Ashford and St Peter's Hospitals NHS Foundation Trust

Governance review

auditone
assurance . counter fraud . advisory

consultone
expertise . insight . improvement

Contents

Context of the review	2
Approach	3
Overview of findings	
Part A – Board, committee and executive level	4
Part B – Divisional level governance arrangements	5
Detailed findings	
Part A – Board, committee and executive level	7
Bibliography (references)	26
Part B – Divisional level governance arrangements	
Background	26
Scope	26
Approach	26
Overview of divisional governance findings	26
Appendix 1 – Recommendations	41
Appendix 2 – Possible example standard DMB agenda	45
Appendix 3 – Detailed findings by division	
Diagnostics, Therapeutics and Cancer Services	46
General Surgery, Anaesthetics, Critical care and Theatres	51
General and Specialist Medicine	56
Specialist Surgery and iMSK	61
Urgent and Emergency Care	65
Women's Health and Paediatrics	71

Context to the review

We understand that there has been significant churn at board level and in particular at executive level in recent times which has led to a loss of organisational memory and consistency in approach to the framework of governance and its associated processes.

As the new Group Chief Executive comes into post in January 2025, the Trust procured an external view of Trust governance arrangements to provide assurance that there is a robust governance structure and framework in place that when looked at holistically provides effective governance of the Trust.

Recognising the work carried out to date at Board, committee and executive levels, the Trust requested a lighter touch (technical compliance) review at this level whilst wanting a deeper dive review of divisional level governance arrangements.

The light touch, technical compliance review of board, committee and executive level governance arrangements reviewed the reasonableness of the governance architecture and alignment with good practice including the recently released *NHSE Insightful Board* guidance.

The divisional level review has sought to understand the current arrangements, identify existing good practice and recommend improvements where either practice is inconsistent or not aligned with good practice. We reviewed both corporate and clinical governance structures and processes at divisional level including how and where these come together to help provide triangulated assurance.

In summary, our report consists of two discrete elements:

Part A - Board, Committee and Executive level

- Technical compliance and good practice review of revised governance arrangements

Part B - Divisional level

- Review of existing practice to understand consistency of approach and alignment with good practice

Approach

To fulfil the scope of the review and ensure adequate engagement, particularly in relation to the divisional level aspect of the review we undertook 1:1 interviews with relevant officers and executive directors and 1:3 (divisional triumvirate) interviews, observed one of each divisions corporate governance and quality governance meetings, observed a sample of the Divisional Review Meetings, and reviewed the following documents where available:

Part A –Board, Committee and Executive level	Part B – Divisional governance arrangements

• Constitution, standing orders, standing financial instructions and schemes of reservation and delegation,
• Board, committee and executive governance structure diagrams (pre and post revision),
• Council of governors, board, board committee and Trust executive board terms of reference and annual work programmes and reporting requirements,
• Board development programme,
• Board skills matrix,
• Fit and proper persons' test process and evidence,
• Non-executive and executive job descriptions,
• Standards of business conduct and raising concerns policies,
• Performance and accountability framework,
• Risk management framework,
• 2023/24 annual governance statement,
• External reports on Trust governance
• Strategy and annual plan priorities.
	• Operational management structure
	• Where available, for each Division Management Board (DMB):
	  ○ Terms of reference
	  ○ Annual work programme
	  ○ Agenda (six months)
	  ○ Action tracker (six months)
	  ○ Minutes (six months)
	  ○ Sample papers (latest meeting)
	• Divisional Quality Governance structure (if separate to DMB)
	• Divisional Quality Improvement structure (if separate to DMB)
	• Divisional management triumvirate job descriptions
	• Directorate / Service Line management structures
	• Other documentation as required

Overview of findings

Part A: Board, Committee and Executive level

Overall, we found a board, committee and executive level governance architecture which reflects widely adopted practice in the NHS.

The Trust's constitutional governance documents broadly reflect requirements of the regulatory framework. From the documents supplied to us, we can see that the majority of the documents have been updated in the last year with the exception of the constitution which was last updated in 2023 and the charitable funds scheme of reservation and delegation which was last reviewed in 2021. We understand that the Trust has subsequently updated its constitution, and this was published in March 2025. Although the documentation has been updated since the introduction of the Health and Care Act 2022, a number of them do not reflect changes introduced as a result of the 2022 Act. Where relevant, we have identified opportunities to strengthen various documents to reflect good practice which are detailed within the report.

The designation of the board's committees and their terms of reference (ToR) generally reflect good practice found across the NHS. We did note however that the cycle of business and in particular having Board committee meetings a week before the Board meeting does not allow much time for outcomes to be enacted and/or the provision of formal assurance into Board. More typically we would expect to see a larger period of time between Board committee meetings and Board meetings.

From our review of the annual work programme for the board we have identified a number of reports that should potentially be remitted to the board that are not included as a discrete report. These include items where the board has either a reserved power or where the board should maintain oversight in accordance with the regulatory framework. In relation to the latter, whilst assurance may be provided by the board's committees via the adoption of triple 'AAA' style reports, the board must ensure that it maintains sufficient oversight. As part of this, triple 'AAA' reports must convey sufficient detail and clarity over how a committee was assured over an agenda item, or where it is not assured, what are the agreed management actions to address this along with timelines and accountability. There also needs to be a clear understanding and consistency in approach regarding what and when to alert, advise and assure for the process to work effectively. From our documentary review, it is unclear whether the board is sufficiently informed to effectively discharge its role in relation to a number of matters required by the regulatory framework. Examples include estates compliance, the green plan and health and safety along with other examples which are listed within the report.

From our review of the committees' work programmes and their alignment with the terms of the reference and good practice, we identified potential gaps in reporting. Examples include medicines management (including controlled drugs accountable officer report) and oversight of research and development activities. These matters may be overseen within the operational governance of the Trust, but we would expect to see these also considered at a board committee.

In terms of executive led governance, the Trust Executive Board (TEB) has been established as the senior executive forum to support the Group Chief Executive in the development and implementation of strategy, monitoring of performance and assessment of risk and the allocation of resources. It is positive to note that the TEB membership has been extended to include Divisional Directors and the Director of midwifery, thus ensuring senior operational and clinical input and ownership into this forum. The role of the TEB is wide ranging and is supported by a detailed work programme. We noted some alignment of the work programme with the ToR, the Trust's corporate objectives and quality improvement objectives.

However, the Trust should satisfy itself that the work programme is comprehensive and is more explicitly aligned with the duties of the forum to ensure that the forum fulfils all of its duties appropriately. We also noted a need for greater clarity regarding what items should be escalated to the TEB. This last point also ties in with our wider view regarding the need for greater specificity and detail to be included within the AAA reports including clarity over the usage of alert, advise and assure.

There are a number of areas where, when read holistically, there are potential gaps and inconsistencies in terms of reporting and relationships between committees. We recognise that this may be due to the current draft position of the development work underway, but the Trust should ensure that there is clear and comprehensive responsibility and reporting across the governance architecture. The detail that supports this view is contained within the body of the report.

Part B: Divisional level governance arrangements

Whilst each division has arrangements for the oversight of corporate and clinical matters, governance arrangements are inconsistent and lack robust central direction. The recommendations pertaining to divisional governance arrangements, from the previous review by Deloitte's in 2022 are yet to be fully implemented and should be considered again in conjunction with our findings. This includes adopting a standardised approach to Divisional Management Boards (DMB albeit with some local flexibility in addition to Trust minimum expectations. DMB meetings should be sighted on and assuring themselves over the effective management of the full range of quality, operational, workforce and financial considerations within each respective division.

