Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of Directors

Report

Subject: **Replacement of Quality Governance Framework**

Date: **25th June 2015**

Lead Director: Kerry Rogers, Director of Corporate Services/Company Secretary

Executive Summary

Last year the Care Quality Commission (CQC), Monitor and the NHS Trust Development Authority (TDA) set out plans for developing an aligned view of a well-led organisation, aimed at supporting NHS providers to improve, and therefore benefiting the broader NHS and its patients. By well led, Monitor 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.

The characteristics of a well-led organisation, as defined by CQC, Monitor and TDA, are now identical. There is now a common understanding of what a good organisation looks like and what it should be able to demonstrate, creating coherence, consistency and transparency across regulatory activities. Monitor is using this in assessments, development work, monitoring and inspections, and in how they decide whether to take action to improve the safety and quality of care for patients.

This aligned view of a well-led organisation is reflected in CQC's assessments and ratings, as set out in its provider handbooks, while Monitor and TDA now use the updated well-led framework as the point of reference for NHS trusts and foundation trusts. **It replaces the quality governance framework (QGF) which is now effectively incorporated within this framework.**

Existing foundation trusts are expected, under Monitor's risk assessment framework (on a 'comply or explain' basis), to undertake an external and independent review of their governance every three years. They should now use the updated well-led framework and advise Monitor of any material governance concerns arising from their review and what they plan to do about them.

As part of its inspection, CQC asks providers how they have assured their governance arrangements. This may include asking for information about any independent reviews and how they have been acted on. CQC seeks Monitor's views as part of the process.

The Board is responsible for ensuring that governance arrangements remain fit for purpose. As set out in the 'Risk assessment framework', Monitor's oversight of governance relies on information, including national standards and third party concerns, as triggers identifying potential governance issues.

As stated NHS foundation trust boards should carry out governance reviews every three years and the Trust chose to undertake its first governance review in December 2014, undertaken by Foresight Partnership. The Trust has developed a Board Governance Action Plan to identify the areas on which the Board will focus improvement activity over the coming months.

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'*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'*.

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. Monitor's guidance included in part at Annex 2 explains also the requirement for Board to continue to self-assess itself against the framework in accordance with the unchanged original QGF 0 to 4 ratings and criteria.

Figure 1 below sets out the four domains of the new framework and the questions trusts and reviewers should ask themselves. Each question has outcomes that the review 'tests'/investigates. As noted above Monitor has aligned these with CQC's approach to well led. If delivered effectively, assessment against this framework should provide boards with assurance over the effective oversight of the care provided throughout their trust

Figure 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

The approach and question and evidence sets reproduced in the annex below have been developed to help NHS foundation trusts gain insight into their leadership and governance practices, and understand if they are well led.

Recommendation
The Board is invited to:

1. Note the new guidance which supersedes the original QGF and members should familiarise themselves with the full content of the Well Led Framework guidance issued by Monitor.
2. Recognise that its own independent review was undertaken by Foresight in December and the resultant action plan is being monitored by the Board of Directors and was submitted to Monitor on 31st May 15.
3. Recognise the last self assessment was presented to Board in March 2015 and agree a further self assessment against the new / enhanced (well led) framework will be undertaken and presented to the July Board meeting.

Relevant Strategic Priorities (please mark in bold)	
To consistently deliver a high quality patient experience safely and effectively	To develop extended clinical networks that benefit the patients we serve
To eliminate the variability of access to and outcomes from our acute services	**To provide efficient and cost-effective services and deliver better value healthcare**
To reduce demand on hospital services and deliver care closer to home	

How has organisational learning been disseminated	N/A
Links to the BAF and Corporate Risk Register	Principal risk 1 – Inability to maintain the quality of patient services demanded
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	N/A
Links to NHS Constitution	Duty of Quality
Financial Implications/Impact	N/A
Legal Implications/Impact	N/A
Partnership working & Public Engagement Implications/Impact	N/A
Committees/groups where this item has been presented before	N/A
Monitoring and Review	N/A
Is a QIA required/been completed? If yes provide brief details	N/A

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**) 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.

*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). Actions 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
Q9 Is appropriate information on organisational and operational performance being analysed and challenged?
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.