NHS Improvement

Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts

June 2017

Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

Contents

1. Introduction

The boards of NHS foundation trusts and NHS trusts (referred to from here on as providers) are responsible for all aspects of the leadership of their organisations. They have a duty to conduct their affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that their organisations are providing high quality, sustainable care.

Providers are operating in challenging environments characterised by the increasingly complex needs of an ageing population, growing emphasis on working with local system partners to create innovative solutions to long-standing sustainability problems, workforce shortages and the slowing growth in the NHS budget.

As set out in *Developing people – improving care*, these challenges require changes in how leaders equip and encourage people at all levels in the NHS to deliver continuous improvement in local health and care systems and gain pride and joy from their work. Robust governance processes should give the leaders of organisations, those who work in them, and those who regulate them, confidence about their capability to maintain and continuously improve services.

In-depth, regular and externally facilitated **developmental reviews of leadership and governance** are good practice across all industries. Rather than assessing current performance, these reviews should identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance.

The external input is vital to safeguard against the optimism bias and group think to which even the best organisations may be susceptible. We therefore strongly encourage all providers to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years, according to their circumstances.

2. About this guidance

This guidance on our updated well-led framework for leadership and governance developmental reviews sets out the process and content of these developmental reviews. It supports providers to maintain and develop the effectiveness of their leadership and governance arrangements. It replaces *Well-led framework for governance reviews: guidance for NHS foundation trusts* (April 2015), and applies to both NHS trusts and foundation trusts

The guidance retains a strong focus on **integrated quality, operational and financial governance** and includes a new framework of key lines of enquiry (KLOEs) and the characteristics of good organisations. It provides strengthened content on leadership, culture, system-working and quality improvement.

In a change from previous frameworks, and in support of our commitment to working more closely with our regulatory partners, the structure of our framework (KLOEs and the characteristics) is **wholly** shared with the Care Quality Commission (CQC), and underpins CQC's regular regulatory assessments of the well-led question. This means that information prepared for regulation can also be used for development, and vice versa.

The main elements of this framework are also reflected in NHS England's improvement and assessment framework for clinical commissioning groups (CCGs).

However, while CQC's regulatory assessments are primarily for assurance, developmental reviews are primarily for providers themselves to facilitate continuous improvement. Drawing on the latest research and evidence, we also describe updated good practice to help providers identify their own areas for development and key barriers to overcome.

This good practice is not a checklist: a mechanical 'ticking off' of each item is unlikely to lead to better performance. The attitude of organisational leaders to the review process, the connections they draw between the framework's different areas, and their judgements about what needs to be done to continually improve, are much more important.

We therefore strongly encourage providers to engage with the review processes openly and honestly, selecting an external facilitator to provide tailored support and prioritise actions arising from reviews.

We also encourage providers to make more use of peer review, to utilise and enhance skills within the NHS, draw on learning from others and share learning back with the system. This is how providers individually and together will gain the greatest benefit from these reviews.

A note on system working

We know the increasing focus on working with partners across health and social care, for example in sustainability and transformation partnerships (STPs), creates a tension for providers as they continue to work on organisational performance as part of wider system performance.

We maintain our focus on organisations because this is the statutory basis for service provision, but we have increased the emphasis in this guidance on working proactively with partners. Many of the principles of good governance at organisational level are applicable at system level and we encourage local system partners to use this framework for development if it is appropriate.

How to use this guidance: comply or explain

This guidance is issued on a **'comply or explain'** basis. This means we strongly encourage providers to carry out developmental reviews or equivalent activities approximately every three years to ensure they identify potential risks before these turn into issues. Better performing providers are probably already doing this, and, for example, using internal audit functions to work on particular areas of concern.

In keeping with the Single Oversight Framework we use to identify the level of support providers need, we are providing extra flexibility based on individual circumstances. This means we can agree longer timeframes for review (up to a maximum of five years) where risks seem lower and shorten the timeframe where risks seem higher, or where particular circumstances suggest a review may be necessary (eg significant turnover of board members, organisational transactions, or significant deterioration in some aspect of performance).

On that basis:

- **Comply** means we strongly encourage all providers to carry out developmental reviews every three years or within the agreed timeframe agreed with NHS Improvement using this guidance.
- **Explain** means a provider needs to give a considered explanation if it uses alternative means to assure itself regarding its leadership and governance or chooses to omit material components of the framework (eg one or more of the eight KLOEs). Departing from the guidance may be justified where a provider can demonstrate it is meeting the actions expected under the guidance in a similar manner, for example partial reviews over consecutive years. We will always consider the circumstances of an individual case.

3. Managing reviews

This section describes the common steps of a developmental review. Providers are free to tailor their approach to suit their organisational circumstances, provided they incorporate the principal areas of enquiry set out in the framework. Annexes A to D provide further detail as noted below.

Stage	Notes
Initial investigation to determine scope of review (see Annex A)	The board should reflect on its performance with an initial investigation that involves self-review against the framework. This should identify any areas in the framework or extra areas outside the framework (eg arising from internal and external audit review findings, annual or corporate governance statements) that require particular focus as part of the review. Clarifying the scope of the review will enable the board to engage external facilitators with appropriate skills. The board should be as honest as possible in this assessment as the congruence between the provider's self-review and the external facilitator's perception can indicate the provider's level of insight.
Commissioning an external reviewer (see Annex B)	External facilitation is a key part of developmental reviews: it provides objectivity and challenge that may not available within the provider. Choosing an external facilitator is the provider's responsibility. As well as the skills and experience needed to address specific areas of focus arising from self-review, the provider must ensure their supplier can take a holistic view of the organisation, connecting findings from different parts of the review and supporting action-planning, including suggesting appropriate interventions. Providers should also ensure reviewers are suitably independent of the board. This includes avoiding using reviewers who have done audit or governance-related work for the provider in the previous three years, unless there are suitable safeguards against conflict of interest

	(ie information barriers). We also encourage providers to consider involving peer reviewers as part of their external facilitation team, where appropriate, to make use of and enhance leadership and governance capability in the NHS.
Detailed review (see Annex C)	Following review and discussion of the initial investigation, the external facilitator should carry out detailed review against relevant aspects of the framework using a variety of methods that offer insight into the provider's leadership and governance processes. Each of the eight KLOEs should be reviewed at a basic level and rated using a scheme that allows the prioritisation of findings and guides action-planning and the escalation of any immediate concerns. External facilitators should engage with peer reviewers, where commissioned, for specialist input (for example on clinical governance, leadership, culture, improvement).
Board report and action planning	The external facilitator should work with the provider board to prioritise the review findings, and agree recommendations and developmental actions in response. These should be detailed in a report for the board. We encourage providers to agree the format of the report with their facilitator at the start of the process.
Letter to NHS Improvement	Once the action-planning is done, providers should send NHS Improvement a letter confirming they have completed the review, any material issues that have been found and/or any areas of good practice that could be shared with others, for example through a case study.
Implementing the action plan (see Annex D)	By far the most important part of a review is what the provider does as a result, and how this is given priority among other organisational activities. We encourage providers to draw on the support offers and resources available from agencies across the NHS and more widely (see our Improvement Hub).

