Monitor

Making the health sector work for patients

Governance reviews: consultation document

www.monitor.gov.uk

About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are run well, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

Contents

Introduction

Monitor's new *Risk assessment framework* (which came into effect on 1 October 2013) serves as guidance for trusts in complying with their Continuity of Service and governance licence conditions. As part of this guidance, we set out our expectation that NHS foundation trusts carry out an external review of their governance (ie that of the board) 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, as part of the health care sector, face significant financial and operational challenges. Boards need to ensure that their oversight of care quality, operations and finance is robust in the face of uncertain future income, potential new models of care and resource constraints. Good governance is essential if they are to continue providing safe, sustainable and high-quality care.

2. **Oversight of governance systems has to date been the responsibility of NHS foundation trust boards**

   In the assessment process, Monitor subjects the governance (including quality governance) at applicant NHS trusts to rigorous scrutiny. 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, 40 NHS foundation trusts (approximately 1 in 4)[1] have been subject to formal regulatory action on at least one occasion, with poor governance contributing to almost all of these cases. At present, 17% of the sector is in special measures or other regulatory action.[2] In our experience, issues leading to regulatory action by Monitor generally[3] occur at least two years post-authorisation. We consequently consider it timely to support foundation trust boards in maintaining robust systems of governance in these challenging times.

[1] At the end of 2011, 27 trusts had been subject to regulatory action over the same period
[2] 22% of acute foundation trusts
[3] In approximately 80% of cases

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. A well-designed and properly carried out independent review of governance is a valuable tool in establishing whether any of the board's governance practices and capabilities need improvement.

About this document

Since its introduction in 2010, Monitor's *Quality governance framework* has become a major part of how we assess governance at applicant NHS trusts, and some foundation trusts have used it to run their own quality governance reviews. To strengthen the degree of governance assurance across the sector, Monitor is seeking a 'reference framework' for good governance for foundation trusts. While this governance framework includes the existing elements of the quality governance framework, it also expands the approach to include the board's role in strategic planning, organisational oversight, and stakeholder engagement, among others.

This proposed framework is built along the lines of the existing quality governance framework, with four domains, 10 high level questions and a body of 'good practice' evidence/outcomes that organisations and reviewers can use to assess governance. It also sets out the proposed review process and what to take into account when choosing an external reviewer.

Its purpose is to support NHS foundation trusts in gaining assurance that they are well led and, therefore, to help them to continue to meet patients' needs and expectations in challenging circumstances.

The guidance in this document represents a starting point for NHS foundation trusts to structure reviews of their governance – provided they incorporate the domains and principal areas of enquiry in the framework set out here, NHS foundation trusts should feel free to tailor the approach to suit their own organisational circumstances.

Using this guidance – "comply or explain"

Monitor considers that these reviews are regarded on a "comply or explain" basis:

- **Comply** means we strongly encourage all NHS foundation trusts to carry out board governance reviews every three years – as set out in the *Risk assessment framework* – having regard to this guidance.
- While it is expected that NHS foundation trusts will use the framework as the starting point for reviewing governance, it is recognised that departure from its

provisions may be justified in particular circumstances. A foundation trust should give a considered **explanation** if it uses alternative means to assure itself regarding its governance. Departing from the guidance may be justified where a foundation trust can demonstrate that it is meeting 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.

For consultation

Our draft guidance includes the following sections, all of which we would like to hear your views on:

- **Section 1:** a summary of our proposed expectations concerning governance in the context of the framework and reviews against it;
- **Section 2 and 3:** the approach to carrying out the reviews, including the main questions in the review; and
- **Section 4:** the suggested approach for choosing an independent reviewer.

Consultation process and timing

In Sections 1 to 4, we have highlighted what we think are the important questions most relevant to this consultation. These are provided to help you to focus on what we believe to be the main considerations. We are also interested in any ideas and views beyond the questions provided (the full set of consultation questions are included in Annex 1.)

Online:

Please complete the consultation response form on our website by **5pm Friday 7 March 2014.**

By post:

You can write to us (to be received by **Friday 7 March 2014**) at:

Governance reviews
Monitor
133-155 Waterloo Road
London SE1 8UG

We will then consider the responses, with the aim of publishing the final guidance later in 2014.

Please direct any questions about the guidance and/or the consultation to governance@monitor.gov.uk

Pilots

In parallel to this consultation taking place, Monitor is piloting the governance review framework and approach with three NHS foundation trusts. Feedback from the pilot and the consultation exercise will be used to inform the final guidance later in 2014.

Section 1: What is board governance and why review it regularly?

NHS foundation trust boards should conduct their affairs effectively and, in so doing, build patient, public and stakeholder confidence that they are providing high-quality, sustainable care. NHS foundation trusts are autonomous organisations, with their boards responsible for all aspects of performance and compliance with their provider licence.

Monitor's guidance, such as *the Risk assessment framework*, supports boards in this by setting out our expectations regarding compliance with conditions of their licence. We generally only intervene when it is clear that boards are unable to ensure compliance with the conditions of their provider licence and that formal regulatory action is necessary to protect the interests of patients.

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 often 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 – eg as people leave roles, or as organisations restructure – regular reviews can ensure governance remains fit for purpose.

Governance reviews and the Care Quality Commission's inspection regime

The Care Quality Commission (CQC) is currently developing an inspection regime that will consider whether, alongside other criteria, providers of care services are well led. While some elements of their inspections are likely to fall outside the scope of the reviews described here, others may not. As we both pilot and consult on the approach in this document, we will also work with the CQC in 2014 to ensure that our respective approaches are complementary, leading to a clear and consistent view of governance expectations for the sector.

Section 2: What should a review of board leadership and governance cover?

To review how well a board is operating, we propose looking at four different domains:

1. **Strategy and planning** – how well is the board setting direction for the organisation?
2. **Capability and culture** – does the board have the appropriate experience and ability and can it communicate this to the organisation?
3. **Process and structures** – do reporting lines and accountabilities support the effective oversight of the foundation trust?

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

This approach incorporates, and builds on, our *Quality Governance Framework*. The *Quality Governance Framework*:

- has been part of our assessment process for aspirant NHS foundation trusts since August 2010;
- was included in the *Compliance Framework* (as a self-certification requirement) from April 2011;
- reports against it are included in the Annual Governance Statement and the Annual Reporting Manual from 2012;
- is included in the *Risk assessment framework* for existing NHS foundation trusts from October 2013; and
- is supported by Monitor's publication *Quality governance: How does a board know that its organisation is working effectively to improve patient care?* published in April 2013.

