Monitor
Making the health sector work for patients

Well-led framework for governance reviews: guidance for NHS foundation trusts
Updated April 2015

About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

Contents

Introduction

Monitor's 'Risk assessment framework' is guidance for trusts in complying with their continuity of service and governance licence conditions. Under the 'Risk assessment framework' and in line with their Code of Governance we expect NHS foundation trusts to carry out an external review of their governance every three years.

We strongly encourage all NHS foundation trust boards to carry out these reviews for a number of reasons:

1. **Good governance is essential in addressing the challenges the sector faces**

   The boards of NHS foundation trusts face significant financial and operational challenges. They need to ensure that their oversight of care quality, operations and finance is robust in the face of uncertain future income, potential new care models and resource constraints. Good governance is essential if they are to continue providing safe, sustainable and high quality care for patients.

2. **Oversight of governance systems is the responsibility of NHS foundation trust boards**

   In the assessment process, Monitor subjects the governance of applicant NHS trusts to rigorous scrutiny. From spring 2015 we will use the well-led framework as the basis of this assessment. Following authorisation, foundation trust boards are responsible for ensuring that governance arrangements remain fit for purpose. As set out in the 'Risk assessment framework', our oversight of governance relies on information, including national standards and third party concerns, as triggers identifying potential governance issues.

3. **Governance issues are increasing across the sector**

   Since 2008, approximately one in three NHS foundation trusts have been subject to formal regulatory action on at least one occasion, with poor governance a contributing factor in almost all of these cases. In our experience, the majority of issues leading to regulatory action occur at least two years after authorisation. This is why we think it is important to support foundation trust boards in maintaining robust systems of governance in these challenging times.

4. **Regular reviews can provide assurance that governance systems are fit for purpose**

Monitor's 'Code of Governance', modelled on best practice UK corporate governance principles, recommends that key elements of organisations' governance, including the board and committee structures, be regularly reviewed to ensure they remain fit for purpose. Well-designed and properly executed independent assessment of governance is a valuable tool in establishing whether any of the board's governance practices and capabilities needs improvement. This framework will help trusts with that assessment.

About this document

To support trusts in maintaining and developing the effectiveness of their governance arrangements, we issue guidance setting out how we expect them to comply with the provider licence conditions. The 'Risk assessment framework', for instance, sets out for NHS foundation trusts how we will consider compliance with their governance licence condition and assess risk to continuity of services.

This document supports NHS foundation trusts to gain assurance that they are well led. It will help them continue to meet patients' needs and expectations in a sustainable manner under challenging circumstances. The framework presented here represents a 'core' reference for NHS foundation trusts to structure reviews of their governance. The individual trust can shape the depth and breadth of the areas for investigation through their self-assessment and initial review team findings at the start of the process. Where trusts choose to exclude core elements of the framework, they should tell us, in line with a 'comply or explain' approach.

The framework has four domains, ten high level questions and a body of 'good practice' outcomes and evidence base that organisations and reviewers can use to assess governance.

The evidence base is not intended to be used for 'box-ticking'; rather it should guide trusts' and assessors' views in considering whether their processes and overall organisational culture in these areas are fit for purpose.

This guidance also sets out the suggested review process and what to take into account when choosing an external reviewer.

Flexible approach

NHS foundation trusts are free to tailor their approach to suit their organisational circumstances, provided they incorporate the domains and principal areas of enquiry in the framework set out here. We would, in any event, expect well-run NHS foundation trusts to actively tailor the guidance to reflect their awareness of their trust's governance.

Using this guidance: 'comply or explain'

For the purposes of this guidance:

- **comply** means we strongly encourage all NHS foundation trusts to carry out board governance reviews every three years using this guidance

- **explain** means that a foundation trust should give a considered explanation if it uses alternative means to assure itself regarding its governance, or if it chooses to omit material components of the framework (eg one or more of the ten questions). Departing from the guidance may be justified where a foundation trust can demonstrate that it is meeting the actions expected under the guidance in a similar manner, eg rigorously reviewing specific aspects of governance on an annual basis while ensuring all areas are covered every three years.

Beyond the four domains and ten questions, NHS foundation trusts are free to add other areas they consider require further attention – in these circumstances no explanation is necessary.

Governance reviews are only useful if their findings are acted on, so we strongly encourage trusts to prioritise actions arising from the reviews. We highlight one approach to prioritising actions below but trusts should consider the approach that works for them as appropriate.

1. What is board governance and why review it regularly?

NHS foundation trust boards are responsible for all aspects of performance and governance of the organisation. They should conduct their affairs effectively and, in so doing, build patient, public and stakeholder confidence that the trusts are providing high quality, sustainable care.

The role of the board is to set strategy, lead the organisation and oversee operations, and to be accountable to stakeholders in an open and effective manner. Foundation trusts are complex and multi-faceted organisations and this guidance is intended to lay out how boards can assess their effectiveness in carrying out their role. As the factors underpinning effective governance can change, for example as people leave or organisations restructure, regular reviews can ensure governance remains fit for purpose.

1.1. Governance reviews, 'well-led' and the Care Quality Commission's inspection regime

The Francis report into failings at Mid-Staffordshire NHS Foundation Trust led to major changes in the Care Quality Commission's regulatory regime, and to Monitor's and the NHS Trust Development Authority's (TDA) routine oversight of providers and assessment of aspirant foundation trusts. It has also resulted in the three bodies working even more closely together, particularly around the sharing of information and intelligence.

The characteristics of a well-led organisation, as defined by CQC, Monitor and TDA, are now identical.

By well led, we mean that the leadership, management and governance of the organisation ensure the delivery of sustainable high quality person-centred care, support learning and innovation, and promote an open and fair culture. We have a common understanding of what a good organisation looks like and what it should be able to demonstrate, creating coherence, consistency and transparency across our regulatory activities.

1.2. Aligning approaches

In this version of the well-led framework guidance, updated from 2014, Monitor has aligned the four domains and ten high level questions asked of NHS provider organisations with the CQC's characteristics of 'good' under their well-led domain. The alignment is shown at a headline level in the main body of text from section 2.1. Further detail of the good practice Monitor suggests, which is used in assessing applicant NHS trusts applying to become foundation trusts, is outlined in annex 1.

It should be noted that within this aligned approach, Monitor and CQC will each continue to focus on their respective statutory remits. Monitor and TDA's assessment of well led focuses primarily at board and committee level, covering strategy and planning, capability and culture, process and structures, and measurement, while CQC's inspections are an independent reality check of patient experience at ward and service level to see whether outcomes demonstrate that the board's policies are operating effectively.

As part of its 'ward to board' inspection regime, CQC will ask NHS foundation trusts how they have assured their governance arrangements. This may include asking for information about any independent reviews and how they have been acted on.

2. Reviewing board governance

We suggest organisations should look at four different domains to review how well a board is operating:

1. **Strategy and planning** – how well is the board setting direction for the organisation?

2. **Capability and culture** – is the board taking steps to ensure it has the appropriate experience and ability, now and into the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?

3. **Process and structures** – do reporting lines and accountabilities support the effective oversight of the organisation?

4. **Measurement** – does the board receive appropriate, robust and timely information and does this support the leadership of the trust?

Table 1 below sets out the four domains of this framework and the questions trusts and reviewers should ask themselves. Each question has outcomes that the review 'tests'/investigates. As noted above we have aligned these with CQC's approach to well led.

Table 1: The four domains of the well-led framework for governance reviews

Strategy and planning	Capability and culture	Process and structures	Measurement
Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver? Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	Does the board have the skills and capability to lead the organisation? Does the board shape an open, transparent and quality-focused culture? Does the board support continuous learning and development across the organisation?	Are there clear roles and accountabilities in relation to board governance (including quality governance?) Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance? Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	Is appropriate information on organisational and operational performance being analysed and challenged? Is the board assured of the robustness of information?

If delivered effectively, assessment against this framework should provide boards with assurance over the effective oversight of the care provided throughout their trust.