4. The well-led framework and descriptions of good practice

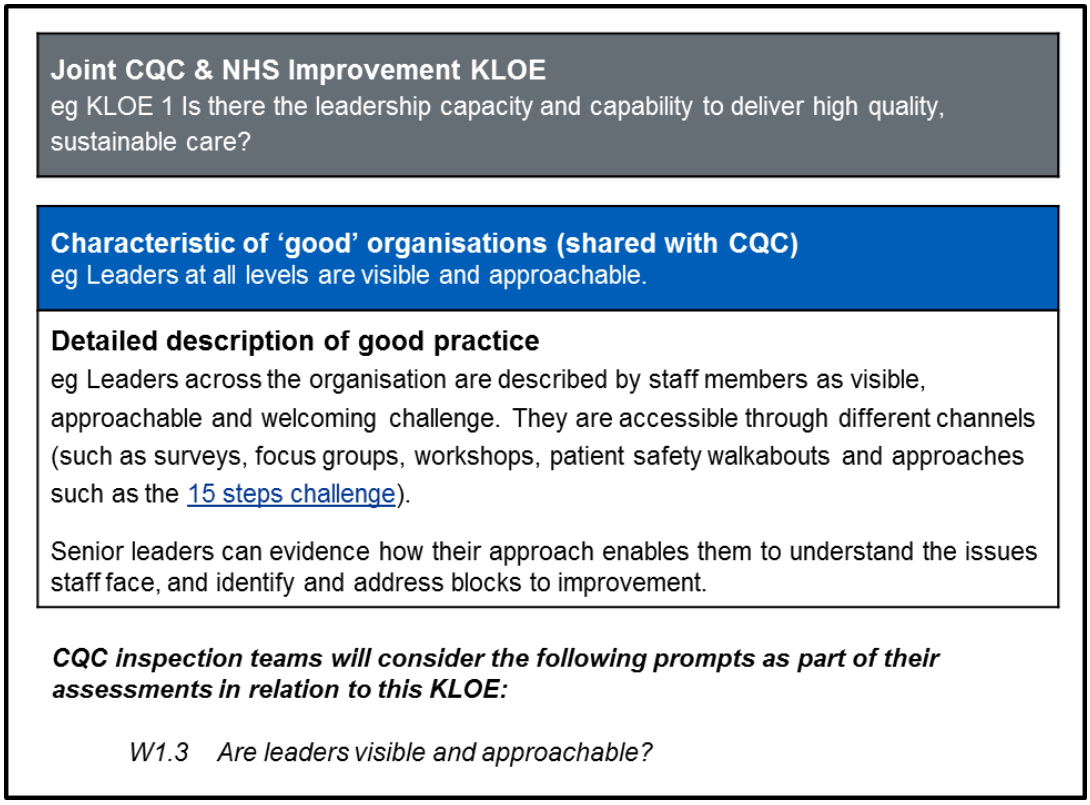
The well-led framework is structured around eight key lines of enquiry (KLOEs):

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

In the pages that follow, each of the framework's KLOEs is supplemented by **characteristics of good organisations**, and **detailed descriptions of good practice**.

For read-across with CQC's assessment process, we have also included the prompts that CQC inspection teams use to assess each KLOE.

Each section follows the format shown on the next page.



Key terms used in the descriptions of good practice

- **The board:** we use this term when we mean the board as a formal body.
- **Senior leaders**: we use this term when we mean the organisation's most senior internal leaders, ie formal board executive and non-executive directors and their direct reports.
- **Leaders across the organisation**: we use this term when we mean people at all levels in the organisation (including senior leaders as defined above) who have formal responsibility for the management of others, service delivery, or particular pieces of work.
- **Staff members**: we use this term to mean everyone in the organisation.
- **Protected characteristics:** this refers to the characteristics defined in the Equalities Act 2010.

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.

Senior leaders can evidence how the organisation has the relevant capability, experience, expertise and capacity across its leadership to manage quality, operations and finance effectively at all levels across the organisation to ensure:

- development and delivery of the corporate strategy and any associated strategies and plans
- continuous organisational development and improvement.

Senior leaders across the organisation, and especially executive and non-executive board members:

- are clear about their roles
- demonstrate personal values and styles aligned with the interests of patients, carers and frontline staff, and the seven principles of public life
- are self-aware and seek personal development and learning
- prioritise safeguarding and quality.

The board is stable, diverse and members function effectively as a team with:

- clear role definition, communication and constructive challenge
- appreciation of diversity of thought, experience and background
- awareness of how their own behaviour affects the rest of the organisation
- awareness of the organisation's impact on the local health economy and environment
- regular time out together to identify, reflect and act on success and failures.

The board regularly reviews its effectiveness (performance, governance, working relationships, skills) and impact on the organisation, and acts on the findings, sharing them openly with staff, patients and the public.

All board subcommittees (such as the audit committee) and subgroups carry out and act on annual self-assessments of their effectiveness.

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

Senior leaders, especially board members, are able to describe:

- the quality, operational and financial issues and challenges the organisation faces, and the priorities within these
- the underlying reasons for these challenges, with reference to wider system factors and benchmarking
- what the organisation is doing to address these challenges and monitor progress in the short, medium and long term.

Senior leaders can evidence that they engage and are encouraged to engage in rigorous and constructive challenge of each other on governance processes, including but not limited to the teams and executives responsible for them.

The chair and non-executive directors participate fully in this challenge and review process, both through the board and by taking part in relevant board subcommittees (such as the audit committee) and subgroups.

Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, development, deployment and support processes and succession-planning.

Senior leaders can evidence that the organisation takes a strategic approach to developing leadership and managing talent to ensure there are enough appropriately skilled, diverse and system-focused leaders to deliver high quality, effective, continuously improving, compassionate care.

Senior leaders can evidence that a leadership strategy and succession plan are in place and regularly reviewed, based on quantitative and qualitative data. They should cover clinical and managerial leadership positions at board level and key roles below board level (such as clinical, operational, finance leads).

Senior leaders can evidence that leadership development, coaching and mentoring programmes are accessible to leaders and potential leaders at all levels and support the development of high quality, sustainable care cultures by:

- bringing together clinical and managerial staff
- supporting team-working and system-working

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- ensuring leaders gain a broader systems perspective (for example through the use of secondments or stretch assignments)
- ensuring there is a balance of experiential learning alongside coaching and classroom-based learning
- focusing on knowledge, skills, attitudes and behaviours
- ensuring that those with protected characteristics are represented in the take up of development opportunities

Leaders at every level are visible and approachable.