We also found variability in quality governance arrangements, with some divisions establishing separate and standalone quality meetings with a disconnect to wider divisional oversight mechanisms and duplication of reporting. Similarly, the standardisation of quality governance stewardship and setting expectations of 'do minimum' reporting would be beneficial in enhancing assurance mechanisms for the division, and ultimately the Trust Board. Despite the lack of uniform quality governance structure we saw evidence by some divisions of the introduction of regular risk reviews and the embedding of the PSIRF framework. The opportunity for cross-divisional learning was noted as being largely informal and lacking in process, however the benefit of Trust wide adoption of improvement huddles was acknowledged. The speciality level quality governance meetings we observed demonstrated a commitment to patient safety, and evidenced active discussions concerning incidents, referenced multidisciplinary approaches to proactive problem solving and shared a willingness to improve practice within a supportive culture. However, we also noted poor documentation, variable clinical representation and inconsistent escalation of risk at these meetings.

From our review, each division appears to have a sound grip of operational matters, however the lack of triangulated insight and intelligence results in variable quality of assurance gained and, in most cases, fails to focus on mitigating actions where performance is adrift of requirements. In common with many Trusts, ASPH has a significant financial sustainability challenge. Whilst DTC division was noted as having instigated service line financial deep dives every two months, the introduction of a minimum expected standard of financial reporting at divisional and speciality level would enhance understanding, ownership and accountability over financial performance. We noted equally variable reporting of workforce and risk matters too.

Wider observations and opportunities for improvement were also noted and include strengthening the connection between the divisions and the Trust's overarching strategic objectives, enhancements to the current risk management and reporting arrangement, policy governance arrangements and the application of agreed taxonomies to support consistency. We also noted the added benefit of having

dedicated, locally appointed divisional quality and performance resources in addition to the allocated central support resource (e.g. UEC) and would encourage the Trust to consider the adequacy and appropriateness of the current corporate resource support.

Whilst not central to our review, we noted that by having six divisions, this places the Trust towards the higher end of Trusts in terms of the overall number of divisions within a Trust. Whilst there is no 'right' approach, it should be recognised that the greater number of divisions will impact on the potential for siloed working, disjointed learning and fragmented/inconsistency of communications/messaging across operational areas, increased running costs (including central support functions) and a greater number of 'hand offs' between divisions. In addition, we understand that divisional clinical leadership appointments are not timebound i.e., fixed term tenures. Whilst not a mandatory requirement, the provision of fixed term appointments e.g., a maximum of two terms of three years, can provide for natural churn which increases clinical engagement in operational management through natural rotation and encourages new ideas and refreshed impetus at regular intervals.

Detailed findings - Part A: Board, Committee and Executive level

This element of the report relates to our findings from the light touch, technical compliance review of board, committee and executive level governance arrangements. We reviewed the reasonableness of the recently revised governance architecture and alignment with good practice including the recently released NHS England (2024) *Insightful provider board* guidance.

Constitutional documents

The way that an NHS organisation is directed and controlled in terms of corporate governance is through the suite of constitutional governing documents. These include the constitution, standing orders, standing financial instructions and scheme of reservation and delegation**.**

Constitution

The Trust's constitution as supplied to us is dated July 2023 (we note the subsequent updating of the constitution in March 2025) and generally reflects the constitution as defined within the schedule 7 NHS Act 2006 (as amended). The constitution does however require updating to reflect the Health and Care Act 2022, the *Code of governance for NHS provider trusts* (2023) as well as other changes. Based on the July 2023 version, these include:

- References to the NHS Act 2006 should include 'as amended' where appropriate to reflect changes made by the Health and Care Act 2022. For example, changes to regulator names including NHS England, as provided by s1H NHS Act 2006 (as amended).
- The model election rules are published by NHS Providers (para 13.2).
- While the constitution includes a clause to the effect that the masculine gender only shall include the feminine gender, this is not deemed good practice and gender neutral language should be used.

In addition, the constitution (23.2) states that the board shall consist of up to seven executive directors. The Trust also has one non-voting director (Chief Digital Information Officer). It would be beneficial to include the distinction between voting and non-voting directors.

Recommendation A1: The Trust should update the constitution to reflect statutory changes and identified good practice.

Standing orders

The standing orders state that they are updated on an annual basis with the next review scheduled for June 2025. The standing orders broadly reflect standing orders adopted by other trusts.

In line with the comments in relation to the constitution, the standing orders should be updated to reflect the Health and Care Act 2022, as described above and including the updating of organisation names, for example NHS Resolution instead of NHSLA. The standing orders should also be updated to include the duty of the board (para 7) to have regard to the 'triple aim' of better health for everyone, better care for all, and efficient use of NHS resources.

Para 2.3.1 should be updated to reflect the *Code of governance for provider trusts* in relation to the maximum term of office for the chair and NEDs. Para 2.4.1 should include the requirement for the Council of Governors to take into consideration any guidance issued from time to time by NHS England in respect of remuneration for the chair and NEDs.

Para A 1.2.14 is the definition of funds held on trust which refers to s 51 NHS Act 2006 which has since been omitted by virtue of NHS (Charitable Trusts) Act 2016 s1(1)(1) (a). The definition should be revised to refer to powers derived under paragraph 14(2)c part 2 schedule 4 of the 2006 Act and those under section 47(2)c 2006 Act.

Para 3.3.1 refers to the use of a board portal (in the past tense). Many trusts have included clauses to reflect modern modes of communications such as email and we would recommend that the Trust updates the standing orders to reflect its modes of communication.

Para 6.2 should be updated to refer to the *Managing conflicts of interest of policy* replacing the *Standards of business conduct policy*.

Recommendation A2: The Trust should update the standing orders to reflect the proposed changes detailed above.

Scheme of reservation and delegation

The standing financial instructions (SFIs) and scheme of reservation and delegation (SoRD) were reviewed and submitted to the Board for approval in August 2024, following consideration by the Audit and Risk Committee (ARC) in December 2023. It is not evident from the documentation why there was a delay between review by the Audit and Risk Committee and submission to the Board.

The SoRD broadly reflects those adopted by other trusts with the exception that it does not describe the delegation of powers to the Board's committees apart from the Audit and Risk Committee (ARC). In addition, the introduction should be more prescriptive as it currently states that the document provides examples of how powers may (our emphasis) be reserved which suggests discretion. In our view, it should be clear that the powers listed are those that have been reserved to the Board.

Subject to including the Board's delegation to its committees the SoRD appears to provide a reasonable framework for the delegation of functions.

We did note however that the SoRD refers to the Modern Healthcare Committee in relation to approval of business cases which we believe should be replaced with the Finance and Performance Committee.

Recommendation A3: The Trust update the SoRD to reflect the proposed changes detailed above.

The Trust's charitable funds have their own scheme of delegation (SoD) which was last reviewed and approved in December 2021. The charitable funds' SoD defines the expenditure limits for the fundholder (<£5k), Chief Financial Officer (>£5k< £50k), Chief Executive (>£50k < £100k) and >£100k reserved to the corporate trustee. Approaches to financial delegated limits for charitable funds varies across trusts although most boards delegate a level of authority to authorise expenditure to the Charitable Funds Committee. The majority of trusts we have reviewed delegated authority to the Charitable Funds Committee for expenditure either beyond the fundholders' delegated limit or beyond the Finance Director's delegated limit. The Trust may wish to consider whether the role of the Charitable Funds Committee should include delegated responsibility for authorising expenditure.

According to the charitable funds SoD, the fundraising policy should be approved by the corporate trustee (the Board), although according to the policy document provided (September 2022) it was approved by the Director of Planning, Director of Finance, Director of Strategy and Head of Communications and ratified by the Charitable Fund Committee.

Recommendation A4: The Trust should clarify responsibility for approving the fundraising policy and either revise the SoD or approve the policy in accordance with SoD.

Recommendation A5: The Trust should consider whether the role of the Charitable Funds Committee should include delegated responsibility for authorising expenditure.

We were provided with a one page schematic of the SoRD which summarises authority levels for the Board, committees, Chief Executive, executive directors, divisional directors and budget holders for people, revenue, capital and contracts. This is a helpful addition to the Trust's governance documents to strengthen understanding of respective responsibilities and should address, at least in part, the recommendation from the leadership and governance review (draft December 2023) which recommended a scheme of delegation and clarity of accountability for divisions. To strengthen this further the guide could be extended to include responsibilities that have a non-monetary value too.