Annex 1 sets out the 10 questions, the associated characteristics and examples of good practice. Sections 2.1 to 2.4 (below) contain a headline mapping of the Monitor questions followed by the relevant CQC characteristics of 'good' well-led organisations.

2.1. Strategy and planning

Q1 Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?

- There is a clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant.

- The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others.

- The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

- Strategic objectives are supported by quantifiable and measurable outcomes which are cascaded through the organisation.

- Staff in all areas know and understand the vision, values and strategic goals.

Q2 Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

- There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.

- Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively. Financial pressures are managed so that they do not compromise the quality of care.

2.2. Capability and culture

Q3 Does the board have the skills and capability to lead the organisation?

- The board has the experience, capacity and capability to ensure that the strategy can be delivered.

- The appropriate experience and skills to lead are maintained through effective selection, development and succession processes.

- The leadership is knowledgeable about quality issues and priorities, understands what the challenges are and takes action to address them.

Q4 Does the board shape an open, transparent and quality-focused culture?

- Leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity.

- Candour, openness, honesty and transparency and challenges to poor practice are the norm. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority.

- The leadership actively shapes the culture through effective engagement with staff, people who use the services, their representative and stakeholders. Leaders model and encourage co-operative, supportive relationships among staff so that they feel respected, valued and supported.

- Mechanisms are in place to support staff and promote their positive wellbeing.

- There is a culture of collective responsibility between teams and services.

- The leadership actively promotes staff empowerment to drive improvement and a culture where the benefit of raising concerns is valued.

Q5 Does the board support continuous learning and development across the organisation?

- Information and analysis are used proactively to identify opportunities to drive improvement in care.

- There is a strong focus on continuous learning and improvement at all levels of the organisation. Safe innovation is supported and staff have objectives focused on improvement and learning.

- Staff are encouraged to use information and regularly take time out to review performance and make improvements.

2.3. Process and structures

Q6 Are there clear roles and accountabilities in relation to board governance (including quality governance)?

- The board and other levels of governance within the organisation function effectively and interact with each other appropriately.

- Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

- Quality receives sufficient coverage in board meetings and in other relevant meetings below board level.

Q7 Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?

- The organisation has the processes and information to manage current and future performance.

- Performance issues are escalated to the relevant committees and the board through clear structures and processes.

- Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.

Q8 Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?

- A full and diverse range of people's views and concerns are encouraged, heard and acted upon. Information on people's experience is reported and reviewed alongside other performance data.

- The service proactively engages and involves all staff and assures that the voices of all staff are heard and acted on.

- Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted upon.

- The service is transparent, collaborative and open with all relevant stakeholders about performance.

2.4. Measurement

Q9 Is appropriate information on organisational and operational performance being analysed and challenged?

- Integrated reporting supports effective decision-making.

- Performance information is used to hold management and staff to account.

Q10 Is the board assured of the robustness of information?

- The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant.

In developing this framework, we consulted experts and reviewed board governance, leadership and quality governance documents alongside our own experience of foundation trust governance.

The domains and question sets are designed to:

- help a board assess their governance practices

- help any independent reviewer to assess whether the processes in place to manage the trust are fit for purpose.

As highlighted above, the outcomes or characteristics for each question have been aligned with the CQC's approach to assessing well-led organisations, so they will vary from earlier versions of this publication.

Annex 1 provides a reference base of evidence and outcomes of good practice against each question with the relevant CQC characteristic mapped alongside the Monitor questions and Monitor good practice as follows:

Monitor question
CQC characteristic of 'good' in the well-led domain, relevant to the Monitor question
Monitor good practice under this question/characteristic
To assist NHS trusts preparing for the foundation trust assessment process, the italicised text refers to the good practice examined as part of the quality governance module.
Standard non-italicised text refers to good practice examined as part of the corporate governance module.
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Figure 1 on the next page sets out how the framework fits together and the main areas for review.
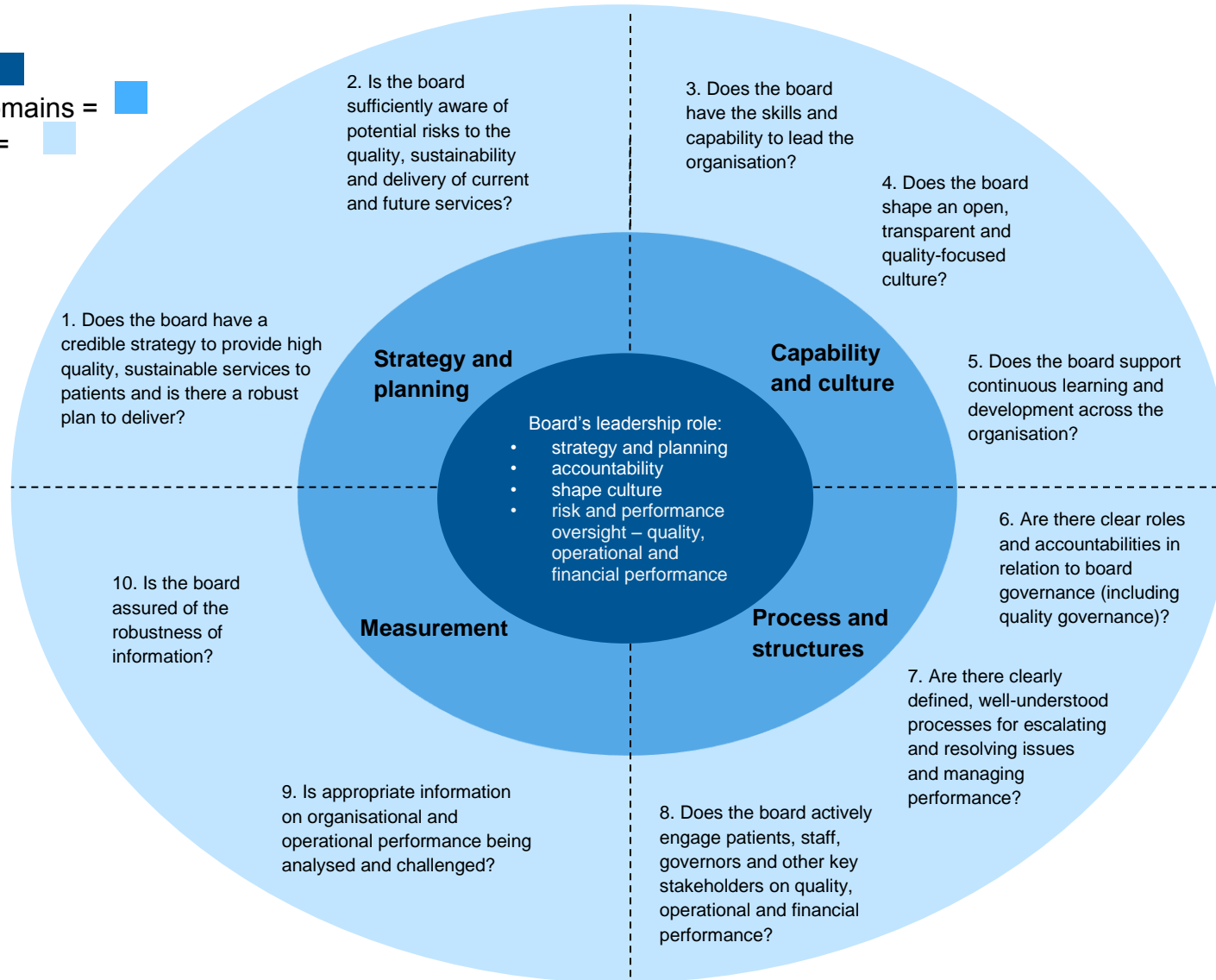
Figure 1. How the well-led framework for governance reviews fits together and the main areas for review

Key:

Board's role = ■

Governance domains = ■

Key questions = □

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

Strategy and planning

Capability and culture

Measurement

Process and structures

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

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?

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

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

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

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

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

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

3. Managing the governance review process

The review process supports boards and reviewers in assessing whether an NHS foundation trust's governance is robust and effective, and in identifying areas for improvement.