Leaders across the organisation are described by staff members as visible, approachable and welcoming challenge. They are accessible through different channels (such as surveys, focus groups, workshops, patient safety walkabouts and approaches such as the 15 steps challenge).

Senior leaders can evidence how their approach enables them to understand the issues staff face, and identify and address blocks to improvement.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W1.1 Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?

W1.2 Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?

W1.3 Are leaders visible and approachable?

W1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?

KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant.

Senior leaders can evidence that there is a clear, well-thought out, comprehensive picture of how the organisation's services will look in the future, centred on the people who use services and their carers, and they have mapped a route to achieving this. This is supported by a vision and values that present a clear and compelling picture of patient and service user centred care in the context of the wider local health and care system.

Senior leaders can evidence a clear focus on continuous improvement, staff and user engagement and ambitions to be a learning organisation in a wider learning system.

Senior leaders can evidence how the organisation's key quality, operational and financial priorities have informed the development of the strategy, which has a small number of clear quality, operational and financial objectives that steer the organisation sustainably towards its vision. The strategy covers:

- safety, clinical outcomes, patient experience,
- workforce capacity and capability
- productivity and efficiency, affordability, financial performance
- the organisation's part in delivering the priorities of the local health and care economy
- sustainable development in relation to the environment
- staff health and wellbeing.

The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population.

Senior leaders can evidence that the organisation's strategy clearly articulates the shared purpose and principles for working with other organisations, and the system's goals in the wider local and national context:

- the organisation's strategy should be aligned to plans for sustainability and transformation across the wider local health and care economy
- there should be an explicit link to the multiyear plans to maintain or achieve clinical and financial sustainability across the wider local health and care economy
- there is a narrative on how the organisation plans to respond to key NHS initiatives on quality, operational productivity and sustainability
- there is a narrative on how the organisation will meet the needs of and work to improve wider population health.

Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.

Senior leaders can evidence how the strategy, vision, values and goals across quality, operations and finance have been shared and promoted across all parts of the organisation, supported by an appropriate communication plan.

Staff members can explain the organisation's goals and initiatives to others when asked, and their own part in delivering the aspects relevant to them.

External partners, including commissioners, key patient groups and service delivery partners, can describe the goals and initiatives relevant to them, and how they support delivery of local health and care economy and/or national priorities.

The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.

Senior leaders can evidence that a structured approach has been taken to strategy development, integrating quality, operations (including workforce capacity) and finance. This includes evidence of how the organisation has understood:

- its current operating environment, its current weaknesses, and the future for which it needs to plan, both in a local health and care context, and in response to national priorities
- the goals and objectives that arise from this
- the determinants of its quality, operational and financial performance
- the options for change and how these are prioritised over the short, medium and long term (for example one year, two to five years and over five years), so that short-term responsiveness contributes to longer term aims.

This also includes evidence of how it has planned to implement the proposed solutions and review the approach/adapt to a changing environment.

Senior leaders can evidence how they have identified stakeholders and involved them in developing the strategy. This will include at least:

- people who use the services and their representatives
- staff
- external partners (such as health and local authority commissioners, other health and care providers, local Healthwatch, local politicians and MPs).

These stakeholders are able to describe how their involvement has influenced the outcomes of the strategy development process.

Progress against delivery of the strategy and local plans is monitored and reviewed, and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.
Senior leaders can evidence how the organisation's strategic goals and objectives, reflecting those of the local health and system, are cascaded through the organisation by informing the objectives and performance targets for business units, teams and staff members. Senior leaders can evidence that there are detailed delivery plans; progress against them is monitored and aggregated in a structured way, and the board and local health and care economy leaders regularly discuss and respond to them as appropriate, focusing on delivering the strategic goals and objectives. Senior leaders can explain and evidence how the strategy is regularly reviewed and refreshed, if needed, to ensure that it remains achievable and relevant.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W2.1 Is there a clear vision and a set of values, with quality and sustainability as the top priorities?

W2.2 Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?

W2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?

W2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them?

W2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?

W2.6 Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?

KLOE 3 Is there a culture of high quality, sustainable care?

Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority.

Senior leaders can evidence that there is a compelling vision and a clear set of values across the organisation, with staff members demonstrating their commitment to high quality, effective, continually improving, compassionate and sustainable care.

Senior leaders can evidence that staff recruitment, promotion and appraisal processes are aligned with the organisation's vision and values and behaviours and reinforce a culture of inclusive, diverse leadership.

Leaders across the organisation develop positivity, pride and identity across the organisation through, for example:

- celebrating the successes of teams and individuals, including rewarding staff who consistently deliver care or perform beyond expectation
- emphasising how the work makes a difference to patients and the community
- building a sense of positivity about the future.

Staff survey results demonstrate high levels of positivity and pride.

Leaders across the organisation celebrate behaviour consistent with the organisation's vision and values, and address behaviour which is contrary to them, wherever and at whatever level this behaviour occurs.

Senior leaders can evidence that there is a comprehensive induction programme for all staff groups (including junior doctor and agency staff) derived from the vision, values and strategy.

Senior leaders can evidence that the provider has a culture of integrity and probity, including fraud awareness and prevention and appropriate standards of business conduct.

Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

Senior leaders can evidence that they look for and take appropriate and timely action to address issues arising from:

- reported incidents and concerns
- complaints and feedback from patients, service users and carers
- input from governors, patient groups, local Healthwatch networks
- internal and external reviews of its culture.

Senior leaders can evidence that the reporting of errors and speaking up is normalised. Staff members are encouraged to raise concerns and report incidents, and to regard complaints and feedback from patients as means of learning for continuous improvement and innovation. They are supported to regard complaints positively.

Senior leaders can evidence that there are appropriate and effective mechanisms, which staff members are aware of and have confidence in, for raising concerns and reporting errors and incidents. The national whistlebower policy has been adopted, and there is an accessible Freedom to Speak Up Guardian who provides regular updates to the board.

Senior leaders can evidence that there are appropriate and effective mechanisms for turning concerns/incidents into improvement actions based on inquiry about the root causes of what has happened, where constructive challenge is welcome at all levels of the organisation, including the board.

There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations.

Senior leaders can evidence that they promote and demonstrate their commitment to continued learning and development for all staff members, so they have appropriate levels of quality, operational and financial skills, qualifications and understanding. Senior leaders can evidence they act on issues such as low training and appraisal rates.