Table 1: The four domains of the board governance framework

Strategy and planning	Capability and culture	Process and structures	Measurement
Does the board have a credible strategy to deliver high quality, sustainable services to patients and is there a robust plan to deliver? Is the board sufficiently aware of potential risks to the quality 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?	Are there clear roles and accountabilities in relation to quality and board governance? Are there clearly defined, well understood processes for escalating and resolving issues? Does the board actively engage patients, staff and other key stakeholders on quality and operational performance?	Is appropriate information on organisational and operational performance being analysed and challenged? Is the board assured of the robustness of information? Is information used effectively to drive improvement?

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

Table 1 sets out the four domains of the board governance framework and the questions we will ask under each:

Strategy and planning

- how well the board is carrying out its role in setting the organisation's vision and strategy;
- how well the board leads the development of the strategic plan, ensuring that engagement with internal and external stakeholders are part of the process;
- how quality considerations drive the trust's strategy & planning;
- the ability of the board to hold management to account for the delivery of the plan; and
- the board's awareness of risks to delivery of the plan.

Capability and culture

- the board's skill mix, capabilities, experience and division of responsibility;
- board development and succession planning programmes;
- board's capacity to lead improvements to sustain high-quality, safe services throughout the trust; and
- the board's ability to lead the organisation effectively, shaping its culture to deliver safe and sustainable care.

Process and structures

- suitability and effectiveness of the board's committee structures, interactions and decision making;
- ability to identify risks and areas of underperformance, for example under the trust's Board Assurance Framework and how it is used in practice;
- accountability of executive directors to ensure risks and underperformance are addressed;
- degree to which risk management systems, processes and culture are established throughout the organisation;

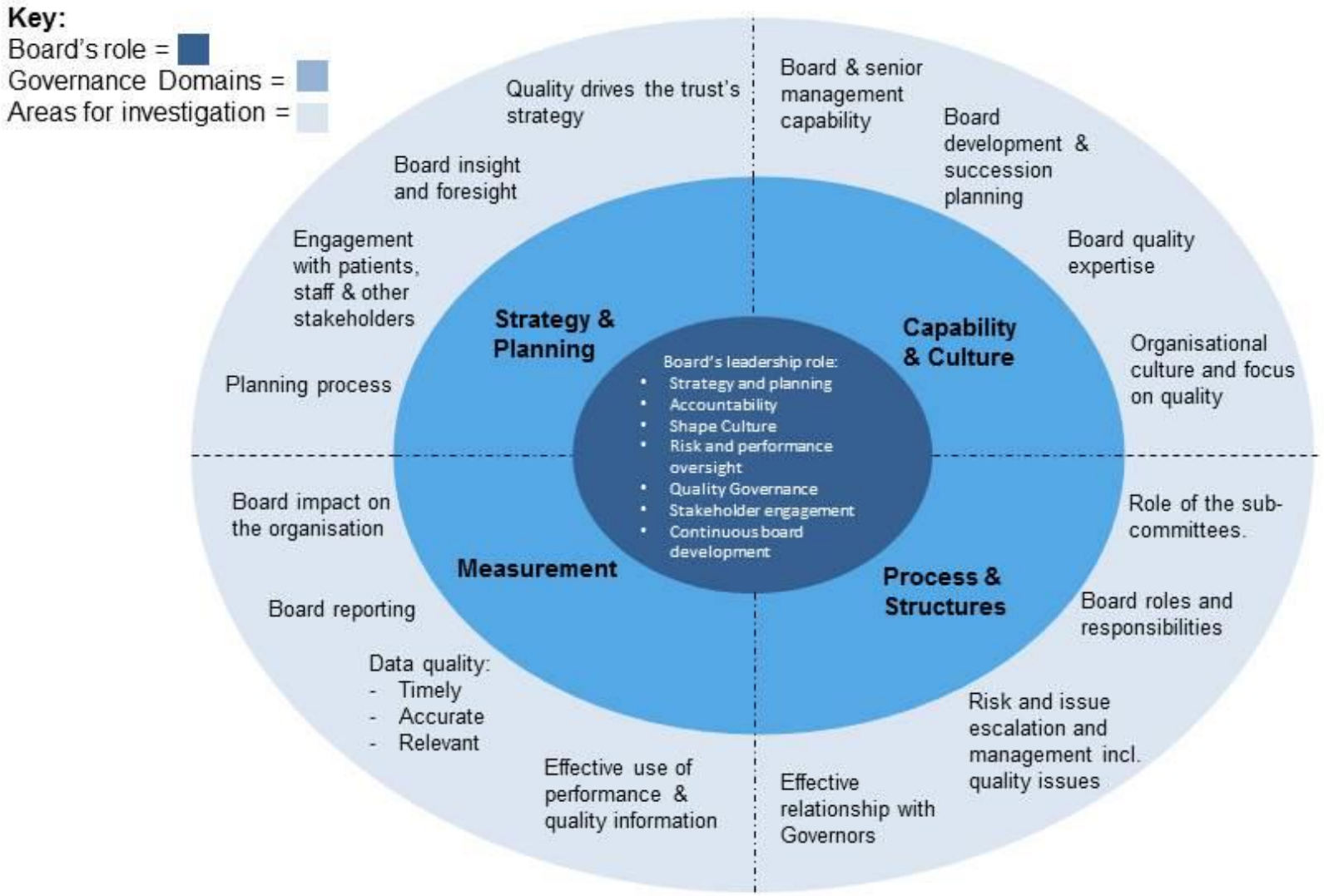
- processes supporting board decision making and ensuring actions are carried out by the trust; and
- the board's relationship with its principal stakeholders (including, patient groups, staff, governors, commissioners) and the views of those stakeholders about the effectiveness of the board.

Measurement

- effective information management and reporting;
- the reliability of the information being used by the board for board reporting; and
- how the board uses information to make decisions.

Diagram 1 (below) sets out how the framework fits together and the main areas for review.

Diagram 1: How the board governance framework fits together and the main areas for review



In developing this framework, we sought input from a variety of experts and document sources within the board governance, leadership and quality governance field in conjunction with our own experience of foundation trust governance.

The domains and question sets are designed to:

(1) help a board assess their governance practices; and

(2) help any independent reviewer to assess whether the processes in place to manage the trust are fit for purposes.