Standing financial instructions (SFIs) – last updated August 2024.

The SFIs generally reflect those adopted by other trusts. As with the other constitutional documents, the SFIs should be updated to refer to Health and Care Act 2022 and changes made as a result. In addition, para 9.2.6 should be updated to refer to the *Managing conflicts of interest policy* as opposed to *Gifts and hospitality policy*.

Recommendation A6: The Trust should update the SFIs to reflect changes as described above.

Other considerations

Good practice observed across other trusts includes a schedule of changes as an appendix to its constitutional documents to ensure that changes can be tracked over time.

We were not provided with the provisions in relation to resolution of disputes (annex 9 of the constitution) and therefore unable to comment on its reasonableness.

Para 4.15 is incomplete in relation to the casting vote of the Chair in that it does not explain what should happen where there is an equality of vote.

Some of the paragraph references within the standing orders and the constitution of the Trust are no longer aligned. For example, para 3.2 standing orders refers to the appointment of the Chair and NEDs in accordance with para 22 of the constitution when the relevant paragraph in the constitution is 26.

Fit and proper person test (FPPT) framework

The FPPT framework was implemented to support the recommendations from the Kark Review and to promote the effectiveness of regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The framework was effective from 30 September 2023 and requires NHS organisations to undertake a formal assessment of fitness and properness on an annualised basis. The Chair is responsible for ensuring that the Trust conducts and keeps under review the FPPT.

The spreadsheet provided to us lists the documents and checks required by the FPPT framework. At the time of writing, we have not been provided with a copy of a local FPPT policy, so we are only able to assess whether the Trust is compliant with the national requirements and not its own arrangements.

The spreadsheet lists all current board members, when compared with board members listed on the Trust website. In relation to leavers, we note the majority of board members who have left the Trust since September 2023 are included with the exception of the Louise McKenzie, Director of Workforce who left in December 2023 and Michael Pantlin, acting Deputy Chief Executive.

The information recorded on the spreadsheet meets the majority of the requirements of NHS England's FPPT framework with the exception of the level of DBS check required. The Trust is required to outline

which DBS check (basic, standard, enhanced or enhanced with barred lists) is required for each individual board member. In defining the required DBS level the Trust should identify those roles that fall within the definition of a 'regulated activity' as defined by the Safeguarding Vulnerable Groups Act 2006. Whilst not shared with us as part of this review, we understand that the trust has recently updated its DBS policy, and this information may be contained within this updated policy. In addition, the DBS checks should be undertaken on a three-year cycle. There are gaps in the recorded information on the spreadsheet including missing DBS checks (Chief People Officer, NEDs x 3) and out of date DBS checks (Chair, NEDs x 2, Chief Operating Officer).

The information recorded on the spreadsheet in respect of appraisals appears to be out of date, as we have been provided with some appraisals that are more recent than those recorded on the spreadsheet. For example:

- John Machin (NED), appraisal signed 18 June 2024 but not by Chair. On FPPT spreadsheet appraisal date shown as 15 December 2022.
- Chris Kane (NED), appraisal signed 9 June 2024 but not signed by Chair. Shown as N/A on FPPT spreadsheet.
- Jason Bincalar (CDIO) appraisal signed by both appraiser and appraisee on 17 June 2024. Shown as N/A on FPPT spreadsheet.
- James Thomas (COO), appraisal signed by appraisee on 27 November 2024 and by Chief Executive on 20 June 2024. According to FPPT spreadsheet, the last appraisal is dated 28 September 2023.

No FPPT checks have been recorded for the recently appointed Group Chief Executive on behalf of the Trust. According to the FPPT spreadsheet, it has been assumed that these are held by Royal Surrey NHSFT (RSFT). Where two or more organisations create a combined role, the host/employing organisation should provide a letter of confirmation to the other organisation to confirm that the board member meets the requirement of the FPPT. We have not been supplied evidence of the Trust receiving such confirmation from RSFT.

A number of checks have not been recorded for the Chief Medical Officer including date of the last appraisal, insolvency checks, disqualified director and self-attestation. Individuals who by virtue of their profession are members of a professional register, for example the General Medical Council, should still be assessed against the FPPT.

The spreadsheet records compliance with completion of competencies, with the number of required competences varying between 11 and 21. It is not apparent from the spreadsheet how the number of required competences has been determined. This information should be included within a local FPPT policy.

A report on the FPPT assessment should be provided to a meeting of the Board in public at least annually, with a report to the Council of Governors in relation to the Chair and the NEDs. These requirements are not included on the Board and Council of Governors' work programmes. We have reviewed the meeting agenda for both the Board meetings and Council of Governors meetings on the website for the previous 12 months and cannot evidence presentation of an FPPT report to either forum.

Recommendation A7: The Trust should ensure that the outstanding FPPT evidence is obtained, and the Chair should undertake the assessment and present a report to a Board meeting and to the Council of Governors.

In terms of good practice, trusts should undertake an internal audit of the FPPT framework at least every three years and we would recommend that the Trust should ensure that one is arranged.

Recommendation A8: The Trust should arrange for internal audit to undertake an audit of the FPPT process.

Board development

A NED skills matrix (January 2025) has been provided to us. NEDs were asked to rank their skills in order of strength from 1 (strongest) to 5 against the following:

- Finance – CCAB qualified with senior commercial sector management experience,
- Commercial expertise in multi-site, complex context,
- Cultural/people change/change management and organisational development skills,
- Patient/consumer perspective,
- Marketing, stakeholder management and communication skills,
- Clinical background in academic or non-medical field,
- Extensive experience in leading improvement, innovation and transformation,
- Senior leadership experience,
- Strategic partnership/alliance experience and
- Digital/IT transformation skills.

At the time of the review, one current NED has not completed the assessment. We understand that historically the matrix has been used for NED recruitment.

In the absence of objective criteria to support the self-assessment rating, the approach is inherently subjective. At best this provides a subjective assessment of an individual's relative strengths as opposed to an objective assessment of strengths against defined criteria which can then be used to inform board development requirements and recruitment priorities.

The board development plan for 2025 contains a list of planned topics including board relationships, hospital of the future, enabling strategies, counter fraud and sustainability. A session on cyber security was undertaken in March 2025. The intention is to use the NHS England *Insightful provider board guidance* alongside outcomes from committee effectiveness reviews to further inform the development plan.

We were provided with the *Together we care strategy refresh 2022-25*, as well as the corporate objectives for 2024/25. We assume that a fundamental review of the Trust strategy is planned recognising that the current strategy is in its final year. Once the new strategy has been developed, we would recommend a formal and more objective board skills assessment of all board members, not just NEDs, is undertaken, aligned to the skills required to deliver the Trust's strategic objectives. This should then form part of the consideration for developing the board development programme as well as future recruitment and succession plans. This will better demonstrate that the Board has the requisite skills, experience, knowledge and understanding to provide effective oversight over all elements of the Trust's strategy.

Recommendation A9: The Trust should undertake a formal and more objective board skills assessment to inform the board development programme and future board appointments.

Board terms of reference

As the Board exercises all of the powers of the Trust it is not necessary for Boards to have defined terms of reference (ToR). However, some Trusts have developed ToR for the Board to ensure that the role of

the Board as distinct from its committees, is defined and nothing falls 'through the gap'. We were not provided with a ToR for the Board and therefore assume that one does not exist for the Trust. We have included this section for completeness and to recognise that this is not a gap in our report.

Board work programme

The Board work programme plan contains many of the items that should be included. However, there are a number of items defined as reserved powers for the Board, which are not included. These are as follows:

- Policy for development of procedural documents,
- Treasury management and investment policy,
- Capital programme,
- Policies for the management of risk including health and safety and risk management strategy,
- Arrangements for dealing with complaints.

Whilst some policy documents may only be reviewed every three years, we would suggest that these should be included on the work programme to ensure that they are not overlooked.