Senior leaders can evidence that there are processes to ensure that all staff members, including senior leaders, are able to:

- do any necessary mandatory training, including updating professional registration/revalidation
- understand functions across the range of activities in the organisation, not just their own (such as finance for non-finance managers)
- develop through leading or taking part in challenging projects or other appropriate learning opportunities, with rapidly increasing equality of access to these opportunities, especially for those with protected characteristics
- take part in high quality appraisal and career development conversations, aiming to help individuals achieve their potential.

Senior leaders can evidence that staff have the freedom to work autonomously, where appropriate and safe, and there is appropriate devolution of decision-making and permission to experiment with new ways of working appropriate to their skills and grounded in a strong safety culture.

Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing.

All staff members demonstrate commitment to acting compassionately towards their colleagues through:

- using a variety of approaches to listen to staff views
- understanding where they need to improve support, engagement, wellbeing and staff feeling valued
- empathising and taking intelligent action in response to what they find.

Seniors leaders can evidence ownership of an organisational development strategy, co-developed with staff across the organisation and regularly updated, that articulates what the organisation is doing to improve.

Senior leaders can evidence that there are systems to monitor, manage and support staff pressure.

Equality and diversity are actively promoted and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

Senior leaders can evidence that members of staff with protected characteristics are treated equitably, and can safely share concerns and be listened to in a meaningful and sustained way.

They can evidence the organisation's commitment to inclusion and equality through:

- proactive engagement with staff, staff networks, trades unions and other staff organisations on the inclusion and equality agenda
- comparing metrics on staff engagement, bullying, harassment, recruitment and promotion among those with protected characteristics and the wider workforce
- ownership and regular monitoring of an effective equality and diversity strategy and plan, shared with all staff and other local interests as needed
- participating in developmental initiatives relating to building an inclusive workforce and wider healthcare services
- action on areas identified for development through any of these means.

There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared.

Senior leaders can evidence that there are appropriate and effective mechanisms to enable effective team working at all levels in the organisation, including the board, and within and across teams (for example between finance and operations). In practice, this means:

- collaboration and co-operation within and across teams, role modelled by the leaders of those teams and senior leaders
- individuals and teams provide practical support to others, particularly in difficult circumstances
- conflicts are resolved quickly
- responsibility is shared to deliver high quality care
- shared leadership so that everyone contributes their experience and ideas
- clear objectives in collaborative work with different members or teams understanding each other's needs and responsibilities
- performance at team level is measured and understood by team members (or by individuals involved in any cross-team collaborations).

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W3.1 Do staff feel supported, respected and valued?

W3.2 Is the culture centred on the needs and experience of people who use services?

W3.3 Do staff feel positive and proud to work in the organisation?

W3.4 Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?

W3.5 Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?

W3.6 Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?

W3.7 Is there a strong emphasis on safety and well-being of staff?

W3.8 Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?

W3.9 Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

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.

Board members can evidence that they understand their personal accountability for the quality, operational and financial performance of the organisation.

Senior leaders can evidence that they are clear about who is responsible and accountable for the provision, quality and performance of services, including decision-making, delivery, and management of risks and issues in relation to quality, operations and finance. This is demonstrated in:

- clear and consistently applied levels of delegations and processes for recording decisions and escalation, which are monitored for compliance
- a clear organisational structure that cascades responsibility for delivering quality, operational and financial performance from 'board to front line to board'
- clear policies in place to ensure that conflicts of interest are identified and managed.
- a clear management structure that defines accountabilities for use of resources (including workforce, financial budgets, IT, estates, etc)
- effective systems and processes that enable close working between quality, operational and finance functions
- clear processes for planning and budgeting for all income and expenditure
- the robust and timely implementing of controls in response to issues/concerns raised by internal or external audit, or encounters with serious fraud.
- regular reviews of governance processes across quality, operations and finance

Senior leaders can evidence that there is a robust system of internal control, overseen by board subcommittees, to safeguard patient safety, service quality, investment, financial reporting and the organisation's assets.

Working with partners

Senior leaders can demonstrate that there are arrangements to ensure appropriate interaction with processes and governance systems that involve groups of partners and/or stakeholders from other local health and care organisations.

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Senior leaders can evidence that all interested parties are clear about roles, responsibilities, structures and processes for planning, budgeting and reporting on any partnerships, joint ventures, shared services and sources of non-NHS income and understand, for example, protocols for:

- governing the use of any pooled budgets, with appropriate management structures to support and enforce the agreed practice
- the escalation and resolution of issues between parties
- dealing with overspends and underspends that are reviewed regularly.
- sharing data
- the termination of any arrangements.

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

The board operates as an effective unitary board demonstrating:

- clarity around its function, including the powers it reserves for itself and those it delegates to subcommittees and others
- stable and regularly attending membership (including non-executive directors) of a size appropriate to the requirements of the organisation
- appropriate balance between challenge and support, for example between executive and non-executive directors, and between governors and non-executive directors (where applicable)
- appropriate information flows supporting decision-making and the timely resolution of risks and issues
- that it operates within its terms of reference, and regularly reviews achievement against them.

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

- strategy and current performance (short term and long term)
- quality, operations and finance
- making decisions and noting/receiving information
- internal matters and external considerations
- business conducted at public board meetings and that done in confidential sessions.

Staff are clear on their roles and accountabilities.
Staff members understand the organisation's key quality, operational and finance priorities, and how their own goals and objectives contribute to the organisation's performance as a whole and how this is measured. Staff members understand they are accountable for delivering high quality, sustainable care, and optimising use of the organisation's resources. They are supported to identify and tackle obstacles in relation to these aims, escalating risks effectively.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?

W4.2 Do all levels of governance and management function effectively and interact with each other appropriately?

W4.3 Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?

W4.4 Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

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

Leaders across the organisation are able to describe the current and future quality, operational and financial risks that relate to their areas of work, and the plans to mitigate them.

Senior leaders can evidence that the organisation has effective, timely, horizon-scanning, scenario-planning and reporting processes so that it is sufficiently aware of changes in the internal and external environment (including risks from the wider local health and care economy) that may affect delivery of strategy and/or affect quality and financial sustainability.

Senior leaders can evidence that a board assurance framework and dynamic risk registers are in place and assessed by the board at least quarterly and demonstrate:

- attention to both internal and external risks, and their impact on planning
- a robust process for collating, evaluating, quantifying and reporting key risks
- a clear understanding of the board's risk appetite and tolerance, which is reviewed regularly (at least annually) and appropriately communicated to staff
- a commitment to learning lessons from inquiries (for example, safeguarding lessons from the 2015 Savile review), internal and external reviews of their own organisation, and of other organisations, and sharing this learning with staff, patients and the public.

Senior leaders can evidence that there is a clear risk management process understood by staff members, including the board, its subcommittees and subgroups, so that they identify, assess, understand, assign responsibility for and act on risks relevant to their area of responsibility. This includes internal escalation and external escalation if the risks affect other organisations.