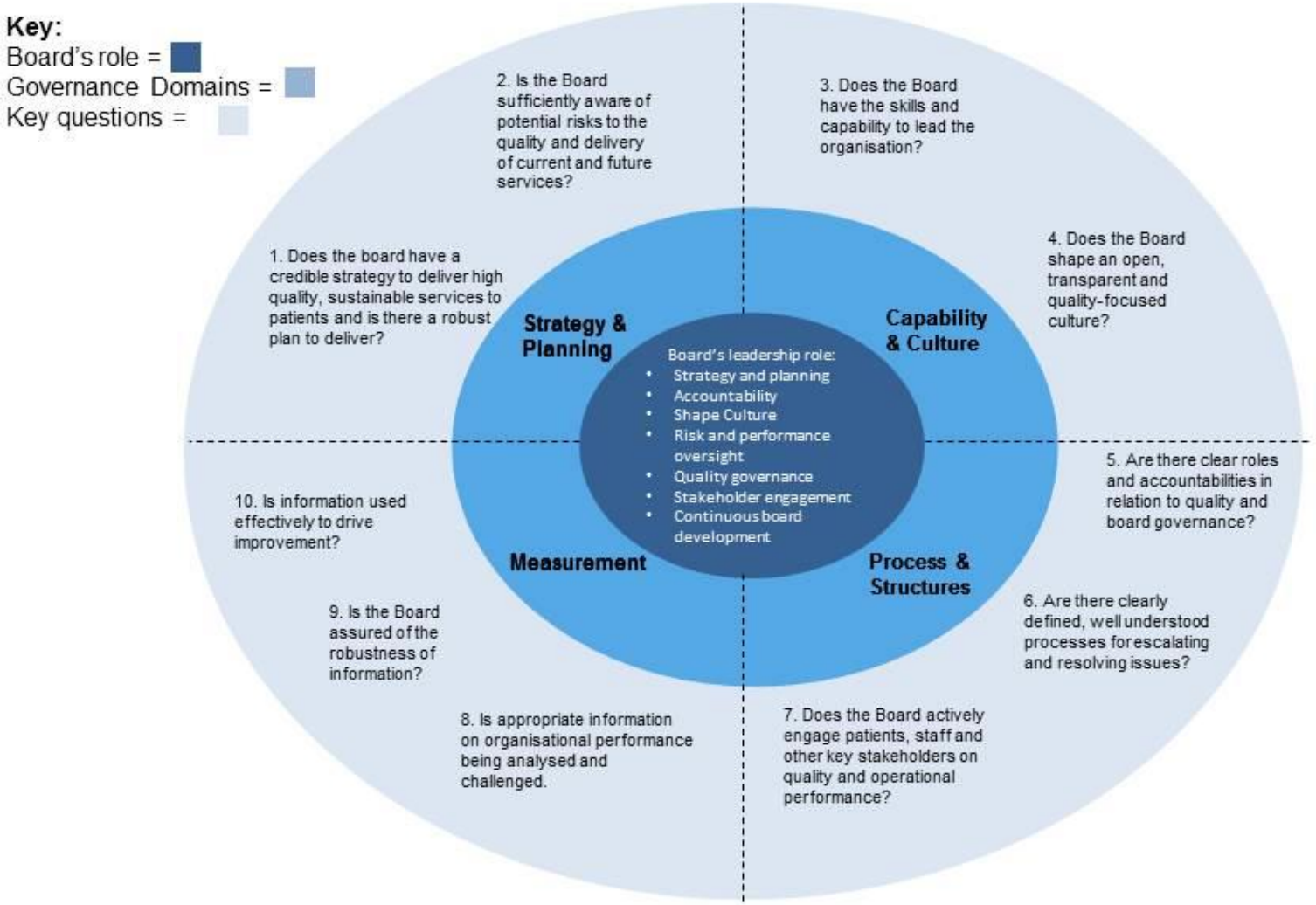
Annex 1 provides a reference base of evidence & outcomes representing good practice against each question.

Diagram 2 (below) sets out the questions under each of the four domains of the framework (which guide the review).

Consultation questions

1. **Is the governance review framework clear and comprehensive? Please share the reasons for your answer.**
2. **Do you think that the review framework and process will provide assurance that a board is doing its job well? If not, please tell us your reason for this.**
3. **Are there any areas of board governance that you think are missing from the framework and why?**
4. **Do the evidence/outcome sets in Annex 1 representing good practice cover an appropriate range of areas for the purposes of gathering evidence to assess governance? Are the examples too detailed or not detailed enough? Please share the reasons for your answer.**
5. **Do you have any other comments on the proposed framework?**

Diagram 2: Questions under each of the four areas of the framework



Section 3: What does an effective review of board leadership and governance consist of?

The review process has been designed to support boards and reviewers in assessing whether an NHS foundation trust's governance is robust and effective, and to identify areas for improvement.

This section summarises some of the considerations in preparing for a review and the five steps involved in the review process. While not intended to be exhaustive, it should provide NHS foundation trusts with the necessary information to kickstart governance reviews.

Governance reviews – frequency/scope/review teams

Frequency of the review process

- Under the proposed approach, NHS foundation trust boards should carry out governance reviews **every three years.**
- It is proposed that NHS foundation trusts work with their Monitor relationship manager to schedule a review in the first instance.

Scope of the review

- The review should be carried out using the board governance framework, incorporating the questions and evidence base in Annex 1 of this guidance as a starting position. We expect boards to go on to tailor the scope of the reviews they commission to cover any additional areas that they would like to specifically focus on. Additional areas in scope 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.
- In considering the length of time required for these reviews, we envisage that 30 to 35 days of independent reviewer time (assuming a team of three) should suffice. This is based on using the base guidance set out in Annex 1. (This assumption is being tested through pilots being run from December 2013 to March 2014.)

Review teams

- In order to gain maximum benefits and assurance from the reviews, we consider that **independent reviewers** should be used to ensure objectivity. Ideally, 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, reviewers should have:
    - experience of evaluating board leadership and governance arrangements;
    - knowledge of the health care sector; and
    - specialist expertise, specifically clinical and leadership experience (including culture and board development).

Section 4 of this document sets out what to consider when choosing an independent reviewer.

Carrying out a review

This section sets out the proposed:

- approaches to carrying out the review;
- methods used to carry out the review;
- methodology for rating a review; and
- time commitments.