This section summarises some of the considerations in preparing for a review and the five steps involved in the review process. It is not exhaustive, but should help to start the process.

3.1. Governance reviews – frequency/scope/review teams

Scheduling governance reviews

- Under the 'Risk assessment framework', NHS foundation trust boards should carry out governance reviews **every three years.**

- Trusts are **free to schedule when the reviews take place within the three-year window** –as long as the gap between governance reviews is not longer than three years.

- As these reviews are a new element in our regulatory framework, we would like to understand the uptake of reviews. When a foundation trust has scheduled a governance review they should inform their Monitor relationship manager of this fact and the organisation(s) chosen to carry out the review.

Scope of the review

- The review should be carried out using this guidance, incorporating the questions, outcomes and evidence base in annex 1 as a starting position. We expect trusts to add to the scope, or change emphasis, to reflect their knowledge of their organisation.[1] We expect boards to go on to tailor the scope of the reviews they commission to cover any additional areas that they would specifically like to focus on.

- Additional areas for review may, for instance, result from findings from internal and/or external audit review findings and information from the annual governance statement and the corporate governance statement.

Review teams

- In order to gain maximum benefits and assurance from the reviews, **independent reviewers** should be used to ensure objectivity. Generally,

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[1] Although boards, based on their knowledge of their own organisation may want to concentrate on specific areas, they should make sure the reviews cover all the 10 questions to some extent, in case there are unknown governance issues or weaknesses.

Monitor considers reviewers should not have carried out audit or governance-related work for the trust during the previous three years.

- Reviewers must be independent of the NHS foundation trust's board. While the ultimate choice of reviewer is up to boards, review teams should be multi-skilled and bring different disciplines to the work including:

  o experience of evaluating board leadership and governance arrangements

  o knowledge of the healthcare sector

  o specialist expertise, specifically clinical, leadership experience (including culture and board development) and management information systems.

- We note that peer organisations – ie other NHS foundation trusts – may have particular insights on governance, especially clinical governance. In arranging governance reviews, we encourage trusts to ensure that the organisations carrying them out have the relevant expertise to conduct the review and therefore will be able to add value and insight across the whole spectrum of the review framework.

- In some cases, clinical organisations may be able to 'partner' with governance experts to provide a more thorough review than either might be able to offer on their own.

See section 4 for what to consider when choosing an independent reviewer.

3.2. Carrying out a review

This section sets out potential:

- steps in carrying out the review

- methods used to carry out the review

- methodology for rating a review.

Approach to a review

The diagram and table below set out the **suggested approach** to the review and reporting steps. **Trusts commission these reviews**.

With this in mind, they need to shape the review process and approach to support their needs. For example, trusts piloting the review process suggested the following:

- the suggested self-assessment steps to support trust boards to reflect on their own performance could be carried out **before** the review to make sure reviewer skills and experience meet the needs of the specific areas of focus

- board members could focus on the 10 questions and the Care Quality Commission (CQC) characteristics outlined from section 2.1 and take a view on the areas where the organisation performs well and less well. This high level 'top-down' view can then be considered alongside any in-depth 'bottom up' analysis that the trust might carry out, informed by the good practice outlined in the annex, to provide a robust picture of the health of the organisation

- when planning the review work, trusts should think about the phasing of the work, allowing enough time between each step; for example:

  o between planning the review (eg logistics for interviews, focus groups, etc) and the review team undertaking the work

  o providing the board with the findings from the review and giving enough time afterwards for developing the action plan, especially if some actions will need to involve discussions with internal and external stakeholders.
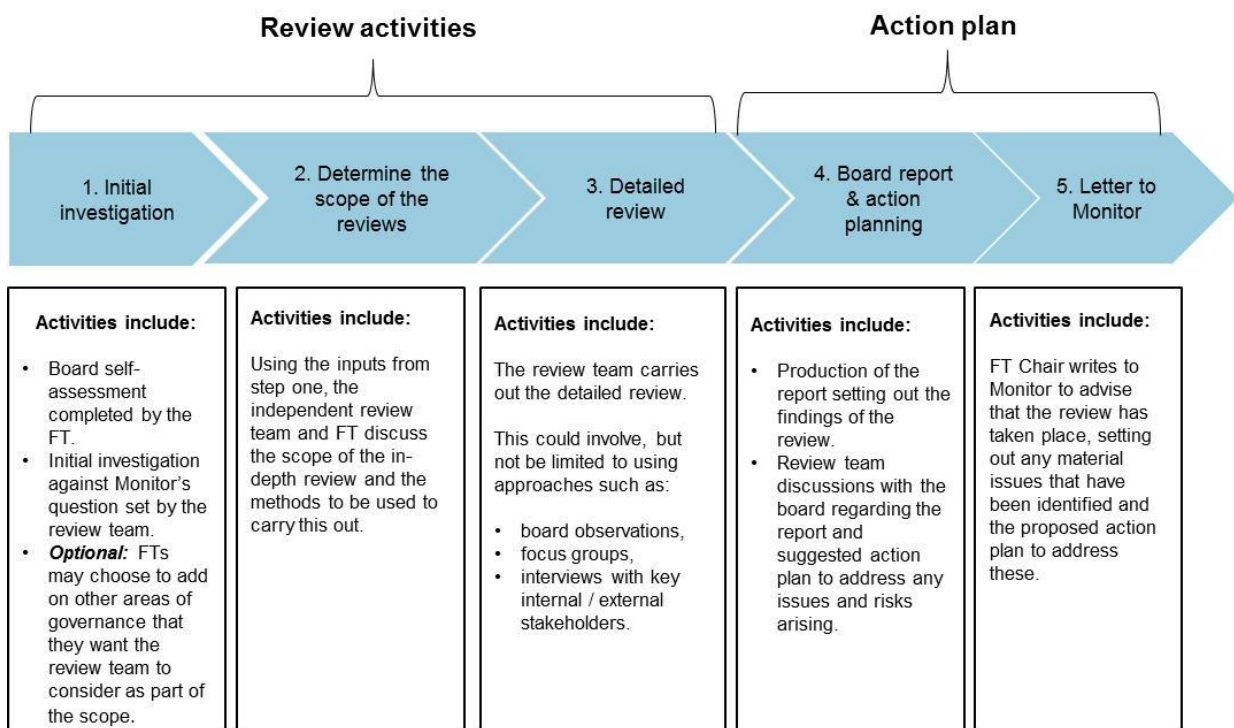
Figure 2: Suggested review steps

Review activities — **Action plan**

1. Initial investigation	2. Determine the scope of the reviews	3. Detailed review	4. Board report & action planning	5. Letter to Monitor
Activities include: • Board self-assessment completed by the FT. • Initial investigation against Monitor's question set by the review team. • *Optional:* FTs may choose to add on other areas of governance that they want the review team to consider as part of the scope.	**Activities include:** Using the inputs from step one, the independent review team and FT discuss the scope of the in-depth review and the methods to be used to carry this out.	**Activities include:** The review team carries out the detailed review. This could involve, but not be limited to using approaches such as: • board observations, • focus groups, • interviews with key internal / external stakeholders.	**Activities include:** • Production of the report setting out the findings of the review. • Review team discussions with the board regarding the report and suggested action plan to address any issues and risks arising.	**Activities include:** FT Chair writes to Monitor to advise that the review has taken place, setting out any material issues that have been identified and the proposed action plan to address these.

Table 2: Suggested review activities and outputs

Step	Activity	Output

1	**Initial review**
	
	  a. **Board self-assessment:** Boards should carry out a rigorous self-assessment[2] of how their governance is working, based on evidence, to confirm they are carrying out their role well and/or to help identify gaps in their performance. Evidence could include findings from internal and external audit reviews and work carried out for the annual governance statement and the corporate governance statement.
	
	  They should rate themselves against the 10 questions in this framework.
	