Senior leaders can evidence that emergency preparedness/crisis management planning has been carried out and there is a robust business continuity plan.

Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.

Senior leaders can evidence that service development or efficiency initiatives:

- are developed with relevant stakeholders (especially service users, their carers, clinical and operational staff), with due regard to the public sector equality duty.
- make use of relevant published research, evidence, benchmarking data and operational experience
- identify measures and early warning indicators to be monitored during and after implementation, with an associated risk management plan
- are assessed consistently according to their impact on quality and sustainability, including the cumulative and aggregate impact of smaller schemes on patient pathways or professional groups
- are monitored during implementation and afterwards, with mitigating actions taken if necessary.

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

Senior leaders can evidence that there is a performance management system for quality, operations and finance across all departments, which comprises:

- appropriate performance measures relating to relevant goals and targets
- reporting lines within which these will be managed, including how this will happen across teams (for example finance and operations)
- policies for managing/responding to deteriorating performance across all activities, at individual, team, service-line and organisational levels, with clear processes for re-forecasting performance trajectories
- a programme or portfolio management approach that allows the co-ordination of initiatives across the organisation, and with external partners as required
- a clear process for identifying lessons from performance issues and sharing these across the organisation on a regular, timely basis
- clear processes for reviewing and updating policies regularly to take account of organisational learning, and changes in the operating environment and national policy.

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

Senior leaders can evidence that there are clear processes for:

- escalating quality, operational and financial performance issues through the organisation to the relevant committees as part of and outside the regular meeting cycle as required, linked to the organisation's risk matrix and consistent with the organisation's risk appetite.
- creating robust action plans, with clear ownership, timeframes and dependencies, all of which are monitored and followed up at subsequent meetings until they are resolved.

Senior leaders can further evidence that:

- these processes are effective
- the appropriate individuals/management levels are aware of the issues and are managing them through to resolution
- themes arising from the most frequent risks and issues are analysed to identify barriers that need to be removed to drive improvement.

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

Senior leaders can evidence that there is a clear, co-ordinated, continuous programme of clinical audit, peer review and internal audit, overseen and challenged by the board, which:

- aligns with priorities identified from risk intelligence and/or gaps in other assurance.
- competent individuals or teams (as appropriate) carry out to meet the needs identified
- is oriented to action, to address gaps from the audits in a timely manner and monitor them to ensure they are driving improvement
- ensures learning from the audits is shared across the organisation to facilitate wider improvement.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W5.1 Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?

W5.2 Are there processes to manage current and future performance? Are these regularly reviewed and improved?

W5.3 Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?

W5.4 Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?

W5.5 Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?

W5.6 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Quality and sustainability both receive sufficient coverage in relevant meetings at all levels.

Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary.

Senior leaders can evidence that the board, its committees and subgroups as a core part of their meetings:

- receive and discuss information covering quality, operations and finance**,** and their inter-relationships; each committee's particular focus arising from its terms of reference
- appropriately challenge and interrogate the information and assumptions presented to inform decision-making, making use of benchmarking and other external sources as appropriate

Senior leaders can evidence that core financial information is presented and robustly challenged throughout the organisation. This information is presented in the context of non-financial information, risks and mitigations, and there is a balance between actuals and projections, detail of cost and income categories, granularity of divisional/ locality/ business unit information, and links with operational drivers.

Senior leaders can evidence that service line reporting approaches (ideally at patient level) are used for financial reporting and patient level costing has been or is being implemented.

Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information.

Senior leaders can evidence that the reporting approach integrates quality, operations and finance, appropriate to the size and complexity of the organisation. The board, its committees and sub-committees, use it to:

- ensure that the impact of all service development and efficiency programmes is understood on the quality and sustainability of all relevant areas of the organisation before decisions are made
- understand areas of good and under-performance
- support evidence-based decision-making, using sensitivity analysis where appropriate

Senior leaders can evidence that there are monthly dashboards covering the most important indicators for the scrutinising committee. These dashboards are used effectively and:

- present the most recent (or recent enough to be relevant) data available
- where appropriate give preference to absolute data over relative data
- present both information for improvement and for assurance:
    - **measurement for improvement** means that data is presented using appropriate statistical methods to enable tracking of processes, balancing measures and outcomes over time, paying attention to variation rather than simply comparing against targets and thresholds at particular times
    - **measurement for assurance** means information is compared with target levels of performance (along with a red-amber-green rating), historic own performance and external benchmarks (where available and helpful).
- are frequently reviewed and updated to maximise effectiveness of decisions; and where useful metrics are lacking, the board commits time and resources to developing new metrics
- form a pyramid of reports, with increasing granularity that can be used to understand individual, business unit, service line, divisional and organisational performance as required.

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

Senior leaders can evidence that there are quality, operational and financial reporting procedures, which provide robust information on organisational performance and enable key strategic and operational risks to be identified and managed. This information can be accessed by any staff members who require it for their work.

Senior leaders can evidence that the board, its committees and subcommittees regularly use information to understand and support the improvement of all areas of the organisation, including qualitative/ narrative text to explain outlying performance alongside the agreed metrics. This includes performance information relating to:

- divisions, localities, service lines and clinical units
- across patient pathways, internal and external
- the organisation's strategy and any associated plans.

Senior leaders can evidence that they make use of relevant indicators in relation to the people or the human resources (HR) strategy, for example:

- safe staffing
- 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.

The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.

Senior leaders can evidence that the information the board, its subcommittees and subgroups receive comes from reliable and suitable sources and covers an appropriate mix of qualitative and quantitative intelligence.

Senior leaders can evidence that there are robust and reliable processes, systems and controls for producing the information covering data collection, checking, processing and reporting, which are captured in clear standard operating procedures.

Senior leaders can evidence that arrangements for supporting how performance indicators are prepared and reported are reviewed regularly.

Information technology systems are used effectively to monitor and improve the quality of care.
Senior leaders can evidence that, through dedicated chief information officer and chief clinical information officer leadership, the organisation is delivering higher quality, more effective and lower cost care through effective use of information technology (IT), data and analytics. Senior leaders can evidence that the organisation is constantly looking to learn from others – both nationally and internationally – on how best to identify and exploit the opportunities that IT, data and analytics provide to monitor and improve the quality of care. Senior leaders can evidence a mature understanding of the role of digital technology as a change management and improvement mechanism to transform operating procedures and care delivery models. Senior leaders can evidence that IT adheres to the latest standards of cyber security to minimise risk to patient care and organisational reputation. Senior leaders can evidence that the organisation's IT adopts all of the relevant data and information standards, enabling accurate timely and comprehensive use of data across the enterprise and effective sharing with trusted partners across the local health and care system. Staff members understand the benefits of working 'paper-free' and have sufficient understanding of the role of IT, data and analytics to improve patient outcomes, organisational and system sustainability. Staff members demonstrate confidence in the use of IT, data and analytics relevant to their roles to support patient care.