Approach to a review

The diagram and table below set out the proposed review and reporting steps.

Diagram 3: Proposed review steps

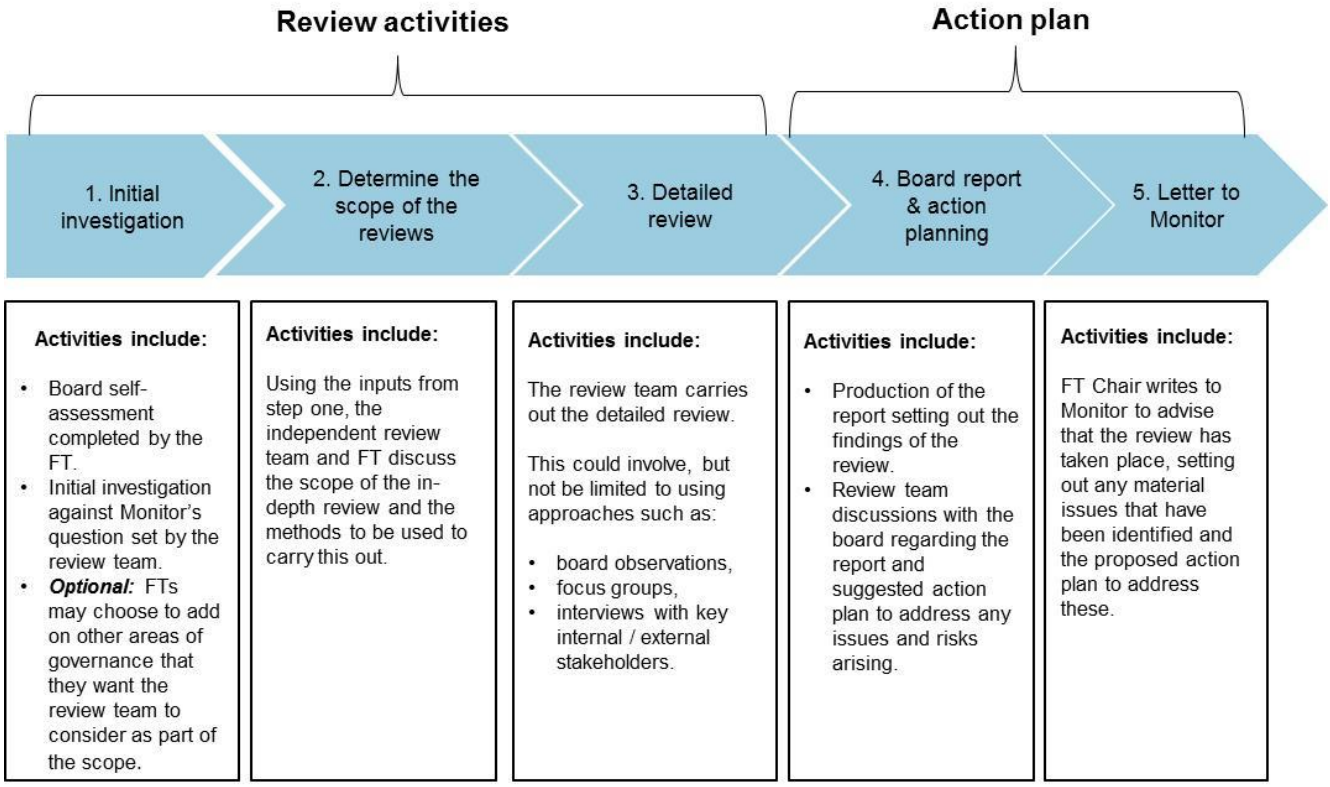


Table 2: Proposed review activities and outputs

Step	Activity	Output
1	**Initial review:** a) and b) below should take place in all cases; c) is optional, as detailed below: a) **Board self-assessment:** Boards should carry out a self-assessment 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. Boards will be asked to rate themselves against the 10 questions that form the board governance framework.	Self-assessment statement outlining: • rationale for their rating against each of the review questions; • documented evidence for the conclusions and ratings; and • based on the outcomes of the assessment, opinion about the areas that need further review with the independent

Step	Activity	Output
	See Annex 2 for the self-assessment questions and form. b) **Initial review against Monitor's question set:** Independent reviewers should gather evidence from a variety of sources including 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. Depending on timing, the activity described under point b) may take place in parallel with the trust's self-assessment or afterwards. Both a) and b) need to have been undertaken to inform **step 2 below.** c) **Optional:** Foundation trusts may choose to ask the independent review team to look at specific areas of governance that they have concerns about. This would be in addition to the areas set out in Monitor's governance review framework and may involve a deeper investigation of particular lines of governance.	reviewer. • Overview to identify areas for further scrutiny • Agreement to additional areas that should form part of the scope of the detailed review
2	**Determine the scope of the detailed review to cover areas that may need further scrutiny:** Both parties should agree any further areas for scrutiny primarily based on risks identified through the initial work (in Step 1). Should no material risks be identified, the trust and review team need to agree on areas which may benefit from further investigation in order to ensure that a comprehensive review has taken place.	• Scope of the detailed review and methods to be used to undertake this.
3	**Detailed review:** Review to be undertaken by the independent review team against the scope agreed in Step 2. The review team will rate each of the 10 questions using the definitions set out in the colour coded rating system to be used for the	• A detailed report of the findings from the review process for the board to consider

Step	Activity	Output
	review (refer to the section below on rating the review)	
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 advising of any "material issues" that have arisen from the review and advise of the action plan (including timings and priorities). This needs to advise of any amber-red/red ratings given to any of the ten questions within the review framework (refer to the section below on rating the review). It should be considered as in line with the exception reporting requirements in the *Risk assessment framework*	• Letter to Monitor

Methods used to carry out a review

While the proposed approach to a review is laid out above, we are not specifying any set methods that a reviewer must use to carry out the review. Experienced reviewers can use their own diagnostic tools and methods to carry out a robust review. From previous experience, these methods may include, but are by no means limited to, those set out in the table below.

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	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.

Tool	Suggested components	Purpose
	other relevant reviews.	
One-to-one interviews	All board members, the trust secretary, lead governor, clinical directors and leads, local stakeholders, including clinical commissioning groups and patient representatives.	To gain individuals' views of the trust's governance and to provide a "safe" environment in which to explore issues and discuss 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 at two board meetings and of relevant sub-committees, including audit, 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.	How an NHS foundation trust compares against any known examples of particularly effective and robust governance practices.