	See annex 2.
	
	  b. **Initial review against questions:** Independent reviewers should gather evidence from a variety of sources including relevant documentation, stakeholder and board questionnaires, focus groups and interviews to gain insight into how the board is working and how it is perceived throughout the trust.
	
	  c. **Optional:** Foundation trusts may choose to ask the independent review team to look at specific areas of governance in addition to the areas set out in Monitor's well-led framework. This may involve a deeper investigation of particular lines of governance.
	
	The review team can be procured either before or after the board's self-assessment step above.
		Self-assessment statement outlining:
		
		i. rationale for their rating against each of the review questions
		
		ii. documented evidence for the conclusions and ratings
		
		iii. opinion about the areas that need further review with the independent reviewer based on the outcomes of the assessment.
		
		Overview to identify areas for further scrutiny
		
		Agreement to additional areas that should form part the detailed review

2	**Determine the scope (depth and breadth) of the detailed review:** Both parties should agree on the depth and breadth of the review required across the 4 domains and 10 questions and agree any further areas for scrutiny primarily based on risks identified through the initial work (in step 1).	Scope of the detailed review and methods to be used to do this.
3	**Detailed review:** Review to be undertaken by the independent review team against the scope agreed in step 2. The review team should rate each of the 10 questions (refer to the section below on rating the review).	A detailed report of the findings from the review process for the board to consider

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[2] This will probably take 2 to 4 weeks, but that is ultimately up to the trust's board

Step	Activity	Output
4	**Board report and action planning:** Independent reviewer to work with the board to consider recommendations and actions required to address the findings of the report.	Action plan
5	**Letter to Monitor:** Trust chair to write to Monitor, within 60 days of the submission of the review to the trust board, either: i. advising Monitor that the review has been completed and that there are no 'material governance concerns' or ii. advising of any material governance concerns that have arisen from the review and the action plan (including timings and priorities) responding to those concerns.[3] This should be in line with the exception reporting requirements in the 'Risk assessment framework'. Monitor will consider the material governance concerns identified and the trust's response and what, if any, steps on our part are appropriate.	Letter to Monitor

Methods used to carry out a review

We suggest a potential approach to review above but it is not compulsory, Experienced reviewers can use their own diagnostic tools and methods. See Table 3 for examples.

Table 3: Diagnostic tools and methods for carrying out a review

Tool	Suggested components	Purpose
Desktop document review	Board minutes, papers, and agendas; board assurance framework; audit reports; strategic documents, eg the trust's strategy and business plan, quality strategy and people strategy; and internal/ external audit reports, annual governance and corporate governance statements, alongside any other relevant reviews	To provide a view of: • how ongoing issues and risks within the NHS foundation trust are communicated and managed • the quality of information being produced to support decision-making and • how the board prioritises issues at the trust and divides its attention.
One-to-one interviews	All board members, the trust secretary, lead governor, clinical directors and leads, local stakeholders, including	To gain individuals' views of the trust's governance and to provide a 'safe' environment in which to explore issues and discuss

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[3] This covers any obligations in the 'Risk assessment framework'.

Tool	Suggested components	Purpose
	clinical commissioning groups and patient representatives	sensitive information, as appropriate.
Stakeholder surveys	Staff and patient groups, commissioners and providers	To get internal and external parties' views of the trust's governance to cross-reference with the board's own views – to test the board's awareness.
Focus groups with internal and external stakeholders	Staff, patient groups, commissioners, contracted or outsourced suppliers	
Board and sub-committee observations	Observations of at least one board meeting and relevant sub-committees, including audit and quality.	To identify the dynamics of the board, including agenda management, depth and breadth of the information used to make decisions and progress priorities, and the way they challenge and hold each other to account for the leadership of the trust.
Board skills inventory	Matching skills to the requirements of the board's work and identify any gaps.	To ensure that the board has the skills and experience needed.
Board self-assessment	Board members to rate how effective they believe the board is.	To provide a view of how effective the board believes itself to be.
Peer practices	On areas of governance in the sector, in similar organisations or NHS foundation trusts.	To assess how the NHS foundation trust compares against any known examples of particularly effective and robust governance practices.

The approach and question and evidence sets (see the annexes) have been developed to help NHS foundation trusts gain insight into their leadership and governance practices, and understand if they are well led.

Prioritising findings

Where a review of governance indicates issues or concerns, it is important that these are prioritised and addressed as soon as possible. We strongly encourage trusts to agree, at the start of the review process, the format in which they would like the findings to be presented.

Red-amber-green ratings

One approach is to classify findings via a green/amber-green/amber-red/red approach, as outlined below.

Table 4: Scoring criteria

Risk rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and no major omissions
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, some minor omissions and robust action plans to address perceived gaps with proven track record of delivery
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in governance identified. Significant volume of action plans required with concerns regarding management's capacity to deliver

If the trust decides not to use the above red-amber-green ratings, it should use another appropriate rating system to ensure that any issues and concerns are prioritised and addressed and that any material governance concerns are reported to us, as set out above. Apart from any material issues worthy of exception reporting (see above), we would not expect to see the results of this prioritisation exercise.

3.3. Exceptions to the review process

We recognise that a number of NHS foundation trusts may have already carried out a similar independent governance review within the one to two years before May 2014 when the framework was originally published. If this is the case and the review covered the areas of this framework, the trust may use this to explain why they are not doing an extra review under this guidance within the relevant time period. If your trust falls into this category, please contact us first to confirm the scope of your review, including its findings and any action plan.

4. Selecting a reviewer

The following section sets out the areas an NHS foundation trust should consider when choosing an independent reviewer to carry out reviews against this framework.

While many organisations are capable of carrying out reviews, boards should assure themselves that the reviewer can carry out a robust and reliable judgment of its governance.

We do not currently have any plans to accredit suppliers or set up a preferred reviewer list.

4.1. Potential criteria

Reviewers should demonstrate the following:

- a clear and concise understanding of the purpose and objective of the review, and its significance to NHS foundation trusts; a solid understanding of how to carry out a rigorous governance review, covering the specific areas detailed in the well-led framework; and an appropriate range of tools and approaches

- relevant experience to carry out the work: the quality of the skills and experience of the reviewer is important to the success of a review, including:

  o credibility and experience in carrying out governance and quality reviews at healthcare providers; ideally, a **multidisciplinary team** with a broad range of skills relevant to all aspects of board leadership and governance, such as strategic planning, quality governance, cultural assessment, organisational development and management information and analysis

  o named personnel (and CVs in the response), and clarity about their role and what they'll do during the review

  o knowledge of the healthcare sector, and the internal and external challenges faced by trusts

  o knowledge of Monitor's licence, and the broader regulatory framework the NHS foundation trust operates within

- ability to manage the review process: the reviewer should advise of the following as part of their response:

  o project governance – reviewers should provide a credible and detailed plan of the proposed project governance regime which includes the approach to the quality of the work, risk management, reporting and escalation lines. This should include evidence of clear leadership for the work with a named individual

- implementation/project plan – reviewers should provide a credible and detailed project plan to meet the specification and requirements of the foundation trust, ensuring the review is completed within set timescales

- capacity – reviewers must assure the board that they have the capacity to carry out the review and that named personnel are available to carry out the work

- conflicts of interest/independent perspective – reviewers should declare any factors that may, potentially, reduce the independence of the reviews, eg if the firm has carried out any governance or board development/review work with the foundation trust within the last three years.

4.2. Peer review teams

We acknowledge that peer organisations – ie other NHS foundation trusts – may have particular insights into governance, particularly clinical governance. We encourage trusts arranging governance reviews to ensure that the organisations carrying these out are able to add value and insight across the whole spectrum of the review framework.

In some cases, clinical organisations may be able to 'partner' with governance experts to provide a more thorough review than either might be able to offer on their own.

Annex 1: Monitor's 10 questions, aligned with CQC characteristics and Monitor good practice

In this annex we provide **examples** of good practice against Monitor's 10 questions. We recognise that how the principles of good practice are applied will vary according to the nature of the services provided.

It is **not** an exhaustive list of practices, nor does it represent a 'tick box' schedule. Trusts and reviewers should consider whether their evidence credibly supports the overall governance outcome on which the review is seeking assurance.