Data or notifications are consistently submitted to external organisations as required.
Senior leaders can evidence that the relevant departments understand the routine and exceptional data requirements of external bodies. Senior leaders can evidence that there are appropriate and effective mechanisms for the collection, preparation and sign-off of the necessary information on routine and exceptional bases to support timely delivery to external organisations.

There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
Senior leaders can evidence that there are an information governance (IG) framework and documented processes and procedures to support the co-ordinated and integrated care through appropriate and lawful information-sharing and the effective management of records. Senior leaders can evidence that the organisation is able to maintain the confidentiality and security of the personal confidential data it processes and all reasonable care is taken to prevent inappropriate access, modification or manipulation of that data. This includes ensuring there are arrangements to: • secure against unauthorised access to data • safeguard against unauthorised modification of data • make readily accessible the required data to authorised users only.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?

W6.2 Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?

W6.3 Are there clear and robust service performance measures, which are reported and monitored?

W6.4 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?

W6.5 Are information technology systems used effectively to monitor and improve the quality of care?

W6.6 Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?

W6.7 Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?

KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.

Staff members are committed to actively seeking the views of patients, service users, carers and the public, both directly and via other groups (such as local Healthwatch organisations, patient representative groups, members and governors (where appropriate)) through a variety of channels and with due regard to the public sector equality duty.

Senior leaders can evidence that these views, including those received as concerns and complaints, are regarded as a way to understand and improve performance, and routinely used to inform service development.

The board receives and reviews quantitatively and qualitatively analysed data at least quarterly, triangulated with other risk intelligence, and addresses any risks or development areas identified.

Senior leaders can evidence that the organisation communicates to the public fully, regularly, and in accessible ways:

- the decisions taken by the Board and the rationale for them
- performance measures and outcomes that include objective coverage of both good and bad performance.

For foundation trusts, senior leaders can evidence how governors are enabled to hold the non-executive directors individually and collectively to account for the performance of the board of directors and to represent the interests of NHS foundation trust members and of the public.

The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.

Senior leaders can evidence that staff at all levels are actively involved in planning and delivery of significant service developments in a variety of ways and with due regard for the public sector equality duty. Senior leaders can evidence how staff input has influenced plans.

Continues...

Staff members can describe how they are encouraged to feed back, through a variety of channels, on an ongoing basis as well as through specific mechanisms. This will include but is not limited to an annual staff survey.

The Board reviews quantitatively and qualitatively analysed data, triangulated with other risk intelligence (such as complaints, incidents), and addresses any development areas identified. Senior leaders can evidence how stakeholder input has influenced plans.

The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

External stakeholders describe working relationships with the organisation as positive, underpinned by trust, respect and co-operation.

Senior leaders can evidence that there are appropriate and effective mechanisms to enable the organisation to work proactively with local health and care system partners to:

- build a shared understanding of population health, patient needs and system challenges
- design improvements to create long term sustainability.

Senior leaders can evidence their commitment to developing positive and effective working relationships with local health and care system partners by:

- dedicating appropriate face-to-face time to working with counterparts in other organisations to build trusting relationships
- regularly attending systems meetings from staff with appropriate capacity, experience and seniority
- engaging external stakeholders in formal internal governance committees where appropriate
- proactively seeking and acting on feedback on the quality of these relationships (for example through 360° stakeholder surveys)
- co-operating constructively with third parties with specific roles in relation to the organisation (such as commissioners and other providers).

Senior leaders can evidence that the organisation responds with flexibility and agility to changes in the local health economy, and takes part in pooled activities which may include:

Continues...

- common quality improvement (QI) approach
- pooled transformation and improvement resources
- trust-building efforts for finance, clinicians, etc
- delegated decision-making
- local area talent management planning and leadership development
- local health economy plans delivery groups

Senior leaders can evidence that the organisation proactively engages and shares data openly on relevant quality, operational and financial performance with all major external stakeholders (including health and local authority commissioners, Health and Wellbeing Boards, Healthwatch, patient groups and MPs).

Senior leaders can evidence that the organisation's decision-making is transparent, and the processes in place enable stakeholders, including commissioners, to find out easily how and why the board has made key decisions in addition to responding to freedom of information requests.

Staff members proactively engage with relevant delivery partners (general practitioners, local authorities, third sector providers, other community, mental health, acute and specialist providers) to identify improvement opportunities, performance or resourcing issues and to ensure overall quality along pathways.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W7.1 Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?

W7.2 Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?

W7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?

W7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?

W7.5 Is there transparency and openness with all stakeholders about performance?

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

Leaders across the organisation can articulate and demonstrate their commitment to the organisation's improvement approach, across quality, operations and finance functions by:

- taking a proactive approach to innovation and improvement, including active engagement in the delivery of initiatives (some initiatives could be led personally by individual board members)
- setting realistic but stretching performance objectives for the organisation
- encouraging learning from sector, national and international best practice, the creation of best practice where it doesn't exist and sharing back learning widely.

Senior leaders can evidence how they create a safe and hospitable environment for experimentation and learning, by:

- seeing failure not as a negative but as learning that can be embedded in future practice to deliver performance improvement
- taking time out to identify and act on the board's own successes and failures
- demonstrating how reviewing quality, operational and financial information has resulted in actions that have successfully improved performance.

There is knowledge of improvement methods and the skills to use them at all levels of the organisation.

Senior leaders can evidence that they actively encourage the use of a standardised improvement methodology embedded across the organisation to improve the quality, efficiency and productivity of services. This can be any method chosen by the organisation.

Board members demonstrate at least a basic awareness of the key improvement concepts (such as variation and system thinking) and can show how they have used these in improvement initiatives (such as understanding performance in terms of variation).

Continues...

Senior leaders can evidence that quality/continuous improvement training is offered to staff at all levels, and staff with appropriate leadership and analytical skills are available to lead and support improvement and innovation.

Staff members demonstrate their confidence and competence by improving their services involving patients and carers, and by sharing their skills with others though coaching and training.

The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.

Senior leaders can evidence how the organisation has learned from internal and external reviews and the effectiveness of its response to recommendations from external auditors and assessors.

Senior leaders can evidence how, where appropriate, external support networks and expertise are used to support ideas for development and improvement (for example use of benchmarking, working with patient groups, participating in peer learning networks on a range of topics, linking with healthcare providers and other improvement interventions and tools).

Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.

Senior leaders can evidence that:

- staff are clear about their personal priorities and objectives
- managers give timely and balanced feedback about progress towards objectives
- staff and teams are able to review these objectives against information and data
- there are appropriate and effective mechanisms for teams to work together to resolve problems, review team objectives, processes and performance on a regular basis.