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

Methodology for rating a review

For the board governance framework, we propose basing our assessment on the RAG rating definitions as used to date in Monitor's existing *Quality Governance Framework*, published and in use since 2010.

An overall score is not required in the proposed approach, instead, we are asking reviewers to rate each of the 10 questions, and for the chair to advise us of the amber-red and red ratings and action plans to address these.

The table below sets out the rating definitions. For the purposes of this review, we expect the trust to inform us of how the board is planning to address any questions that have been flagged as amber-red/red.

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, 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, 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

Time commitments

As outlined above, we envisage reviews against this framework to take an average of 30 to 35 days of independent review time, over a six to eight-week period, although the size of the trust, number of sites and scheduling challenges – eg, key individuals on leave – may affect this.

The question set, the approach to the review and time commitment are being tested through our pilot process, which is taking place at the same time as this consultation.

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 April 2014. If this is the case and the scope of the review covered the areas of our board governance framework, then the trust may use this to explain why they are not undertaking an additional 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 the review that was carried out, including its findings and any action plan.

Consultation questions

6. **Do you agree that the proposed approach to the review is suitable for all types of NHS foundation trust or are there any exceptions that should be considered? Please share the reasons for your answer.**

7. **Do you have any comments on the proposed rating method for the reviews and what information is provided to Monitor? Please share the reasons for your answer.**

8. **Does the expected time commitment for reviews reflect your experience of similar governance reviews? Please share the reasons for your answer.**

9. **How long do you think the self-assessment step in the review should take? What information is your response based on?**

Section 4: Selecting a reviewer

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

We do not currently have any plans to accredit suppliers or set up a preferred reviewer list. This is something that we may look into in the future once we have greater insight into the support trusts may need in finding and selecting reviewers.

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

Potential criteria

Reviewers should demonstrate the following:

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

- Relevant experience to carry out the work. The quality of the skills and experience of the reviewer are important to the success of a review, including:

    - credibility and experience in carrying out governance and quality reviews at health care providers. Ideally, a multi-disciplinary team with a broad range of skills relevant to all aspects of board leadership and governance, from strategic planning to quality governance (clinicians) and cultural assessment and change (HR/organisation development specialist skills);

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

    - knowledge of the health care sector, and the internal and external challenges faced by trusts; and

    - 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:

    - 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.

Consultation questions

10. **What other information would be helpful to support you in choosing an external reviewer? Please share the reasons for your answer.**
11. **How would you find out about potential reviewers in the market?**
12. **Would it be helpful if Monitor published a list of reviewers who had carried out governance reviews for particular NHS foundation trusts? Please share the reasons for your answer.**
13. **Peer review teams, ie, from other NHS foundation trusts, could be used to undertake the governance reviews. If this was the case, would you use a peer review team for the full review, for parts of the review or not at all? Please share the reasons for your answer.**

Annex 1: Questions and good practice examples

The following information provides **examples** of good practice principles against the questions in the board governance framework. Monitor recognises that how these are applied in each NHS foundation trust's specific context will vary according to the nature of the services provided. The examples are intended to provide guidance only, these are **not** intended to provide an exhaustive list of practices.

Domain 1: Strategy

Question	Good practice examples
1) Does the board have a credible strategy to deliver high-quality, sustainable services to patients and is there a robust plan to deliver?	**The trust has put in place a structured strategic planning process which ensures that board and executive time is regularly spent debating strategic issues, at the correct point in the trust calendar** • The strategic planning process enables the board to deliver a credible strategy, which delivers quality and value for patients and identifies risks to sustainability. The process should support the following: 1) facilitate the board to undertake the necessary planning actions at the right time; 2) the development and refresh of a 5-10 year strategic plan, with content that is based on accurate and correctly analysed inputs, that establishes an evidence-based, sustainable vision and explains how these initiatives will be delivered; and 3) monitoring of the delivery of the initiatives, ensuring that staff, patients and other stakeholders understand why transformation is necessary and what part they must play in delivering it. • The strategic planning process takes account of relevant **internal factors**, for example o an assessment of the organisation's capabilities and weaknesses; o costs and cost reduction priorities; o previous performance and delivery of plans; o operational performance improvement; o that the people strategy fits the needs of the organisation; and **external factors,** for example o local health economy factors; o service reconfiguration drivers and changes; o local area demographics; o health care access; o workforce plans and projections; and o other providers. • Quality goals are embedded in the overall strategy: o The trust's strategy comprises a small number of ambitious trust-wide quality goals covering safety, clinical outcomes and patient experience which drive year-on-year improvement. o Quality goals reflect local as well as national priorities, reflecting what is relevant to patients and staff.

Question	Good practice examples
	○ Quality goals are selected to have the highest possible impact across the overall trust. ○ Wherever possible, quality goals are specific, measurable and time-bound. ○ Overall trust-wide quality goals link directly to goals in divisions/services (which will be tailored to the specific service). ○ There is a clear action plan for achieving the quality goals, with designated leads and timeframes. • The board is clear about who their external stakeholders and opinion formers are, who will have the greatest impact on the delivery of the organisation's particular services • The board have regular and transparent engagement on strategy and direction with: ○ a range of local health economy stakeholders (eg, commissioners, other providers, Local Health Watch, local politicians and the MP), and understand their perspectives; ○ staff who are clear about the organisation's vision and strategy and how their work supports this; ○ patient groups and the council of governors; and • The board can demonstrate that the quality goals are effectively communicated and well understood across the trust and the community it serves. • The trust has detailed delivery plans for each of its strategic initiatives that lay out milestones, resource requirements, dependencies and risk mitigations. • The organisational objectives in the plan are linked through to the performance targets of clinical business units. • 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 two to three years in an organisation of similar complexity and challenges. • The board has assured itself that the capabilities and capacity are in place within the senior management team to develop the strategy. Examples of experience and skills include: ○ strategic thinking, planning and the ability to take a long term approach to planning; ○ commercial business experience; ○ problem solving and analytical; ○ strong interpersonal skills (eg, influencing and facilitation); and ○ technical skills & experience (eg, financial, program management). • The board is assured that there is the right level of capacity and skills throughout the workforce to deliver the plans. • The strategic planning process reflects the board's commitment to continual improvement through the way that it approaches innovation and change, ie, it will seek to improve services by looking at best practice across the health care sector and, where appropriate, use benchmarking as a way of evaluating the services