In accordance with the SoRD, the Board has reserved the responsibility to approve the Health and Safety Policy. In addition to approving the policy, it is regarded as good practice for the Board to receive at least an annual report evidencing compliance with the Trust's health and safety arrangements, including responsibilities in relation to fire safety as required by the Regulatory Reform (Fire Safety) Order 2005. The Annual Governance Statement 2023/24 states that the Board has received regular reports on health and safety although these do not appear as discrete agenda items on the current work programme, and we assume these are therefore embedded as part of a wider report. A number of trusts include within the health and safety report, work in relation to violence prevention and reduction as required by NHS England » Violence prevention and reduction standard. We are unsighted as to whether the Board is in receipt of such updates.

Equally, it is not evident from our review of the committee ToR or work programmes where compliance with health and safety is monitored. We note from the SoRD that the Chief Finance Officer is the executive lead for health and safety although this is not explicitly referenced in the job description beyond a generic responsibility for estates and facilities. Good practice would be that there is explicit reference within the job description where an executive is the identified lead for a specific area of responsibility.

We have not reviewed board agendas in detail as part of this review, so it is not possible to determine whether all issues that are reserved to the Board, have been referred to the board. This includes decisions in relation to business cases where revenue > £1m p.a or capital £2m p.a. which under the current SoRD should be being presented to the Board for determination. Moving forward, we would suggest that the Trust reviews its financial sign off limits with a view to ensuring appropriate authorisation limits are applied across individuals and forums. In our view, the current levels appear quite low for a Board to consider as opposed to individual authority, an executive forum or committee of the Board.

Recommendation A10: The Trust should ensure all powers that are reserved to the Board are included, where appropriate, on the board work programme.

There are a number of items that we would expect the Board to receive that are not currently included on the work programme for the part 1 Board meeting i.e., meeting in public, based on national guidance or observed good practice. It may be that some of the items are discussed through committees and reported within the AAA report. It is not possible without viewing the AAA reports to determine whether this occurs and also provides sufficient visibility for the whole Board to allow it to discharge its duties. The Trust needs to satisfy itself that the Board has sufficient visibility over the following matters:

- Patient safety report (currently listed as discussed in part 2), whereas good practice would see this discussed in part 1 with only confidential matters being discussed in part 2.
- FPPT framework for Board members,
- Workforce plan Developing-workforce-safeguards.pdf. One of the requirements is for the Board to approve a workforce plan in part 1 Board meeting.
- Green plan - Greener NHS » Organisations. Green plans should be approved annually by the Board.
- Estates including summary of the premises assurance model - to be presented to the Board for approval at least annually as per https://www.england.nhs.uk/wp-content/uploads/2023/05/Premises-Assurance-Model-NHS-PAM-2023.pdf.
- Oversight of disciplinary cases – requirement for Boards to have oversight of disciplinary cases Letter template.

We also note that in a previous external review, it was recommended that consideration be given to how to position strategy at the Board. Whilst trusts vary in terms of their approach to monitoring delivery of their strategic objectives, we would expect updates on progress re delivery of the strategic objectives to be presented to the Board. This is also confirmed in the NHS England *Insightful provider board* guidance. We understand that delivery of the strategic objectives is assured via committee annual reports and therefore thought should be given as to the adequacy of frequency of updates.

Recommendation A11: The Trust should review the board work programme to ensure that it is comprehensive, aligns with meeting agendas and will enable oversight by the Board of all its responsibilities.

Other considerations

The standing orders (8.2.3) state that the Board will receive at least a quarterly report on the use of the Trust seal. In accordance with the work plan, a report will be brought as and when required. Many trusts bring a report on an annual basis.

The requirement for trusts to produce a corporate governance statement was removed in March 2023 and can therefore be removed from the Board work programme (https://www.england.nhs.uk/long-read/nhs-provider licence-consultation-response). In addition, reference to the corporate governance statement should also be removed from the Annual Governance Statement.

There is no longer a national requirement for NHS foundation trusts to obtain external auditor assurance on the quality account - NHS England » Quality accounts requirements. This can be removed from the work programme. In addition, we note that the approval of the quality account is included on the Board work programme. Many trusts delegate the responsibility for the approval of the quality account to their quality committee.

Committee governance architecture

According to the governance structure (January 2025) the following Board committees have been established:

- Audit and Risk Committee (ARC)
- Remuneration and Nomination Committee (RNC)
- Finance and Performance Committee (FPC)
- Quality of Care Committee (QCC)
- People Committee (PC)
- Charitable Funds Committee (CFC)

We have reviewed the terms of reference alongside the work programmes for each committee to ensure that they are aligned. We comment below by exception. It should be noted that whilst re state that all committee terms of reference were in draft status at the time of our review, we understand that this is due to the recent governance restructure and that Board committee terms of reference were to be finalised at the March 2025 committee meetings and approved at the April 2025 Board meeting.

Audit and Risk Committee (ARC)

The ToR largely reflect the HFMA ToR available at NHS audit committee handbook 2024 – hfma-uk.

As per the HFMA handbook, 'an 'audit and risk' committee should take a more active oversight of the system of risk management and associated assurance framework, ensuring that the system works as a whole, for example ensuring other committees provide oversight of risks'. It is positive to note that the role of the ARC specifically references both quality and clinical risk. There is some inconsistency in the ARC ToR as to the scope of the responsibility between quality/clinical and other strategic risks, for example, workforce. While the ToR states that the committee will seek assurance from *all committees* that the *quality and clinical risk elements* (our emphasis) of the Trust's BAF, risk register, risk management strategy and underpinning risk management and clinical governance processes are fully effective, it should be clear that the responsibility should extend to all strategic risks on the BAF. We have also noted inconsistencies in the ToR for QCC, F & P and PC in relation to how the reporting relationship with ARC is defined. We would recommend that the relationship with ARC and the other assurance committees is consistently defined in the ToRs and applied in practice.

The ARC ToR refers to the limited assurance report on the quality account from external audit. This is no longer required. The ToR also includes reference to the risk and control related disclosure statements for the quality report (which is no longer required) as part of the annual report.

Recommendation A12: The Trust should revise the ARC ToR to ensure comprehensive oversight of risk management across all strategic risks, not just quality/clinical, and its relationship in this respect with the other Board committees.

The work programme contains the majority of standing items that we would expect to see with some exceptions. Whilst the ToR includes the requirement 'to review the adequacy of the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements' this should also, in our view, include compliance with the NHS provider licence, code of governance for provider trusts and FPPT (see above). These items are not currently included on the work programme for the ARC.

In addition, we would expect the following reports to be included on the ARC work programme:

- An annual overview of the Trust's systems for ensuring compliance with CQC standards (as per ToR) together with associated declarations of compliance.
- Tender waivers are currently remitted to F & P. Recognising ARC's role in reviewing the maintenance of an effective system of governance, we would expect the ARC to receive the report to both challenge the justification and to seek assurances in relation to tender waivers that these are exceptions and improvements have been made to minimise instances of single tender waivers being applied.

We note that the work programme was submitted to the ARC in December 2024, for discussion. We would suggest that it is the role of the committee to approve the work programme.

Recommendation A13: The Trust should review the work programme for ARC to ensure it includes all items relevant to its ToR.

The ToR should be updated to reflect regulatory name changes as a result of the Health and Care Act 2022.

The annual report from ARC to the Board is scheduled for September and was, we understand, completed in March 2025 in line with other committee annual reports. Moving this to March each year will provide greater alignment with the production of the Annual Governance Statement as the Chief Executive will normally include a statement on their reliance on the ARC for certain matters within the statement. This is best met by the requirement for the ARC to provide an annual report, in support of the Annual Governance Statement that aligns with the committee's responsibilities and duties.

The ToR includes an invitation to the Trust Chair to attend the committee at least annually to discuss with external audit the programme for the annual external audit. Whilst it is good practice for the Chair to occasionally attend the ARC as an observer, it is unusual for the Chair to be invited to discuss the programme for the annual audit.