There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.

Senior leaders can evidence that there is an improvement strategy that promotes the adoption of the chosen improvement methodology and ensures it is reflected in the organisation's systems and processes. This means that:

- improvement is seen as the way to address performance in teams, between teams, or along pathways as appropriate
- staff objectives and appraisal processes include innovation and improvement
- improvement and innovation successes are celebrated throughout the organisation and learning is shared widely in the organisation, with other organisations in the health and care system, and more widely though contributions to conferences and journals.

Senior leaders can evidence that all staff members are supported to carry out improvement work with:

- appropriate resources (time and money) to deliver the projects they identify
- timely access to the data they need (such as service line data), the tools they need to analyse it (such as templates or software to generate statistical process control/run charts, etc) and analytical expertise to support them if required.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?

W8.2 Are there standardised improvement tools and methods, and do staff have the skills to use them?

W8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?

W8.4 Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?

W8.5 Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?

Annex A: Scoping your developmental review

This annex summarises some points you should consider in preparing for a review. It is not exhaustive, but should help to start the process.

Scope of the review

The scope of developmental reviews should cover the eight KLOEs in this guidance at an appropriate level. There may also be development areas the provider is aware of outside the framework arising from, for instance, internal and/or external audit review findings, or information from the annual governance statement and the corporate governance statement. The board should tailor the scope, or place emphasis within the review accordingly.

Self-review

Purpose of regular self-review

The purpose of regular self-review is to promote self-knowledge, reflection and vigilance, and the development and improvement of leadership and governance. It helps providers identify their strengths and development areas to deliver continuous improvement. High performing providers are likely to carry out some form of self-review of their leadership and governance regularly and frequently.

As with the scope of the developmental review, boards are responsible for setting the scope of regular self-reviews, but we suggest they should cover the full scope of the well-led framework at an appropriate level. Ideally, self-reviews will be carried out annually but providers should determine this for themselves.

Completing self-reviews

A nominated provider lead or team may co-ordinate the self-review but it 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. The whole board is responsible for arriving at an overall conclusion.

The output of the self-review will include the self-review questionnaire (or equivalent), ratings and rationale for the ratings. This information may help inform the CQC well-led provider information request as part of the regular regulatory assessment process, but supplying the full self-review is not mandatory.

Preparation for development reviews

Self-review is an important first step in preparing for externally facilitated developmental reviews. Providers should assess themselves to provide insight for themselves and the external facilitator into how they gauge their own leadership and governance performance and identify any particular areas of interest or concern either within or outside the eight questions.

A good self-review should help identify where the provider needs to focus and therefore inform the choice of external reviewer.

During a developmental review, the self-review should be presented to the external facilitator for comments and further discussion. The reviewer will then agree areas for further scrutiny with the board.

Rating the self-review

Each of the KLOEs should be rated using a scheme that allows prioritisation of findings and escalation of concerns, informed by the good practice examples in the framework. Each judgement should be backed up by evidence where appropriate.

Rating will aid prioritisation and ensure that issues are brought to the attention of the board. Boards should ensure that their approach facilitates continuous improvement rather than a compliance mindset. The reviews should not be about ‘meeting a bar’, but rather about prioritising improvement actions.

Key line of enquiry	Priority rating	Explanation of self-rating assessment	How is the board assured? Evidence for assessment	What are the principal actions/areas for discussion with your external review team
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?				
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?				
3. Is there a culture of high quality, sustainable care?				
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?				
5. Are there clear and effective processes for managing risks, issues and performance?				
6. Is appropriate and accurate information being effectively processed, challenged and acted on?				
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?				
8. Are there robust systems and processes for learning, continuous improvement and innovation?				

Annex B: Commissioning an external facilitator

This annex sets out what to consider when choosing an external team to facilitate developmental reviews against this framework.

Boards need to assure themselves that the appointed external facilitator is independent and able to provide a robust and reliable judgement of a provider's leadership and governance.

As part of the commissioning process, facilitators should also demonstrate:

- a clear and concise understanding of the purpose and objective of the review; knowledge of how to carry out a rigorous leadership and governance review, covering the specific areas detailed in the well-led framework; and the ability to use an appropriate range of tools and approaches
- relevant skills and experience, including:
    - credibility and experience in carrying out leadership and governance reviews at healthcare providers; ideally, the selected team will be multidisciplinary with a broad range of skills relevant to all aspects of board leadership and governance, such as strategic planning, quality governance, cultural assessment, organisational development and management information and analysis
    - experience in supporting healthcare providers to develop their leadership and governance with an understanding of continuous quality improvement and methodologies
    - knowledge of the healthcare sector, and the internal and external challenges faced by providers
    - knowledge of the regulatory framework the provider operates in
    - an ability to manage the review process: reviewers should provide a credible and detailed plan of the proposed project governance regime including the approach to the quality assurance of the work, risk

management, reporting and escalation lines, and evidence of clear leadership for the work with a named individual.

- named personnel (and CVs in the response), and clarity about their role and what they will do during the review.

Peer review input

Our ambition is that, over time, making use of and participating in developmental reviews will become an integral part of the role of senior leaders across the NHS. This is one of the main ways in which we can share the valuable learning, experience and ideas within the NHS leadership community and make it accessible to everyone, across our organisations.

This ambition will take some time to realise, but as a first step, we encourage providers where possible to involve, or to select suppliers who offer to involve, appropriately skilled peer reviewers as part of the external facilitation team. We will be providing further support and guidance about this in due course.

We will also be compiling a list of peer reviewers and this list will be available on request. We will include details about this on our website later this year. https://improvement.nhs.uk/resources/well-led-framework/

Annex C: Carrying out a developmental review

This annex sets out:

- potential methods of carrying out a review
- the process of prioritising and rating your findings
- action-planning.

There is no 'one size fits all approach' to developmental reviews: we encourage providers to think about how to shape the methodology to support their needs. Providers are responsible for commissioning these reviews and so should assure themselves that the review tools and methods are suitable for their circumstances.

Because of this, the guidance below provides examples of tools and is not prescriptive. Experienced reviewers can use their own tools and methods.

Prioritising and rating findings

The findings from the review will usually be presented in a report for the board, covering methodology, scope, findings, and areas of good practice or weakness against which to plan developmental actions. It is important that issues or concerns are prioritised but plans for maintaining good practice should also be considered.

We encourage providers to agree the format in which they would like the findings to be presented at the start of the review process.

Action-planning

The board is ultimately accountable for delivering improvements, and so action-planning should involve the whole board. The board should consider how to track actions and the timeframe for resolution. Developmental reviews are most useful where issues are resolved in a timely manner.

NHS Improvement has a range of support offers (see Annex D) that boards may draw on when addressing issues.