Question	Good practice examples
	being delivered. The board can monitor this improvement via clearly defined, communicated and measured metrics.
2) Is the board sufficiently aware of potential risks to the quality and delivery of current and future services?	• The risk register and Board Assurance Framework are in place and reflect the initiatives in the plan and this is regularly reviewed (at least quarterly). • Responsibilities for risks flagged in the Board Assurance Framework can be "mapped" to either the board or a specific sub-committee. • Board members can comprehensively describe the same set of risks, including quality risks, facing the organisation. • Risk areas are monitored and this is integrated with performance management. • Risk scenarios and contingency plans are in place and are subject to regular updates and reviews. • The board regularly assesses and understands current and future risks to quality and takes steps to address them. • The board regularly reviews quality risks in an up-to-date risk register. • The board 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 timely action to mitigate risks to quality and it is proportionate to the risk severity. • Proposed initiatives are rated according to their potential impact on quality (eg, clinical staff cuts would likely receive a high-risk assessment). • Initiatives with significant potential to impact quality are supported by a detailed assessment that could include: o "Bottom-up" analysis of where waste exists in current processes and how it can be reduced without impacting quality (eg, lean). o 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 are examples which can be markers of quality). o 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). • The board is assured that service changes and transformations initiatives have been assessed for quality: o measures of quality and early warning indicators identified for each initiative. o quality measures monitored before and after implementation of

Question	Good practice examples
	service changes. o initiatives' impact on quality is monitored on an ongoing basis (post implementation). o all initiatives are accepted and understood by clinicians. o there is clear subsequent ownership (eg, by the relevant clinical director). o there is an appropriate mechanism in place for capturing front-line staff concerns, including a defined whistle-blower policy. o mitigating action taken where necessary.

Domain 2: Capability and culture

Question	Good practice examples

3) Does the board have the skills and capability to lead the organisation?	**The board visibly leads the organisation and promotes a patient-centred culture of openness, transparency and candour.**
	• The board is assured that it has the capabilities in place to lead the organisation and this assurance is based on findings from regular reviews. These could include:
	  ○ insight into the organisation, eg the ability to describe the services provided by the organisation and understand at a high level the capacity, capability and culture of the organisation;
	  ○ awareness of the organisation's impact on its environment, eg an understanding of both how the organisation as a whole and how key services it provides are perceived by the local community and media;
	  ○ clarity of role, eg ability to describe the role of the board and their own role on that board;
	  ○ personal values and style, eg consistently acting in the interests of patients and carers;
	  ○ personal style, eg an ability to explain things without using jargon;
	  ○ personal development and learning, eg willingness to admit and take responsibility for own mistakes and shortcomings.
	• The board uses regular reviews to consider the effectiveness of board relationships with specific focus on the board working relationships in place:
	  ○ between the chair and chief executive officer (CEO);
	  ○ between the board and the senior management team/divisional managers; and
	  ○ between the council of governors and the board.
	• The board is open to independent reviews taking place to measure its performance, governance and impact across the organisation. Key findings are openly shared with patients, the public and staff and acted upon.
	• The board is assured that the senior management has the capability, experience and capacity necessary to deliver the strategy.
	Succession and development plans
	• 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.
	• Governors are supported (eg, through training) about how to make judgements about the appointment/re-appointment of the non-executive directors (NEDs) and the chair.
	• The board uses lessons learnt from previous recruitment exercises.
	• The board takes time out to identify and act upon successes and failures.
	• Board members have attended training sessions covering the core elements of quality governance and continuous improvement.

Question	Good practice examples
	• The board conducts regular self-assessments to test its skills and capabilities and has a succession plan to ensure these are maintained.

4) Does the board shape an open, transparent and quality-focused culture?	**The board uses a diverse range of tools to gain insight into the performance of the NHS foundation trust and engage with stakeholders.**
	• The board has communicated a clear set of values and behaviours, which have regard to the *NHS Constitution* and have described how this supports the delivery of the vision and strategy.
	• The board is aware of any organisational cultural differences across the trust and where there is an impact on staff performance and patient care, have plans in place to address this. Examples can be provided of how management have responded to staff that have not behaved consistently with the trust's stated values and behaviours. (eg, HR/people strategy and policies are in place to address the areas where poor behaviours have been identified).
	• The board has an internal and external engagement plan for staff, patient groups and their representatives and actively takes steps to shape the organisational culture by:
	  ○ engaging and challenging staff through different channels, eg surveys, focus groups, workshops; and
	  ○ engaging with major stakeholders (eg, patient groups/ commissioners/Health Watch)
	• The board takes an active leadership role on quality.
	• The board is actively engaged in the delivery of quality improvement initiatives (eg, some initiatives led personally by board members).
	• The board takes a proactive approach to improving quality (eg, it actively seeks to apply lessons learnt in other trusts and external organisations).
	• The board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review (either through participation in Audit Committee or relevant quality-focused committees and sub-committees).
	• The board regularly commits resources (time and money) to delivering quality initiatives.
	• The board has developed a performance framework which is used to discuss the performance of the organisation with staff, patient groups and other stakeholders, ensuring all have clarity on progress towards delivering the vision and strategy for the trust.
	• The organisation has reflected on findings from formal assessments and measured its safety culture using standard tools (ie, Manchester Patient Safety Framework (MaPSaf)).
	Staff engagement
	• Staff are aware and understand how the organisation is performing overall and how this is being measured.
	• Different communication activities are in place to provide an

Question	Good practice examples
	opportunity for staff to discuss the performance, generate improvement ideas and contribute to departmental and organisational strategy. • Staff feel listened to and the results of surveys and organisational action plans are shared with them. • Staff work in an environment where they feel empowered and the culture supports the generation of new ideas and new ways of thinking to encourage innovation and organisational development. • The board encourages staff empowerment on quality. Good practice could include: o mechanisms to capture staff initiatives and suggestions, including but not limited to quality improvement initiatives and cost reduction plans; o staff awareness and use of risk management tools such as whistle-blowing policy, incident procedures, use of risk registers, particularly awareness of how they can be used to improve quality; o staff awareness of quality goals and quality strategy; and o recognition events and awards • Personal development initiatives encourage staff to participate in quality/continuous improvement training and development. • Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment). • Staff are entrusted with delivering the quality improvement initiatives they have identified (and are held to account for delivery). • Internal communications (eg, monthly newsletter, intranet, notice boards) regularly feature articles on quality. • The board discusses the results of staff feedback on a regular basis (eg, every quarter) to understand if staff feel valued, supported and developed and put in place an action plan to address any major issues emerging. **Governors** • Board members spend time developing the relationship with the governors. • Governors are trained and supported to in holding NEDs 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 they receive sufficient information in a timely fashion to carry out their role. **Commissioners/providers** • The board co-operates with third parties with roles in relation to NHS foundation trusts, eg there is a constructive relationship with commissioners and providers which, as a minimum, involves: o discussing and sharing the overall strategy of the organisation; o sharing information on specific services and care pathways; o contract/performance issues are addressed and resolved quickly without recourse to arbitration; and