We note that the ARC is currently in three parts – a traditional audit committee of members and regular attenders, part 2 with internal or external auditors and part 3 with NEDs and executive directors. Whilst it is regarded as good practice for an audit committee on occasions to meet separately with representatives from internal and external audit and LCFS it is not common practice for this to feature at each meeting. Equally, whilst it would be appropriate for the committee to occasionally meet without external partners being present (to discuss performance of the audit and counter fraud providers) we would expect this to be infrequently and not each meeting. The Trust should reflect on the current meeting arrangements and ensure appropriate governance and operation of the ARC is in place. This should include ensuring that the minutes of the meeting reflect the current governance arrangement regarding the three part approach to the meeting, with formal transition (opening and closing) between each element.

Finally, we note that the Chair and Chief Executive expenses are a standard item on the work programme although the responsibility of the ARC in relation to the expenses is not defined within the ToR.

Remuneration and nomination committee (RNC)

The ToR reflects the responsibilities of a Board RNC, including reference to national guidance.

In terms of opportunities to strengthen, many trusts also include reference to the role of the committee in relation to interim appointments. The ToR state that the committee monitors the remuneration of non-clinical senior leadership roles remunerated above those specified in agenda for change (AfC). Many trusts include the responsibility for setting the remuneration policy for all senior managers not on AfC or clinical contracts.

We were not provided with the work programme for the RNC, so we are unable to comment on whether one exists and whether the programme is comprehensive and reflects all the responsibilities of the committee.

Quality of Care committee (QCC)

The ToR reflect the core responsibilities for a quality committee.

The ToR do not correctly distinguish between membership by Board members and attendance by others. A foundation trust can only delegate to a committee consisting wholly of board members unless it is a joint committee under s65Z6 of the NHS Act 2006 (as amended). The ToR should be revised to distinguish between membership by Board members and attendance by others.

Recommendation A14: The Trust should revise the QCC ToR to reflect membership by Board members and attendance by others.

The ToR include attendance by divisional directors by way of open invitation and annually as part of rotational reporting. The difference in approach between committees in terms of inviting divisional directors to attend was noted in the developmental well led review in 2022. Currently divisional directors are invited on a rotational basis to QCC and PC but not FPC. It is a matter for the Trust to determine the purpose and value added through attendance by divisional directors. We would however encourage the Trust to adopt a consistent approach across the assurance committees, whilst remaining cognisant of the role of a Board committee.

We note that the ToR of the QCC does not specifically refer to health inequalities. Whilst some trusts oversee inequalities through an over-arching programme for equality, diversity and inclusion, other trusts have separate governance arrangements for addressing inequalities. This may include the quality committee overseeing population health inequality matters whilst the people committee has responsibility for diversity, equality and inclusion from a workforce perspective. Irrespective of the agreed approach the Trust should ensure that there are appropriate arrangements in place to oversee the health inequalities objective which is one of the Trust's quality improvement priorities for 2024/25.

According to the ToR the QCC will receive assurance on the co-ordination of digital activities, although digital is not currently on the work programme for QCC. In accordance with the revised governance structure (January 2025), the digital oversight committee (executive led), which is currently 'under development' is intended to report into the FPC although digital is not included in the FPC ToR nor contained within the work programme.

Recommendation A15: The Trust should determine the arrangements for oversight of its digital arrangements and reflect within the ToR and work programme of the relevant forum(s).

Overall, the work programme includes most items that we would expect to see on a quality committee agenda with the exception of the following:

- Medicine management annual report (including accountable officer for controlled drugs report)
- Research and development (although this is sometimes discharged via a separate committee)
- CQC improvement plans. We note that delivery of maternity and medicine CQC improvement plans was one of the Trust's quality improvement priorities for 2024/25.

According to the ToR the patient safety report is considered in the closed part of the meeting. It is not clear why the QCC is held in two parts, and who is excluded from the closed part of the meeting. This is

not something that we would typically see at committee level and if required may indicate broader issues linked to membership and attendance.

In accordance with the ToR, we note that the QCC will receive an AAA report from the executive led safety and quality committee. According to the governance structure, four other groups report to the QCC (learning from patient experience group, safeguarding committee, continuous improvement and maternity and neonatal assurance group). Whilst we note that the safeguarding, patient experience and maternity and neonates provide assurance reports to the QCC it is not evident how continuous improvement reports to QCC.

Whilst it is open to the Trust to define how reporting groups operate and report to committees, the Trust should ensure that there is sufficient visibility via the AAA report from the executive led safety and quality committee to QCC. It is important that reporting provides robust assurance, including how assurance was gained supported by evidence along with identifying gaps in assurance and describing timescales for any identified actions. Inadequate reporting from sub-groups into committee will potentially leave the committee open to criticism in terms of being unsighted over key matters that it could and should have been sighted on.

According to the work programme, the QCC receives regular assurance reporting in relation to learning from mortality reviews and end of life care, it not evident how the committee receives assurance into learning opportunities more generally including from clinical incidents and how learning is disseminated as per the QCC ToR.

Recommendation A16: The Trust should update the committee work programme to ensure that it reflects all the responsibilities of the QCC.

According to the Annual Governance Statement 2023/24 the QCC has a duty to ensure that the Trust's governance systems, behaviours and processes relating to clinical risk management, clinical and *non-clinical governance* (our emphasis) are effective. It is not evident from either the ToR of the QCC or the work programme how the committee discharges the responsibility in relation to non-clinical governance, or whether this is a typographical error in the Annual Governance Statement. It would be unusual for a quality committee to have responsibility of oversight of non-clinical governance matters as this appears to stray into territory of other committee oversight responsibilities.

Finance and Performance Committee (FPC)

The ToR correctly differentiates between membership by Board members and attendance by others. We note that the Chief Medical Officer and Chief Nursing Officer are both shown as being 'in attendance' and alternate attendance but are not members. Whilst shared membership may be appropriate the Trust should consider why a board member is required to attend a committee on a rotational basis but is not regarded as a member and also the benefits and disbenefits of rotational attendance given the need for continuity and organisational memory.

Recommendation A17: The Trust should consider membership by the Chief Medical Officer and the Chief Nursing Officer and how this is reflected in the ToR alongside the benefits/disbenefits of the requirement for rotational attendance.

FPC includes within its ToR that it will receive internal audits relevant to the delivery of its strategic objective and BAF risks. This potentially contrasts with the QCC ToR which states that internal audit is the responsibility of ARC. Whilst this may be open to interpretation, we would recommend that a consistent approach to internal audits is applied across all assurance committees.

Recommendation A18: The Trust should ensure that there is a consistent approach to oversight and involvement in internal audit reports across the assurance committees.

The work programme is broadly aligned with its ToR and contains the majority of items which we would expect to see on a Finance and Performance Committee. Whilst oversight of the winter resilience plan is included in the ToR, it does not appear on the work programme.

We note from the ToR, that FPC is responsible for considering the Trust's programme of work to improve operational performance, reduce clinical variation and drive quality improvement. Whilst the cost improvement programme is included on the work programme and includes *Getting it right first time* updates, it is not clear how the responsibility of FPC for quality improvement is overseen and is aligned with the QCC and its oversight of the quality of care objective which is underpinned by a culture of continuous improvement.

Recommendation A19: The Trust should clarify responsibility for overseeing quality and continuous improvement and reflect within the appropriate committee ToRs.

According to the governance structure (January 2025), FPC has four groups (cancer board, estate strategy, capital control, commercial group) reporting to it. Whilst there are standing items in relation to the estate strategy group and capital it is not clear from the work programme how commercial activities and cancer board report into FPC.

Recommendation A20: The Trust should ensure that the work programme is comprehensive and reflects reporting from all linked sub-groups.

People Committee (PC)

The ToR reflect the responsibilities that we would expect a People Committee to discharge.

As referenced earlier the ToR do not specifically refer to the relationship with ARC.

Under the management section of the ToR, a number of working and steering groups are referenced including the equality, diversity and inclusion steering group, medical workforce strategy and scrutiny group and nursing and midwifery workforce strategy and scrutiny group. According to the ToR, these groups report to both the TEB (for management accountability) and to the PC (for assurance), the working and steering groups are not referenced within the TEB ToR nor included on the governance structure (January 2025) as reporting to TEB.