Following the alignment exercise that Monitor has undertaken with CQC, the good practice is now presented in the following format:

Monitor question
The relevant CQC characteristic of 'good' in the well-led domain
Monitor good practice under this question/characteristic *To assist NHS trusts preparing for the foundation trust assessment process, the italicised text refers to the good practice examined as part of the quality governance module.* Standard non-italicised text refers to good practice examined as part of the corporate governance module.

Strategy and planning

Q1 Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?

There is a clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant.
The trust has developed a comprehensive and sustainable picture of how its services will look in the future and its strategy is clear and well thought out. The strategy includes: • specific aims that steer the organisation towards its vision • a small number of ambitious trust-wide quality improvement goals or objectives • a set of values and behaviours supporting and underpinning the strategy. There is likely to be a narrative about how the trust is planning to respond to the Five Year Forward View, aligned with its vision and values.

Quality goals:

- *cover safety, clinical outcomes and patient experience*
- *support continuous improvement*
- *comprise local as well as national priorities, reflecting what is relevant to patients and staff.*

The organisation has been informed by an analysis of its performance on key quality indicators when identifying the strategic goals; and overall trust-wide quality goals link directly to goals in divisions/services, suitably tailored to the specific service.

The board can explain how the quality goals have been selected to have the highest possible impact across the overall trust. There is evidence of patient, service user and carer engagement in determining the quality goals. There is a clear action plan for achieving the quality goals, with designated leads and timeframes.

The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others.

The board has self-assessed its approach to strategy development using a suitable framework, such as Monitor's strategy development toolkit, or equivalent. There is clear evidence that the trust:

- understands its external opportunities and challenges and its internal strengths and weaknesses
- has robust solutions to address the opportunities and challenges in light of its strengths and weaknesses
- has the capability and a credible plan to deliver the strategy (see also the section on capability below).

In examining the internal and external challenges facing services, boards should consider whether services are financially, operationally and clinically sustainable in 3 to 5 years time.

In examining the solutions to address the challenges, boards should consider whether transformation is required to achieve long-term sustainability − such as reconfiguration of services, moving to new care models and/or changes to organisational form.

There should be clear evidence of the trust having mechanisms in place to suitably engage with local health economy partners to address critical issues impacting on long term sustainability.

The planning process reflects:

- current and future priorities of local commissioners

- evidence-based forecast changes in the local environment regarding public health, socio-demographic and economic factors

- local and national policy developments and

- an appropriately thorough market assessment for each of the key service lines, including competitive opportunities and threats and how the trust plans to respond.

The strategic planning process takes account of relevant internal factors, for example:

- the organisation's capabilities and weaknesses

- costs and cost reduction priorities

- previous performance and delivery of plans

- operational issues such as people and resources, estates and facilities

- clinical issues of scope and scale of services (are volumes sufficient to support high quality care)

- whether the people strategy fits the needs of the organisation and workforce plans and projections.

The board should be able to demonstrate: who their main stakeholders are; that they have an understanding of those stakeholders' views; and that those stakeholders have been suitably engaged in the development of its vision and strategy.

Stakeholders would normally include:

- patient groups and the council of governors

- staff (who are clear about the organisation's vision and strategy and how their work supports this)

- commissioners and other local health economy stakeholders (such as other providers, local Healthwatch, local politicians and MPs).

The board identifies its main stakeholders based on criteria such as who will have the greatest impact on the delivery of the organisation's particular services.

The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

The board demonstrates that it has effective, timely horizon scanning and reporting processes in place, so that it is sufficiently aware of changes in the internal and external environment which may impact on the delivery of the strategy/plan and/or impact on clinical and financial sustainability.

Processes are in place to monitor and manage the delivery of the plan.

Strategic objectives are supported by quantifiable and measurable outcomes which are cascaded through the organisation.

The organisational objectives in the plan are linked through to the performance targets of business units.

The trust has detailed delivery plans for each of its strategic initiatives that lay out milestones, resource requirements, dependencies and risk mitigations.

The development of the quality improvement strategy includes:

- *analysis of the organisation's performance on key quality indicators*

- *directly linking the quality accounts with the quality improvement strategy.*

The quality strategy is supported by clear, specific, measurable, achievable and time-bound action plans, with leads and delivery dates to achieve the specific and ambitious goals.

The board monitors action plans relating to the quality strategy or quality account and takes action where performance is off trajectory.

Staff in all areas know and understand the vision, values and strategic goals.

The board can demonstrate that the strategic vision, values and goals (including quality goals) are effectively communicated through an implemented plan, across the trust and its sites.

The goals are well understood and the board can demonstrate how staff at all major sites have been informed of the goals.

The non executive directors and the trust divisional management should be able to articulate the trust's quality goals.

The quality strategy is supported by a communication plan and there is evidence that this plan is being implemented.

Q2 Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.

Board members can comprehensively describe the same set of risks facing the organisation. Dynamic risk registers and a board assurance framework are in place and assessed by the board at least quarterly, reflecting risks to the initiatives in the strategic plan. These are considered and reviewed regularly.

The board regularly assesses and understands current and future risks to quality and performance and is taking steps to address them. The board regularly reviews quality risks in an up-to-date risk register.

The risk register is supported and fed by quality issues captured in directorate/service risk registers. The risk register covers potential future external risks to quality (eg new techniques/technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks. There is clear evidence of action to mitigate risks to quality.

Management and reporting

The board has clear risk management plans (including quality risks) and there is evidence of action being taken to mitigate risks to quality and performance – for example, key risks and issues being escalated from relevant sub-committees on a consistent basis. As part of these plans:

- *risk-related reporting lines should be in place from ward to board (eg to ensure overall risk is managed)*
- *responsibility for each risk flagged in the board assurance framework is owned by an executive lead*
- *responsibilities for maintaining an oversight of risk mitigation are clearly attributed to board members/sub committees*
- *risk scenarios and contingency plans are in place and are subject to regular updates and reviews.*

Training

Appropriate training is provided to staff and managers on risk and assurance and, as a consequence, the organisation can evidence that risks are owned and managed at all levels of the organisation.

Evaluation and review

The board has reviewed lessons learned from inquiries, internal and external reviews and has considered the impact on the trust. Actions arising from this exercise are captured and progress is followed up.

Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively. Financial pressures are managed so that they do not compromise the quality of care.

The board is assured that proposed initiatives are assessed according to their potential impact on quality (eg clinical staff cuts would likely receive a high risk assessment). There is a quality impact assessment approach that is consistently applied.

Initiatives are developed with clinicians; have a clinician as a sponsor or a consultation has been held by clinicians. Schemes have been modified or rejected where concerns have been raised.

Initiatives with significant potential to impact quality are supported by a detailed assessment that could include:

- *'bottom-up' analysis of where waste exists in current processes and how it can be reduced without impacting quality (eg lean)*

- *internal and external benchmarking of relevant operational efficiency metrics (of which nurse−bed ratio, average length of stay, bed occupancy, bed density and doctors−bed ratio are examples that can be markers of quality)*

- *historical evidence illustrating prior experience in making operational changes without negatively impacting quality (eg impact of previous changes to nurse−bed ratio on patient complaints).*

Measures of quality and early warning indicators are identified for each initiative. Quality measures are monitored before and after implementation and there is clear ownership of risk (for example, the relevant clinical director).

Post-implementation, the impact of initiatives on quality is monitored on an ongoing basis. Mitigating action is taken where necessary.

Capability and culture

Q3 Does the board have the skills and capability to lead the organisation?

The board has the experience, capacity and capability to ensure that the strategy can be delivered.

The board has assured itself that the capabilities, experience and capacity are in place within the senior management team and workforce to develop and deliver the strategy.

One or more individuals on the board have strategic planning skills and background and have led the development and implementation of a strategic plan in the last 2 to 3 years in an organisation of similar complexity and challenges.

Board members can clearly explain why the current balance of skills, experience and knowledge on the board is appropriate to effectively govern the trust. The capabilities required in relation to delivering good quality governance are reflected in the make-up of the board.