Question	Good practice examples
	○ regular reviews and discussions to resolve any lessons learnt. • The board receives assurance that third parties used to deliver care and/or services are also “well led” to the requisite standards set out in good practice for the health and social care sector. **Other stakeholders** • Where appropriate, the board use external support networks and expertise to support on ideas for development and improvement. For example, use of benchmarking, working with the Foundation Trust Network on development areas and linking into other healthcare providers as appropriate.

Domain 3: Process and structures

Question	Good practice examples

5) Are there clear roles and accountabilities in relation to quality and board governance?	**Structures, processes and systems of accountability are:**
	(i) in place for the organisation;
	(ii) have been designed to fit its needs; and
	(iii) are used.
	• The board's agenda is appropriately balanced and focused between:
	  ○ strategy and current performance;
	  ○ finance and quality;
	  ○ making decisions and noting/receiving information;
	  ○ matters internal to the organisation and external considerations; and
	  ○ business conducted at public board meetings and that done in confidential sessions.
	• 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.
	• Board sub-committees have a stable, regularly attending membership and manage to their terms of reference, eg quality performance is discussed in more detail each month by a quality-focused board sub-committee.
	• The council of governors are actively involved in holding the NEDs to account for their work at the board.
	• The board are assured that a sound system of internal control to safeguard public and private investment, the NHS foundation 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 levels of delegation are in place and are working to support the delivery of the plan and management of risks and issues throughout the organisation and that these delegation processes are monitored and decisions captured and escalated to the appropriate committees, divisions and teams.
	• 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.
	• 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.
	• Each and every board member understands their ultimate accountability for quality.
	• There is a clear organisation structure that cascades responsibility for delivering quality performance from "board to ward to board" (and there are specified owners in post and actively fulfilling their responsibilities).
	
	Joint ventures and partnerships (if applicable)

Question	Good practice examples

	• The board is assured that governance and management of joint ventures and partnerships are clearly set out and understood, eg:
	  ○ 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; and
	  ○ a process for dealing with overspends and underspends exists and is reviewed regularly.
	Monitoring and reporting
	• Processes are in place to monitor and manage the delivery of the plan and to drive the improvement of the organisation's performance.
	• The processes enable risks and issues to be addressed and the impact of changes to delivery plans to be evaluated to support board decision making.
	• The board regularly tracks performance relative to quality goals.
	• 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).
	• Board reporting takes place against an agreed set of local metrics outside the national and regionally agreed metrics that are relevant to the trust given the context within which the trust is operating and what it is trying to achieve.
	• The board reviews the effectiveness of previous action plans and interventions and drives changes where necessary.
	• Clinical business units discuss their quality performance, feeding into the trust's formal governance processes.
	Assurance
	• The board reviews systems of accountability on at least a biennial basis (ie, checking that sub-committees are working to their terms of reference and managing risks and issues that are part of their delegated authority) and are assured that these systems are supporting the delivery of the trust's strategy and plan (eg, assurance received through internal audit reports, the Head of Internal Audit, (HOIA) opinion and annual governance statement).
	• The outcomes of these reviews have been actioned and the changes have had a positive impact on the way that the governance process is working.

6) Are there clearly defined, well-understood processes for escalating and resolving	Processes for escalating performance issues to the board are clear and are working: • there is a defined procedure for bringing significant issues to the board's attention outside of monthly meetings; • processes are documented; • there are agreed rules determining which issues should be escalated. For quality, these rules cover, amongst other issues,

Question	Good practice examples
issues?	escalation of serious untoward incidents and complaints; • the board is assured that the processes are working and that the appropriate person/management level are aware of the issues (ie, things that have come up or remain in the way of delivery or care) and are managing these through to resolution; and • 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. • The board is assured that the complaints handling system and arrangements are accessible, "user friendly" and facilitate the speedy resolution of questions raised and spot where improvements in service need to be made. • Robust action plans are put in place to address performance issues (eg, for quality, including issues arising from serious untoward incidents and complaints). Actions have: o designated owners and time frames; and o regular follow-ups at subsequent board meetings. • 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. • Continuous rolling programme that measures and improves quality. • The board actively oversees a co-ordinated programme of clinical audit and peer review (and internal audit) which is aligned with identified risks and/or gaps in other assurance. • Action plans completed from audit. • Re-audits undertaken to assess improvement. • A "whistle-blower"/error reporting process is defined and communicated to staff; and staff are prepared if necessary to blow the whistle. There is a performance management system with clinical governance policies for addressing under-performance and recognising and incentivising good performance at individual, team and service line levels.
7) Does the board actively engage patients, staff and other key stakeholders on quality and operational performance?	**Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance.** **Patients** • The board actively engages patients on quality, eg patient feedback is actively solicited, made easy to give and based on validated tools. • Patient views are proactively sought during the design of new pathways and processes. • All 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).

Question	Good practice examples

	Staff
	• The board actively engages staff on quality, for example:
	  ○ staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (eg, monthly "temperature gauge" plus annual staff survey);
	  ○ staff are encouraged to co-create quality measures with the board to understand speciality and service level performance; and
	  ○ all staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the board.
	Other stakeholders
	• The board actively engages all other major stakeholders on quality, eg quality performance is clearly communicated to commissioners to enable them to make educated decisions.
	• For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway.
	• The board is clear about governors' involvement in quality governance.