Recommendation A21: The Trust should ensure that reporting groups which report to TEB (for management accountability) and to committees (for assurance purposes) are consistently reflected in the relevant ToRs and the governance structure document.

The work programme contains many items that should be considered by a People Committee. However, when the work programme is aligned with the ToR it is not evident how reporting on the education and training, staff wellbeing and cultural/organisational development occurs. These may form part of the standing NHS people plan/workforce transformation board report. We note reference within the Annual Governance Statement 2023/24 to a staff wellbeing annual report being provided to the PC although this does not appear on the current version of the work programme.

Recommendation A22: The Trust should review the work programme to ensure that all responsibilities from the PC ToR are reported into it and on an appropriate frequency.

Other considerations – Board assurance committees

There is inconsistency between the assurance committees in terms of the frequency of the review of the BAF and the use of a scorecard to monitor progress against the strategy. According to the ToR for QCC and PC, the BAF is considered twice a year, whilst according to the work programme for FPC BAF is a standing item at every meeting. In addition, the FPC ToR refer to a scorecard which is reviewed at each meeting and reported to TEB to monitor progress of the strategy and for assurance to the board. The ToR for QCC and PC do not reference a scorecard although we would expect both committees to have some strategic oversight responsibilities. We would recommend the Trust adopts a consistent approach across the committees in terms of frequency of the review of the BAF. In addition, the Trust should review the value of the production of a scorecard and if deemed appropriate apply to all assurance committees as appropriate.

Recommendation A23: The Trust should review and standardise oversight of the BAF by the Board committees.

The Trust currently uses the term committees to apply to both board (NED chaired) committees as well as to executive chaired meetings. This can lead to confusion. Generally, good practice is to adopt a naming nomenclature which is consistent and helps to reinforce roles and responsibilities and supports clear demonstration of where the forum fits within the governance structure. See also page 37 regarding consistency of naming and a recommendation concerning having a consistent taxonomy.

Charitable Funds Committee (CFC)

The ToR broadly reflect the role of a Charitable Funds Committee. The ToR state that the committee is responsible for day to day management of the charitable funds. We would suggest that rather than responsibility for the day to day management, the committee's role is to ensure that the charitable funds are managed in accordance with Charity Commission requirements and ensuring appropriate delegated responsibility for the day to day management of designated charitable funds and the establishment of satisfactory controls and processes by which donations are facilitated and properly accounted for.

The membership consists of statutory Board members. Two governors are invited as attendees, as opposed to observers. This contrasts with other board committees where governors are invited to observe. Whilst schedule 7 NHS Act 2006 does not preclude people who are not directors attending committee meetings, the Trust may wish to reflect whether this approach is appropriate.

We note that the Trust Chair (acting) is a member of the committee. It is unusual for the Trust Chair to be a member of a board committee. We note that the fundraising policy states that membership is 3 NEDs and two executive directors.

We were not provided with a work programme for CFC although from reviewing two sample agendas the items appear appropriate.

Trust Executive Board (TEB).

The board has established the TEB as the senior executive operational forum to support the development of strategy and ensure operational oversight and decision making. The TEB ToR were approved by the Board in February 2024. Whilst a senior executive forum is widely adopted in NHS organisations, the direct establishment by the Trust Board does not, in our view, reflect good governance practice. Whilst it

is for the Board to establish committees and delegate powers to them, it is generally accepted that it rests with the Chief Executive to define the senior operational decision making forum(s) for the Trust.

We would suggest that the ToR are revised to make it clear that the remit of the TEB is a matter for the Chief Executive in accordance with their delegated powers.

Recommendation A24: The Trust should revise the ToR to ensure that the role and the responsibility of the TEB is delegated by the chief executive.

The primary responsibility for the TEB is to oversee the day to day operational and developmental decision making. It is positive to note that membership consists not only of the Chief Executive and executive directors but also divisional directors and the Director of Midwifery thus ensuring senior clinical and operational involvement.

We note from the governance structure that the Digital Oversight Committee which will report to TEB and provide assurance to FPC is 'under development'. We refer earlier in our report to the need to clarify responsibility for digital oversight and the provision of assurance to the Board, ensuring that digital receives sufficient profile and scrutiny.

The TEB ToR includes a list of groups/programmes which report to TEB via specific members but are not regarded as sub committees of TEB. The list of groups does not include all executive led meetings which are included on the governance structure (January 2025). In addition, as referenced earlier, this does not accord with the ToR for PC which states, for example, that medical workforce and nursing and midwifery workforce groups will report to TEB. This may be an issue of timing with a number of changes being progressed in relation to the Trust's governance structure. The ToR and the governance structure need to be aligned and to clarify how reporting and escalations are made to TEB.

Recommendation A25: The Trust should ensure the ToR for all committees and sub committees/reporting groups are aligned and reflected on the governance structure diagram.

The work programme is draft and includes many items that are appropriate for consideration by a senior executive decision making forum. However, what is not evident is how the items have been identified. We have read the Trust's corporate objectives for 2024/25. We note that there are 12 priorities and c40 objectives. We note that it was agreed that the objectives would be monitored at TEB. However, there is not full alignment between the corporate objectives and the work programme for TEB. For example, although continuous improvement is one of the Trust's corporate objectives it does not appear on the TEB work programme.

We note that the FPPT is included on the work programme. As referenced earlier in the report this is the responsibility of the Chair of the Trust and should be reported to the Board in part 1 and to the Council of Governors (for Chair and NEDs).

Recommendation A26: The Trust should review the TEB work programme plan to ensure that it is comprehensive and includes all priorities as agreed.

Recommendation A27: The Trust should ensure that there is an agreed understanding of items that should be escalated to TEB.

Joint Transformation Committee

In October 2024, the boards of Ashford and St Peter's Hospitals NHS Foundation Trust and the Royal Surrey NHS Foundation Trust agreed to establish a group model. The group is a collaboration between

the two Trusts, each of which will remain distinct organisations. A joint committee has been established between the Trust and RSFT with responsibility for managing the programme of collaborative work, enabling collective decision making and risk sharing.

In accordance with the ToR the Joint Transformation Committee is accountable to both Boards for its performance and effectiveness, with both Boards retaining responsibility for the strategic objectives and programmes of work of the respective trusts.

The committee Chair reports to both Boards and committee updates are included on the Board's work programme. As referenced earlier, the Trust's SoRD should be revised to include responsibilities for all the board's committees, including the Joint Transformation Committee.

Recommendation A28: The Trust should revise the SoRD to include delegation of responsibilities to all committees.

We were not provided with a work programme for the Joint Transformation Committee.

Council of Governors (CoG)

We were not provided with a ToR for the CoG but were referred to the standing orders for the CoG contained in annex 7 of the constitution. Whilst para 3.2 of the standing orders (March 2021) defines the role of the CoG, we would recommend that the Trust develops a ToR to provide clarity to the governors on their role and how this will be discharged. Model ToR are published by NHS Providers at nhsproviders.org/topics/governance/a-guide-to-good-governance-in-the-nhs/compendium.

Recommendation A29: The Trust should consider developing a ToR for CoG.

The standing orders for the CoG should be updated to reflect changes in legislation including the Health and Social Care Act 2012, the Health and Care Act 2022, as well as the *Code of governance for provider trusts* including updates to regulatory organisations.

Clarity should be provided in relation to the period of appointment for the lead governor (para 3.5). The paragraph refers to 12/24 months for appointment but does not describe the process for determining the period of appointment or any extension. This may be available elsewhere but should be referenced within the standing orders.

We would recommend that provision for urgent decisions is included in the standing orders.

Recommendation A30: The Trust should revise the standing orders for the CoG as described above.

We have reviewed the work programme for the CoG. It contains most of the agenda items which are expected although should be revised to include:

- FPPT for Chair and NEDs as referenced earlier under the FPPT section of this report.
- Trust's annual plan to provide opportunity for the CoG to feedback to the board on the annual plan in accordance with C5.15 and C5.16 NHS England » Code of governance for NHS provider trusts.