Board members:
- have insight into the organisation

- are aware of the organisation's impact on its environment

- have clarity on their role

- demonstrate personal values and style that are aligned with the interests of patients and carers

- are effective communicators

- seek personal development and learning.

Trusts are able to give specific examples of when the board has had a significant impact on improving quality performance (for example, providing evidence of the board's role in leading on quality).

Board reviews

The board uses reviews to measure its performance, governance and impact across the organisation. Key findings are openly shared with patients, the public and staff and acted on. The board also reviews the effectiveness of board relationships regularly, with specific focus on board working relationships:

- between the chair and chief executive

- between executive and non executive directors

- between the board and the senior management team/divisional managers

- between the council of governors and the board.

The appropriate experience and skills to lead are maintained through effective selection, development and succession processes.

The board has a development programme and succession plan to ensure that its skills and capabilities are appropriate and maintained (including in relation to quality governance). It conducts regular self-assessments to test its skills and capabilities.

Governors are supported (with training as appropriate) on how to make judgements about the appointment/re-appointment of the non executive directors and the chair.

When vacancies arise, the selection process considers the skills of the existing non executive directors, to ensure that the recruitment process delivers the blend and balance of skills and experience to complement the existing board.

All members of the board, both executive and non-executive, are appropriately inducted into their role as a board member in a timely fashion.

The board takes time out to identify and act upon successes and failures.

The board has put in place a leadership development programme for clinical leadership and non-clinical management that:

- *demonstrates learning and impact on behaviours*

- *encourages and trains clinical leadership and non-clinical management to participate in setting the quality agenda.*

The audit committee (as a group) has the appropriate skills and experience to fulfil its responsibilities:

- the audit committee carries out an annual self-assessment of its effectiveness and

- at least one member of the audit committee has recent and relevant financial experience.

The leadership is knowledgeable about quality issues and priorities, understands what the challenges are and takes action to address them.

Board members are able to:

- *describe the trust's top quality-related priorities*

- *identify well − and poorly − performing services in relation to quality, and actions the trust is taking to address them*

- *explain how it uses external benchmarks to assess quality in the organisation (eg National Institute for Health and Care Excellence guidelines, recognised Royal College or faculty measures)*

- *understand the purpose of each metric they review, be able to interpret them and draw conclusions from them*

- *be clear about basic processes and structures of quality governance*

- *feel they have the information and confidence to challenge data*

- *be clear about when it is necessary to seek external assurances on quality, eg, how and when they will access independent advice on clinical matters.*

The board is assured that quality governance is subject to rigorous challenge, including full non executive director engagement and review (either through participation in audit committee or relevant quality-focused committees and sub-committees).

The board can demonstrate how it has provided challenge to the executive on clinical quality.

Q4 Does the board shape an open, transparent and quality-focused culture?

Leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity.

There is evidence of leaders at every level asserting safe, high quality, compassionate care as top priority. Their behaviour demonstrably emulates that of a strong safety culture.

Staff at all levels of the organisation are subject to an appraisal process in which goals are aligned with the vision and values of the organisation. The organisation has an effective and robust diversity and equality strategy. *A comprehensive induction programme is in place for all staff groups (including junior doctors and agency staff) derived from the organisation's vision, values and strategy.*

> Candour, openness, honesty and transparency and challenges to poor practice are the norm. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority.

The trust can demonstrate that challenges to poor practice made by board and committee members are delivered, received and acted on positively.

The trust has a senior independent director.

Board behaviours should be consistent with the identified trust values.

The board is aware of any behaviours contrary to the trust's vision and values and is taking active steps to manage these, wherever they exist in the organisation.

Examples can be provided of how management has responded to staff that have not behaved consistently with the trust's stated values and behaviours (for example, demonstrably effective HR policies are in place to address the areas where poor behaviours have been identified). There are comparable processes to manage non executive director and governor behaviours – for example through a standards committee.

The organisation has reflected on the findings of internal and external sources that provide insight into its safety culture (staff survey, patient surveys, NRLS, CQC IMR and any formal cultural assessments).

> The leadership actively shapes the culture through effective engagement with staff, people who use the services, their representatives and stakeholders. Leaders model and encourage co-operative, supportive relationships among staff so that they feel respected, valued and supported.

The board responds to challenges in a positive manner with inquiry about the root causes as opposed to, for example, questioning the data as a first resort.

The board is visible and can be challenged by staff through different channels (eg surveys, focus groups, workshops, patient safety walkabouts and approaches such as the 15 steps challenge)[4] to identify and address blocks to improvement.

The board demonstrably listens to patients (complaints and other feedback, governors, patient groups and Healthwatch) to identify deficiencies in organisational quality culture and actively takes steps to address these and improve.

Board members spend time developing the relationship with the governors. Governors are trained and supported in holding non executive directors to account and asking them the right questions to check they are in turn holding the executive directors to account for quality and operational delivery. Governors consider that they receive sufficient information in a timely fashion to carry out their role.

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[4] The 15 steps challenge is a series of toolkits developed by the NHS Institute based on a parent having said 'I can tell what kind of care my daughter is going to get within 15 steps of walking on to a ward'.

The board co-operates with third parties with roles in relation to the trust – for example, there is a constructive relationship with commissioners and other providers which, as a minimum, involves:

- discussing and sharing the overall strategy of the organisation
- sharing information on specific services and care pathways
- contract/performance issues are addressed and resolved quickly without recourse to arbitration and
- regular reviews and discussions to resolve any lessons learnt.

Where appropriate, the board uses external support networks and expertise to support ideas for development and quality improvement, for example: use of benchmarking, working with patient groups, linking with healthcare providers and other improvement interventions and tools.

Mechanisms are in place to support staff and promote their positive wellbeing.

The board can demonstrate how the organisational development strategy addresses staff support and wellbeing.

The board discusses the results of staff feedback on a regular basis to understand if staff feel valued, supported and developed. An action plan is put in place effectively to address any major issues emerging.

The results of staff surveys and organisational action plans are shared with staff.

There is a culture of collective responsibility between teams and services.

The board can demonstrate it has mechanisms in place so that teams work collectively to resolve conflict quickly and constructively and share responsibility to deliver good quality care.

Staff are aware of and understand how the organisation is performing overall, their part in that, and how this is being measured.

The trust can demonstrate it has an approach to recognising staff achievements, such as best practice awards.

The leadership actively promotes staff empowerment to drive improvement and a culture where the benefit of raising concerns is valued.

There is a demonstrable commitment to improvement and evidence of its achievement. There is appropriate devolution of decision-making, and use of approaches such as service line management.

Staff are supported to deliver the quality improvement initiatives they have identified: for example, staff are provided with quality improvement training to embed quality initiatives; and the board regularly commits resources (time and money) to delivering quality initiatives.

The reporting of harm and error is encouraged as a means of learning from experience, including how the trust learns from incidents, complaints and feedback from patients.

Q5 Does the board support continuous learning and development across the organisation?

Information and analysis are used proactively to identify opportunities to drive improvement in care.

The board takes a proactive and self-challenging approach to improving quality and actively looks at how to do this in ways relevant to its context – through adopting or setting sector best practice, setting stretching performance objectives for the trust and using peer/external review. The board challenges itself on whether objectives are sufficiently stretching.

The board seeks to further improve services by looking at best practice across the healthcare sector and, where appropriate, uses benchmarking as a way of evaluating the services being delivered. It seeks to apply lessons learned in other trusts, organisations and industries.

Information in quality reports is displayed clearly and consistently. The board has sufficient information derived from, for example, ward or service line quality data, service line management/service line reporting to identify areas of underperformance or good practice; and is able to demonstrate how reviewing quality information has resulted in actions which have successfully improved quality performance.

The organisation has a way of measuring the success or the progress of quality improvement, including innovation, and sees failure not as a negative but as a learning experience. Lessons are learned and embedded in practice from failures to deliver performance improvement.

