learning from external agency visits, inspections and accreditations / external reports and guidance and incidents, complaints and claims