The over-riding role of the Council of Governors is to hold the NEDs 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. Trusts adopt different approaches in terms of provision of information to the CoG to enable the discharge of its role.

The CoG currently receive reports from NED committee chairs on the work of the Board's committees. This reflects good practice and should enable the holding to account of NEDs for the performance of the Board. We would recommend that this should be extended to include ARC which should provide evidence how, amongst other things, that the Trust is complying with its licence conditions. We note that digital is included as a separate item on the work programme and may, once aligned with a Board committee, form part of that committee chair's report to the CoG.

Recommendation A31: The Trust should revise the work programme for the CoG to include FPPT, the annual plan and a chair's report from ARC.

Good practice would also require the CoG to receive the quality account to both involve governors in identifying quality priorities for the Trust and using the quality account to hold to the NEDs to account for performance of the Board.

Many Chairs provide an update report to the CoG summarising key issues and providing an update on what they are doing. This is helpful both in terms of reporting to the CoG on the activities of the Chair and to provide context to governors including system working.

Governors have a duty to represent the interests of members and the public. Many trusts develop a membership strategy or plan with targeted engagement opportunities for governors, reporting on progress to the CoG.

As stated above, the work programme, subject to the addition of the FPPT and the annual plan provides a reasonable framework for the CoG to discharge their responsibilities although there are opportunities to strengthen the information provided as explained above. As part of the next evaluation of the CoG the Trust may wish to consider whether the information needs of the CoG are being effectively met.

Recommendation A32: The Trust should as part of the next evaluation of the CoG consider whether the information needs of the CoG are being met and consider opportunities to strengthen.

The term Chairman is used in the standing orders of the CoG. This should be changed to gender neutral language.

Job descriptions

We were provided with executive job descriptions, with the oldest dating back to 2018 (Chief Operating Officer and Executive Director of Strategy and Sustainability). We were also provided with a draft job description for the Chair dated January 2023 and a job description for the NEDs.

All job descriptions should be updated to reflect the NHS leadership competency framework (LCF) excepting the Chief Medical Officer and Chief Finance Officer whose job descriptions already refer to the LCF.

The principal accountabilities that would be expected within executive roles are reflected across the entirety of executive job descriptions with the exception of an identified lead executive for health and safety. Whilst responsibility for health and safety is delegated to the Chief Finance Officer as per the SoRD, we would expect this to be specifically referenced within the job description and not just implied as part of their responsibility for estates and facilities.

The Chair's job description should be revised to reflect that the Chair is responsible to NHS England and the Council of Governors, and not the Chief Executive. In addition, the Chair's responsibility for overseeing the FPPT framework for all Board members should be included.

The Group Chief Executive's job description still refers to NHS Executive controls assurance programme. We would recommend that this is updated to refer to current guidance on systems of internal control including the accounting officer memorandum.

Job descriptions should be updated to reflect changes to regulator names.

Key policy documents

The freedom to speak up policy is dated November 2023. It fully reflects the national NHS policy and includes Trust specific details as required and therefore reflects good practice.

The managing conflicts of interest policy is dated December 2024 and reflects national guidance, although the links within the policy document should be updated to include the guidance published by NHS England in September 2024 to take account of changes introduced by the Health and Care Act 2022. Subject to this change the policy will reflect nationally prescribed good practice.

The declaration of interests by Board members are included on the board work programme every 6 months and are published on the Trust website Board Register of Interests (Feb 2025), reflecting good practice.

In accordance with the Trust policy, annual declarations should be made by decision making staff and submitted to TEB annually and also published on the Trust website. The register of interests was included on the TEB work programme for 2024 but with no date included. It is currently listed for May 2025. The gifts and hospitality register available on the Trust website is out of date with the latest entries dated 2018/2019 Gifts and Hospitality Register.

According to the Trust's policy, the strategic decision-making groups are:

- Trust board,
- FPC,
- TEB,
- Capital Control Group,
- Commercial Group and
- Drugs and Therapeutic Committee.

According to the SoRD, capital investment up to £600k must be approved by Capital Control Group, ISSG (not defined in the abbreviations) or the Medical Equipment Group. Neither the ISSG nor the Medical Equipment Group are referenced in the *Managing conflicts of interest policy.*

Recommendation A33: The Trust should review the *Managing conflicts of interest policy* and the SoRD to ensure that all decision making groups are appropriately reflected in the governance documents and are aligned.

Risk management framework

The Trust's risk management framework consists of a risk management strategy 2021 – 2024 and risk policy (March 2024). The risk strategy includes a risk management vision and key performance indicators. The risk policy includes a methodology for describing and managing risk. Both reflect areas of good practice.

There is some duplication between the documentation, and we would suggest that the strategy should reflect the underpinning principles for risk as well as the risk appetite, attitudes and philosophy with the policy containing the roles, responsibilities and processes for managing risk.

We understand that the risk management strategy 2021-24 is due to be reviewed and we would recommend that the areas of duplication are removed.

Recommendation A34: The Trust should update the risk management strategy and policy and remove any areas of duplication.

The Risk Scrutiny (sub) Committee (RSC) has oversight of the Trust's risk registers at divisional and corporate level ensuring cross divisional risks are escalated and triangulated as well as undertaking risk deep dives. The RSC makes recommendations on the BAF, and the corporate risk register to the ARC. Having a senior executive led forum overseeing operational risk is good practice.

Integrated governance, performance and accountability framework (IGPAF)

The IGPAF is currently under development. The development of an integrated framework is regarded as good practice. It is positive to note that it includes meetings from divisional boards through to Trust Board. It is important that it accurately reflects roles, responsibilities, systems and processes and is aligned with the regulatory framework and other Trust documents. There are some inconsistencies within the current draft which should be addressed prior to finalisation. For example, in 6.1.2, the draft document currently states that the Board holds the Chief Executive and *the TEB* (our emphasis) to account for delivery of the strategy, whilst later in the same paragraph the document states that the Board holds the executive team accountable for performance. We reference elsewhere within our report that the TEB includes senior clinical and operational management members and therefore it may be inappropriate for the Board to hold the TEB to account given that a number of members are not executives.

As referenced earlier, clarity is also required in relation to escalation of risks and issues between the various forums.

Recommendation A35: The Trust should continue to develop the IGPAF ensuring clarity of roles and responsibilities including the recommendations as set out within this report. The Trust should also better define escalation of risk and issues between the different forums.

References

HFMA (2024) NHS audit committee handbook | HFMA

NHS England (2024) » Managing conflicts of interest in the NHS: guidance for staff and organisations

NHS England (2023) » Code of governance for NHS provider trusts

NHS England (2024) » The insightful provider board

NHS England (2013) Governors_guide_August_2013_UPDATED_NOV_13.pdf

NHS England (2022) » Addendum to your statutory duties – reference guide for NHS foundation trust governors

NHS England (2024) » Violence prevention and reduction standard.

NHS England (2018) Developing-workforce-safeguards.pdf. One of the requirements is for the board to approve a workforce plan in part 1 board meeting.

NHS England (2022) Greener NHS » Organisations.

NHS England (2023) https://www.england.nhs.uk/wp-content/uploads/2023/05/Premises-Assurance-Model-NHS-PAM-2023.pdf.

NHS England (2019) board oversight of disciplinary cases Letter template.

NHS England (2023) » Quality accounts requirements

NHS Providers terms of reference available at Compendium - NHS Providers

Detailed findings - Part B: Divisional level governance arrangements

Background

During Q4 2021/22, the Trust commissioned an external governance review by Deloitte in accordance with NHSE/I guidance. Deloitte's final report was approved and issued in May 2022 and identified several recommendations, including enhancements in governance arrangements at divisional level.