There is a strong focus on continuous learning and improvement at all levels of the organisation. Safe innovation is supported and staff have objectives focused on improvement and learning.

The trust's vision sets out a focus on continuous improvement and ambitions towards being a learning organisation or system. The trust's strategy contains a number of trust-wide ambitious quality improvement goals.

The board can articulate the trust's quality and other improvement initiatives and is actively engaged in their delivery (some initiatives could be led personally by board members).

Governance structures and controls exist in order to support the generation and implementation of new ideas to drive innovation and organisational development. The board has a clear corporate methodology that it uses to drive improvement across the organisation.

Quality/continuous improvement training and development is offered to staff at all levels.

Quality is communicated effectively across the organisation (for example, newsletters, intranet, noticeboards regularly feature articles on quality).

> Staff are encouraged to use information and regularly take time out to review performance and make improvement.

Arrangements are in place for leadership to review performance against targets and then update targets for continual improvement on an ongoing basis.

Across the organisation arrangements appropriate to particular roles are in place for frontline staff to identify and report areas for improvement.

Operational performance improvement processes are in place and the board reviews the outcomes of this work, actively encouraging staff to look at how they can continually improve the way that they work (processes, pathway deployment, etc).

Process and structures

Q6 Are there clear roles and accountabilities in relation to board governance (including quality governance)?

> The board and other levels of governance within the organisation function effectively and interact with each other appropriately.

The board operates as an effective unitary board, demonstrating corporate leadership and a good balance between challenge and support. The board is assured that the size of the board (including voting and non-voting members) is appropriate for the requirements of the organisation.

There is clarity on the functions of the board of directors and how it will exercise those functions. A formal statement is in place that specifies the types of strategic decisions, including levels of investment and those representing significant service changes that are expressly reserved for the board, and those that are delegated to committees or the executive. There are defined lines of accountability into directorates and services.

Information flows (between the board and its committees and between senior management, non-executive directors and the governors) support decision-making and the rapid resolution of risks and issues. Board sub-committees have a stable, regularly attending membership and operate within their terms of reference.

The board's agenda is appropriately balanced and focused between:

- strategy and current performance
- quality
- finance
- making decisions and noting/receiving information
- matters internal to the organisation and external considerations
- business conducted at public board meetings and that done in confidential sessions.

The council of governors are actively involved in holding the non executive directors to account for their work at the board.

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

The trust's senior leadership is clear about who is responsible for making decisions about the provision, safety and adequacy of services. Every board member understands their ultimate accountability for quality.

The board is assured that levels of delegation are in place and is working to support the delivery of the plan and management of risks and issues throughout the organisation and ensure that these delegation processes are monitored and decisions captured and escalated to the appropriate committees, divisions and teams.

There is a clear organisational structure that cascades responsibility for delivering quality performance from 'board to front line to board' (and there are specified owners in post and actively fulfilling their responsibilities).

The board is assured that a sound system of internal control to safeguard investment, the trust's assets, patient safety and service quality is in place and that board sub-committees are set up to focus on these areas.

The board is assured that governance and management of any partnerships, joint ventures and shared services are clearly set out and understood, for example:

- all parties are clear about their roles
- clarity and rules are in place to govern the use of any pooled budgets, and appropriate management structures exist to support and enforce the agreed practice
- parties are clear and use the protocols for escalation and resolution of issues between parties
- a process for dealing with overspends and underspends exists and is reviewed regularly.

If any issues/concerns have been raised by either internal or external audit, recommendations have been implemented in a timely and robust manner. If the trust has encountered any serious fraud in the last two years, procedures and controls are now in place and the trust has received assurance that they are effective.

Quality receives sufficient coverage in board meetings and in other relevant meetings below board level.

Quality is a core part of main board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions.

Quality performance is discussed in more detail by a quality-focused board sub-committee with a stable, regularly attending membership.

Discussions suitably interrogate issues to locality/clinical business unit level.

Q7 Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?

The organisation has the processes and information to manage current and future performance.

The board has agreed and implemented a performance management system which comprises:

- a set of appropriate performance measures covering financial, quality and other areas which are defined, subject to appropriate targets and monitored

- appropriate reporting lines to manage overall performance against these targets in a transparent and timely fashion

- *clinical governance policies for addressing under-performance and recognising and incentivising good performance at individual, team and service line levels*

- means of addressing underperformance across the full range of the trust's operations.

In particular, arrangements are in place to manage/respond to adverse performance in:

- finance

- clinical and other operations

- organisation/HR and

- long-term strategy.

Lessons from performance issues are well documented and shared across the trust on a regular, timely basis, leading to rapid implementation at scale of good practice.

Performance issues are escalated to the relevant committees and the board through clear structures and processes.

The trust is clear about the processes for escalating both quality and financial performance issues to the board:

- *processes are documented*

- *there are agreed rules determining which issues should be escalated (in respect of quality, for example, these cover escalation of serious incidents, complaints and matters related to legal and audit)*

- *there is a defined procedure for bringing significant issues to the board's attention outside monthly meetings.*

The board is assured that the processes are working and that the appropriate person/management level is aware of the issues and are managing these through to resolution.

The board is aware of the most frequent issues being flagged by the workforce to analyse which barriers need to be removed in order to drive improvement.

Robust action plans are put in place to address performance issues (across quality, finance and operations). A*ctions have:*

- *designated owners and timeframes and*
- *regular follow-ups at subsequent board meetings.*

Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.

There is a continuous rolling programme that measures and improves quality. The board actively oversees a co-ordinated programme of clinical audit, peer review and internal audit which is aligned with identified risks and/or gaps in other assurance.

Action plans are completed from audit; and re-audits are undertaken to assess improvement.

Q8 Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?

A full and diverse range of people's views and concerns are encouraged, heard and acted on. Information on people's experience is reported and reviewed alongside other performance data.

The board is assured that patient and public views are heard and acted on, complementing other means of assessing performance. For example:

- *Patient feedback is actively solicited. The process to give feedback is well publicised, feedback is easy to give and based on validated tools.*

- *Patient views are proactively sought during the design of new pathways and processes.*

- *Patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the board.*

- *The board regularly reviews and interrogates complaints and serious untoward incident data.*

- *The board uses a range of approaches to engage with individual patients (eg face-to-face discussions, video diaries, ward rounds, patient shadowing, patient stories).*

Feedback from external representatives, eg Healthwatch, is considered alongside the views of current patients and service users, members and governors.

The service proactively engages and involves all staff and assures that the voices of all staff are heard and acted on.

The board can demonstrate a variety of methods to capture the views of staff. Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (for example, monthly 'temperature gauge' plus annual staff survey).

All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the board.

Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted on.

There is an appropriate mechanism in place for capturing frontline staff concerns. This includes a defined 'whistleblower' policy/error reporting process which is defined and communicated to staff; and staff are prepared if necessary to blow the whistle.

Organisations have considered and implemented the recommendations of the 'Freedom to speak up' review into creating an open and honest reporting culture in the NHS.

The service is transparent, collaborative and open with all relevant stakeholders about performance.

The board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to find out easily how and why the board has made key decisions without reverting to freedom of information requests.

The board works with the council of governors on communicating fully the decisions taken and the reasons that the board reached them, recognising its accountability to the council as the representatives of service users and the public. *The board is clear about governors' involvement in quality governance.*

The board actively engages with the public and stakeholders on significant policy developments. Performance outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance.

The board actively engages all other major stakeholders on quality: for example, quality performance is clearly communicated to commissioners to enable them to make informed decisions

For care pathways involving GP and community care, discussions are held with all providers to identify potential performance issues and ensure overall quality along the pathway.

Measurement

Integrated reporting supports effective decision-making.

An integrated reporting approach, appropriate to the size and complexity of the trust, is used by the board to ensure that the impact on all areas of the organisation is understood before decisions are made.