Domain 4: Measurement

Question	Good practice examples
8) Is appropriate information on organisational and operational performance being analysed and challenged?	• The board is assured, and can demonstrate, that they are using the relevant level and quality of information to hold management to account to deliver the plan. • The board oversees the balance to be struck between maintaining patient information security and optimising the sharing of information to support safe and effective care both in within its own organisation and externally with providers that the patient is referred to/uses. The Caldicott Guardian is used to support this balance. • Board reporting provides assurance that patients are receiving person centred co-ordinated care. Boards review the performance of patient pathways rather than reviewing metrics based purely on the performance of divisions and/or clinical units. • An integrated reporting approach is used by the board to ensure that the impact on all areas of the organisation is understood before decisions are made, eg including patient, clinical, regulatory, staffing and financial perspectives. • Monthly reporting is supported by a "dashboard" of the most important metrics. The board is able to justify the selected metrics as being: o relevant to the organisation given the context within which it is operating and what it is trying to achieve; o linked to the trust's overall strategy and priorities; o covering all of the trust's major focus areas; o the best available ones to use; and o useful to review. • Information includes relevant indicators in relation to the people or HR strategy, eg: o workforce capacity and capability to deliver the future strategy; o intelligence on values, behaviours and attitudes; o HR health indicators, including information on equality and diversity; o performance appraisal, training and development; and o leadership and management development, including talent mapping. • The board can measure the impact of the organisation's strategy through the use of agreed KPIs (eg, productivity and efficiency measures), national and local indicator sets, etc. There is robust narrative text/qualitative analysis of outliers/poor performance. • Information is clearly aligned to priorities/elements of the trust plan and its delivery. • Data can be reported at a granular level to identify "hot spots" in terms of performance. • Historical analysis and performance forecasts are used to inform board discussions and decisions. • 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, eg talking to staff, patients and other external stakeholders. • Internal audit of data takes place on a regular basis. • The board receives information on how well the organisation is performing against improvement indicators that are benchmarked against national averages and other similar organisations. • The board dashboard is backed up by a "pyramid" of more granular reports reviewed by sub-committees, divisional leads and individual service lines quality information is analysed and challenged at the individual consultant level. • 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. • Good practice dashboards on quality could include: ○ performance against relevant national standards and regulatory requirements; ○ selection of other metrics covering safety, clinical effectiveness and patient experience (at least three each); ○ selected "advance warning" indicators; ○ adverse event reports/serious untoward incident reports/ patterns of complaints; ○ measures of instances of harm (eg, Global Trigger Tool); ○ 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.
9) Is the board assured of the robustness of information?	• The board assures itself that information it receives is robust (from reliable and suitable sources) and covers a mix of intelligence (qualitative and quantitative) and regularly reviews their arrangements for supporting how they prepare and report performance indicators. • Assurance covers 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** – is data recorded correctly and is it in line with the methodology for calculation?; ○ **validity** – has data been produced in compliance with relevant requirements?; ○ **reliability** – has data has been collected using a stable process in a consistent manner over a period of time?;

	○ **timeliness** – is data captured as close to the associated event as possible and is available for use within a reasonable time period?; and ○ **relevance** – is data used to generate indicators meets eligibility requirements as defined by guidance?. • There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness: ○ 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.
10) Is information used effectively to drive improvement?	• Information in quality reports is displayed clearly and consistently. • Information is compared with target levels of performance (in conjunction with a RAG 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). • The trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance.

Annex 2: Governance and capability review self-assessment form

The following sets out:

1. The purpose of the self-assessment step;
2. how to complete the self-assessment step; and
3. how to rate the self-assessment.

Purpose of the self-assessment questionnaire

The self-assessment process is based on the high-level questions set out in this guidance and is designed to provide insight to the NHS foundation trust and the independent reviewer about how the trust gauges its own leadership and governance performance.

Completing the self-assessment

Before the self-assessment process starts, 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

NHS foundation trust boards should rate themselves against each of the self-assessment questions using the proposed 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.

Risk rating	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, 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 quality governance identified. Significant volume of action plans required and concerns about management's capacity to deliver

Self-assessment questions

1. Strategy

No.	Question	RAG 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 deliver 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 and delivery of current and future services?				

2. Capability and culture

No.	Question	RAG 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?				

3. Process and structures

No.	Question	RAG 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	Are there clear roles and accountabilities in relation to quality and board governance?				
6	Are there clearly defined, well understood processes for escalating and resolving issues?				
7	Does the board actively engage patients, staff and other key stakeholders on quality and operational performance?				

4. Measurement

No.	Question	RAG 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
8	Is appropriate information on organisational and operational performance being analysed and challenged?				
9	Is the board assured of the robustness of information?				
10	Is information used effectively to drive improvement?				

Annex 3: All consultation questions

1. Is the governance review framework clear and comprehensive? Please share the reasons for your answer.
2. Do you think that the review framework and process will provide assurance that a board is doing its job well? If not, please tell us your reason for this.
3. Are there any areas of board governance that you think are missing from the framework and why?
4. Do the evidence/outcome sets in Annex 1 representing good practice cover an appropriate range of areas for the purposes of gathering evidence to assess governance? Are the examples too detailed or not detailed enough? Please share the reasons for your answer.
5. Do you have any other comments on the proposed framework?
6. Do you agree that the proposed approach to the review is suitable for all types of NHS foundation trust or are there any exceptions that should be considered? Please share the reasons for your answer.
7. Do you have any comments on the proposed rating method for the reviews and what information is provided to Monitor? Please share the reasons for your answer.
8. Does the expected time commitment for reviews reflect your experience of similar governance reviews? Please share the reasons for your answer.
9. How long do you think the self-assessment step in the review should take? What information is your response based on?
10. What other information would be helpful to support you in choosing an external reviewer? Please share the reasons for your answer.
11. How would you find out about potential reviewers in the market?
12. Would it be helpful if Monitor published a list of reviewers who had carried out governance reviews for particular NHS foundation trusts? Please share the reasons for your answer.
13. Peer review teams, ie, from other NHS foundation trusts, could be used to undertake the governance reviews. If this was the case, would you use a peer review team for the full review, for parts of the review or not at all? Please share the reasons for your answer.

Annex 4: References and further reading

Monitor guidance:

Monitor (October 2013) *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 (August 2013) *Risk Assessment Framework*

Monitor (December 2013) *Strategic planning to achieve sustainability: additional guidance for providers of NHS-funded healthcare services*

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

Although Monitor does not necessarily endorse or support them, interested readers may, in addition to the above, find the particular 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*

Foundation Trust Network and DAC Beachcroft (2013) *The 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)*

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Making the health sector work for patients

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