Examples of tools

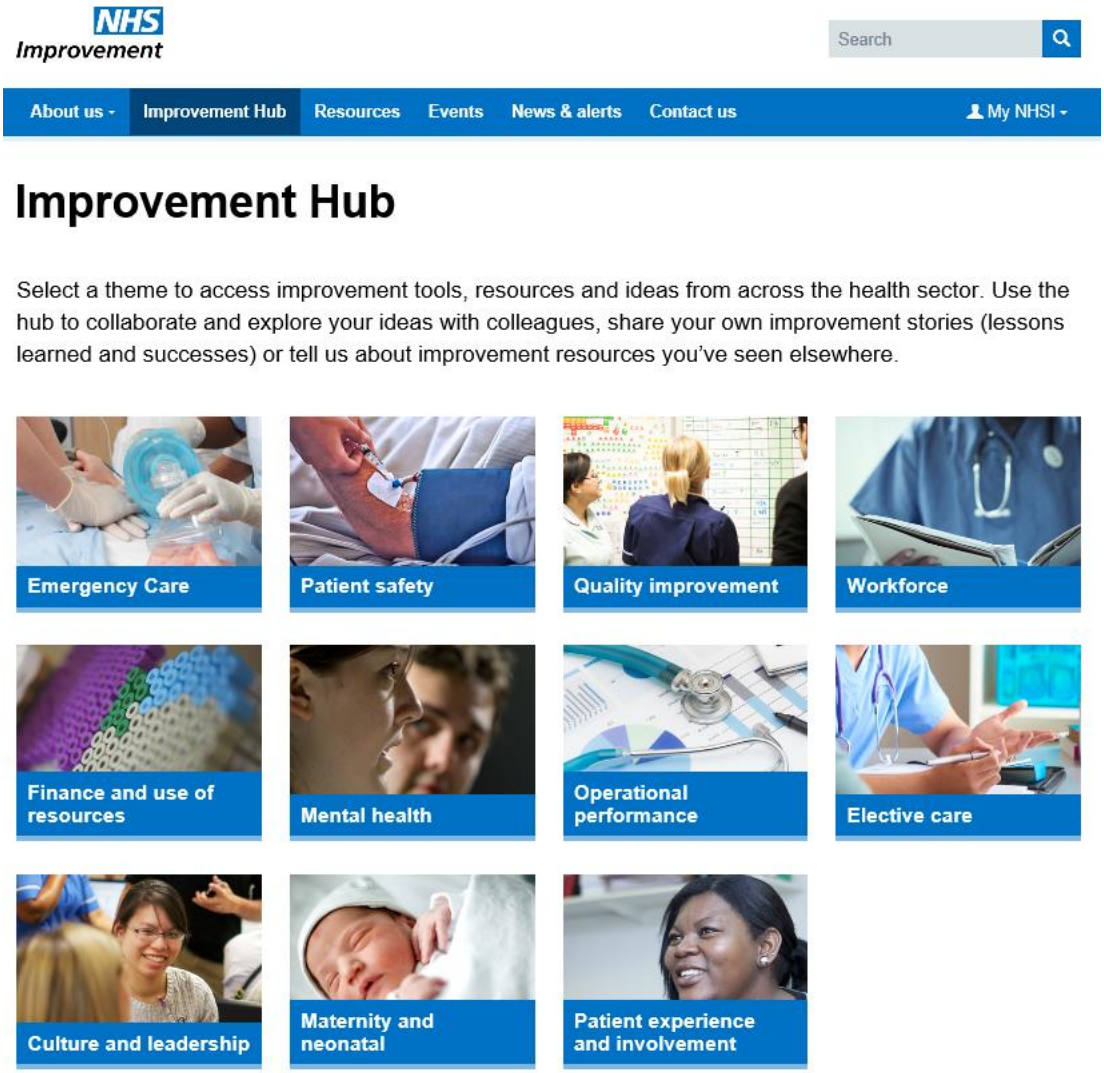
Tool	Suggested components	Purpose
Desktop document review	Board and key subcommittee agendas, minutes and papers; board assurance framework; audit reports; strategic documents, eg the provider's strategy and business plan, quality strategy, quality improvement plan and people strategy; and internal/ external audit reports, annual governance and corporate governance statements, alongside any other relevant reviews.	To provide a view of: • how ongoing issues and risks in the provider are communicated and managed • the quality of information produced to support decision-making • how the board prioritises issues at the provider and divides its attention.
One-to-one interviews	All board members, the trust secretary, lead governor, head of quality governance, head of workforce, clinical directors and heads of business units, and local stakeholders (including clinical commissioning groups and patient representatives).	To gain individuals' views of the provider'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 provider's governance to cross-reference with the board's own views and test the board's awareness.
Focus groups with internal and external stakeholders	Staff, patient groups, commissioners, contracted or outsourced suppliers	To get internal and external parties' views of the provider's governance to cross-reference with the board's own views and test the board's awareness.

Tool	Suggested components	Purpose
Board and subcommittee observations	Observations of at least one board meeting and relevant subcommittees, including audit and quality.	To identify the dynamics of the board, including agenda management, depth and breadth of information used to make decisions and progress priorities, and the way they challenge and hold each other to account for the leadership of the provider.
Board skills inventory	Matching skills to the requirements of the board's work and identifying any gaps.	To ensure 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 providers.	To assess how the provider compares against any known examples of particularly effective and robust governance practices.

Annex D: Accessing support and further reading

New support offers are available all the time. The easiest way to find out about them is to visit the Improvement Hub: https://improvement.nhs.uk/improvement-hub/

This includes resources from across the NHS, as well as discussion forums and case studies.



Further reading

Good governance practice

British Quality Foundation (2013) EFQM Excellence Model

Committee on Standards in Public Life (1995) The 7 principles of public life

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

Department of Health (ongoing) Information Governance

NHS Providers and DAC Beachcroft (2015) *Foundations of Good Governance: A Compendium of Best Practice* (3rd edition)

NHS Leadership Academy (2013) *The Healthy NHS Board 2013: Principles for Good Governance*

NHS England (2017) Managing Conflicts of interest in the NHS

Reviews and investigations

Department of Health (2016), Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (Lord Carter)

Department of Health (2014), Examining new options and opportunities for providers of NHS care: The Dalton Review

Department of Health (2014) Better leadership for tomorrow: NHS Leadership Review. (Lord Rose)

Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

Lampard K., Marsden E. (2015) Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

National Advisory Group on the Safety of Patients in England (2013), A promise to learn – a commitment to act: Improving the safety of patients in England

National Improvement and Leadership Development Board (2016) Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services

Smith, E. (2015), Review of centrally funded improvement and leadership development functions, Final report of review on behalf of NHS England, Monitor, NHS Trust Development Authority, Health Education England, Public Health England and the Care Quality Commission.

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