Dashboards

Monthly reporting is supported by a 'dashboard' of the most important metrics. The board is able to justify the selected metrics as being:

- *relevant to the organisation given the context within which it is operating and what it is trying to achieve*

- *linked to the trust's overall strategy and priorities*

- *covering all the trust's major focus areas*

- *the best available ones to use*

- *useful to review.*

The board's information 'dashboard' is frequently reviewed and updated to maximise effectiveness of decisions; and in areas lacking useful metrics, the board commits time and resources to developing new metrics.

The board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines. Supporting performance detail is broken down by service line so members can understand which services are high and low performing from a financial and quality perspective. *Quality information is analysed and challenged at the individual consultant level.*

Information is compared with target levels of performance (in conjunction with a red-amber-green rating), historic own performance and external benchmarks (where available and helpful).

Information being reviewed must be the most recent available, and recent enough to be relevant. 'On demand' data is available for the highest priority metrics.

Information is 'humanised'/personalised where possible (eg, unexpected deaths shown as an absolute number not embedded in a mortality rate).

Good practice quality dashboards might include:

- *performance against relevant national standards and regulatory requirements*

- *selection of other metrics covering safety, clinical effectiveness and patient experience*

- *selected 'advance warning' indicators*

- *adverse event reports/serious incident reports/ patterns of complaints*

- *measures of instances of harm*

- *Monitor's risk ratings (with risks to future scores highlighted)*

- *where possible/appropriate, percentage compliance to agreed best-practice pathways and*

- *qualitative descriptions and commentary to back up quantitative information.*

A balanced policy exists for data sharing which demonstrates safe and effective sharing of information to facilitate integrated patient care.

The board is willing to use 'soft' information, for example:

- *use of questionnaires and focus groups throughout the organisation and*

- *tools for assessing impact with patients, council of governors and other major stakeholders.*

Board reports reflect the issues and themes that board members are picking up through other channels of information, for example talking to staff, patients and other external stakeholders.

Internal audit of data takes place on a regular basis.

Performance information is used to hold management and staff to account.

Information is clearly aligned to priorities/elements of the trust plan and its delivery.

The board can measure the impact of the organisation's strategy through the use of agreed key performance indicators (eg productivity and efficiency measures), national and local indicator sets, etc. There is robust narrative text/qualitative analysis of outliers/poor performance.

Board reporting provides assurance that patients are receiving person-centred co-ordinated care. Boards also review the performance of patient pathways rather than purely reviewing metrics of the performance of divisions and/or clinical units.

The trust has established financial reporting procedures which provide robust information on organisational performance and enable key risks to be identified and managed, in both operational and strategic terms.

Information includes relevant indicators in relation to the people or HR strategy, eg:

- workforce capacity and capability to deliver the future strategy

- intelligence on values, behaviours and attitudes

- HR health indicators, including information on equality and diversity

- performance appraisal, training and development; and leadership.

Q10 Is the board assured of the robustness of information?

The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant.

The board assures itself that information it receives is from reliable and suitable sources and covers an appropriate mix of intelligence (qualitative and quantitative).

There is assurance covering the data collection, checking and reporting processes in place for producing the information and testing the systems and controls. The following dimensions of data quality could be used to assess the processes and data quality:

- accuracy: data is recorded correctly and is in line with the methodology for calculation

- validity: data has been produced in compliance with relevant requirements

- reliability: data has been collected using a stable process in a consistent manner over a period of time

- timeliness: data is captured as close to the associated event as possible and is available for use within a reasonable time period

- relevance: data is used to generate indicators that meet eligibility requirements as defined by guidance.

The board regularly reviews their arrangements for supporting how they prepare and report performance indicators.

There are clearly documented, robust controls to assure the board on the accuracy, validity and comprehensiveness of information. Local operating procedures are in place to ensure the consistency of data handling and processing, for example :

- *Each directorate/service has a well-documented, well- functioning process for clinical governance that assures the board of the quality of its data.*

- *The clinical audit programme is driven by national audits, with processes for initiating additional audits as a result of identification of local risks (eg, incidents).*

- *Electronic systems are used where possible, generating reliable reports with minimal ongoing effort.*

- *Information can be traced to source and is signed off by owners.*

- *There is clear evidence of action to resolve audit concerns:*

- *Action plans are completed from audit (and subject to regular follow-up reviews).*

- *Re-audits are undertaken to assess performance improvement.*

- *There are no major concerns with coding accuracy performance.*

Annex 2: Governance and capability review self-assessment form

This annex sets out:

- the purpose of the self-assessment step

- how to complete the self-assessment step

- how to rate the self-assessment.

Purpose of the self-assessment questionnaire

The self-assessment process is an important step in setting the starting point for a governance review. Trusts beginning the review process should assess themselves to (i) provide insight to the NHS foundation trust and the independent reviewer about how the trust gauges its own leadership and governance performance; and (ii) to shape the emphasis and scope of the review, identifying areas within the four domains for extra attention or other areas outside the 'core' scope in this document.

Completing the self-assessment

If the self-assessment process is carried out once the external review team have been procured, we suggest that members of the NHS foundation trust board leading the review meet with the independent reviewer to discuss the approach to the self-assessment, ensure consistent expectations about types and levels of evidence to use and make effective use of the tool to inform the review.

While a nominated trust lead or team may co-ordinate the self-assessment and other aspects of the review, the self-assessment should be completed and signed-off by the full board. In practice, this could mean that a nominated board member works with the board secretary and their staff to gather the information and the evidence against each question and present their findings and initial conclusions to the board for discussion and challenge.

Once the board has come to an overall conclusion, the self-assessment questionnaire, ratings and rationale for the rating should be presented to the independent reviewer for comments and further discussion. The reviewer will then agree areas for further scrutiny and approach with the board.

Rating the self-assessment

One way in which NHS foundation trust boards could rate themselves against each of the self-assessment questions might be through using a colour-coded (RAG) system. The good practice examples linked to the questions in annex 1 should be used as a guide to make a judgement about the RAG rating for each question. The self-assessments should be evidence-based. For convenience we repeat the rating table below.

Table 5: Risk ratings explained

Risk rating (or other means of assessment)	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, no major omissions and robust action plans to address perceived gaps with proven track record of delivery
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, some minor omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in quality governance identified. Significant volume of action plans required and concerns about management's capacity to deliver

Strategy and planning

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
1	Does the board have a credible strategy to provider high quality, sustainable services to patients and is there a robust plan to deliver?				
2	Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?				

Capability and culture

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
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?				

Process and structures

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
5	Does the board support continuous learning and development across the organisation?				
6	Are there clear roles and accountabilities in relation to board governance (including quality governance)?				
7	Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?				
8	Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?				

Measurement

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
9	Is appropriate information on organisational and operational performance being analysed and challenged?				
10	Is the board assured of the robustness of information?				

Annex 3: References and further reading

Monitor guidance

Monitor (October 2013, revised version expected, April 2015) 'Applying for NHS foundation trust status: Guide for Applicants'

Monitor (December 2013) 'NHS Foundation Trust Code of Governance'

Monitor (July 2010) 'Quality Governance Framework'

Monitor (April 2013) 'Quality governance: How does a board know that its organisation is working effectively to improve patient care?'

Monitor (April 2014, updated March 2015) 'Risk assessment framework'

Monitor (October 2014) Strategy Development: A toolkit for NHS providers

Monitor and PA Consulting (June 2012) 'Director-governor interaction in NHS foundation trusts: A best practice guide for boards of directors'

Interested readers may also find the publications below useful in considering governance (we have provided links where possible)

British Quality Foundation (2013) EFQM Excellence Model

Department of Health (December 2011) 'Board Governance Assurance Framework for Aspirant Foundation Trusts'

NHS Providers and DAC Beachcroft (2013) 'Foundations of Good Governance: A Compendium of Best Practice (2nd edition)'

NHS North West Leadership Academy Board Development Guide 'Knowing what you know and don't know': A practical guide to reviewing effectiveness at Board-level

National Quality Board (March 2011) 'Quality Governance in the NHS – A guide for provider boards'

NHS Leadership Academy (2013) 'The Healthy NHS Board 2013: Principles for Good Governance' (joint introduction from David Bennett and David Flory)

Monitor

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