Further to this, a presentation was shared at TEB in May 2024 outlining aspirations and proposed changes to the Trust's governance structure, including:

- Standardising divisional boards & Executive Divisional Reviews (EDRs)
- Development of templates, terms of reference and reporting lines to aid consistency of approach
- Agreement to the scope of developmental work required to support and embed divisional boards
- Timescales for implementation
- Proposal to discuss the proposed changes at Senior Leadership Forum to support wider engagement and buy-in

We noted that a further presentation at TEB in August 2024, reinforced the need to standardise divisional boards (with template Terms of Reference being drafted), as well as a recommendation to hold a meeting 'amnesty' following the completion of a meeting mapping exercise. We were informed that due to competing priorities regarding the forthcoming group model and probable associated revisions to aspects of Trust governance, the resource to support the strengthening of the divisional governance arrangements was diverted. However, we understand that the template Terms of Reference was circulated to divisions to adopt. Resultingly, the need to fully implement the Deloitte recommendation and attain a consistent and standardised approach to divisional governance arrangements remains.

We were asked as part of this review to review existing divisional level governance practice and see how this aligns in terms of consistency of approach and good practice principles.

Scope of inclusion

Recognising the work that has previously commenced in terms of attempting increase standardisation of governance arrangements across divisions we were asked to understand the current arrangements, identify good and inconsistent practice and recommend improvements to align with good practice.

The scope as agreed, was for the review to encompass both corporate (business) and quality governance structures and processes.

Approach

As part of the agreed scope, we reviewed all six divisions and sample tested speciality level arrangements particularly in relation to clinical governance.

Our review considered both corporate and clinical governance aspects of divisional arrangements, recognising that these operate separate, but alongside each other in the main. We do, however, recognise that divisional management board (DMB) meetings need to be overseeing and assuring themselves over the full range of quality, operational, workforce and financial considerations and we sought to understand where and how clinical and corporate governance came together in order to provide this holistic overview of performance.

Our approach across all divisions was to review relevant documentation relating to divisional governance arrangements covering the preceding six months (broadly July 2024 – December 2024), meeting with each divisional leadership team and observation of one each of their divisional management board (or equivalent) meetings. Where separate quality governance arrangements exist, we also observed one each of their divisional level meetings. In addition, we sampled a number of service/specialty level quality governance meetings in order to gain an understanding of how these also operate in addition to the supplied documentation.

Overview of findings

Divisional governance arrangements

Summary overview of Divisional Management Board meeting governance arrangements

Key: Substantial assurance | Reasonable assurance | Needs improvement | Limited assurance | No assurance

Division	DMB ToR	Information shared in advance	Meeting frequency	Meeting formality	Agenda	Information	Discussions	Attendance	Escalation	Link to Corporate body
GASCT	Not Trust template version	Shared >5 wd	monthly	Welcoming, structured, information aligned to agenda. Atts given opportunity to present/brief	ToR shared in pack but not on the agenda for discussion / approval.	£ - high level 1 page, HR high level KPIs, no Op Perf data shared, some quality metrics but poor format, adequate risk info	Opportunity for updates/escalations. Lack of mitigating actions for underachieving areas	All clinical Services represented and FBP and HRBP in attendance.	Lack of overall summary and identification of matters to escalate to TEB / other routes.	Acknowledgement that Datix is a focus of the Executive Team. No other identifiable obvious links.
UEC	Trust template	Shared >5 wd	monthly	Some confusion why some papers presented and some logistics issues in absence of administrator	Agenda including digital and strategy updates as well as service updates	£ - no Div wide update, HR - high level KPIs, service level Op Perf and quality data, risk headlines	Service representatives presented current positions with some mitigating actions	No MH representative, no FBP in attendance therefore finance report not discussed.	Lack of overall summary and identification of matters to escalate to TEB / other routes.	DD articulated connection to TEB and other relevant discussions impacting division
DTC	None provided	not circulated in advance	monthly	welcoming, structured, information aligned to agenda. Atts given opportunity to present/brief	Agenda covered. Trust wide and divisional updates via AoB	£ - 1 slide o/view, HR - summary narrative BPs, no Op Perf, limited quality metrics with poor formatting, adequate risk reporting.	Quality update provided. Speciality verbal updates not aligned with papers. Lack of mitigating actions for underachieving areas.	Most clinical Services represented. FBP and HRBP in attendance.	Evidence of escalation via Risk Deep Dive review	Trust wide and relevant corporate updates provided via AOB as well as reference to Trust financial position, and CIP target.
GSM	None provided	Shared 2 wd	Bi-monthly	Semi structured - some items on agenda not discussed and other (new) items included for discussion. Atts sought feedback where necessary.	Trust relevant updates provided. despite 'regular reports' included on agenda little update provided (apart	No £ update,very limited HR data, no Op Perf, no quality, no risk	No updates from services provided. No mitigating actions for underperforming area (HR update only given)	No FBP or HRBP in attendance	Lack of overall summary and identification of matters to escalate to TEB / other routes.	Trust wide and relevant corporate updates provided and linkage to discussions referenced at TEB
iMSK Board	None provided	Shared 3 wd	monthly - last convened Nov 2024	Generally positive collegiate atmosphere, sense of being "out of practice" as previous meeting Nov 2024	No items for ratification, no finance/workforce update on agenda, no link to wider Trust	No £ update,very limited HR data, waiting times info shared, no quality, no risk	Discussion limited by poor attendance and narrative-based updates/reports. No quality matters discussed.	Last 2 meetings cancelled owing to poor attendance. Limited clinical representation. Unclear quoracy.	Lack of overall summary and identification of matters to escalate to TEB / other routes.	Acknowledgement of £13M pay issue across organisation.

SSM	None provided	Shared 2 wd	monthly - last convened Aug 2024	A collegiate atmosphere, sense of "finding their feet" due to last meeting Aug 2024. Flexed agenda to accomodate atts	Operational updates brief and without supporting data. No risk or matters for escalation. Sevice development updates were	adequate £ and HR perf update, no Op perf, some quality metrics, no risk report.	Discussion limited by poor attendance and narrative-based updates/reports.	Not met since Aug 2024 due to poor attendance. Most services represented, poor clinical attendance, FBP and HRBP in attendance.	Lack of overall summary and identification of matters to escalate to TEB / other routes.	Acknowledgement of £13M pay issue across organisation.
WHP	Approved Nov 2023 (review date Nov 2024) - Trust template version.	Shared c2 weeks.	monthly	Lacked formality and no agreed presentation order for service updates	Agenda items not explicitly talked to - covered via service and divsional updates	No £ or HR perf update,OP Perf and Quality shared but not discussed, adequate risk reporting.	Speciality 'one page' highlights. Limited focus on actions, assurance, triangulation, or risk detail. Service score cards circulated in advance but not referred to.	Divisional Director not in attendance until towards end of meeting (Director of Midwifery chaired in absence). No FBP or HRBP in attendance.	Meeting sumnmarisation but lack of clarity of escalations.	Trust update and implications for WHP included on agenda

In our view, the primary aim of a divisional management board should be to seek assurance with regards to the effective delivery of the division's business and objectives, including the delivery of safe care. This should include, in addition to quality related matters, operational performance and efficiencies, financial resilience, workforce sustainability, risk management and transformation as well as consideration of estates matters and digital advancements. To be effective, divisional oversight must also include connection with the wider corporate body in terms of strategic direction and escalation.

Despite the prior request for divisions to implement a Trust agreed standardised approach to governance we observed that some divisions have adopted differing approaches in terms of nomenclature as well as adopting local, non-Trust standard, agendas. In addition, we noted that the Specialist Surgery and MSK Division stood down their divisional board arrangements in late 2024 (due to poor attendance) and re-established separate corporate and clinical governance oversight meetings in the new year which disaggregates the ability of divisional management to form a holistic view of performance.

In the absence of reinforced central direction or expectations, divisions have locally determined their governance oversight arrangements which in some cases appears to be leading to duplication of reporting/escalation as well as effort. This includes both SSM and IMSK who have separated out their corporate and clinical governance arrangements whereby it is recommended that these are amalgamated back together to form an overarching divisional management board and reinforce the need for clinical representation and attendance at meetings.

Recommendation B1: The Trust should revisit the rationale for implementing a consistent approach to divisional governance arrangements and reinvigorate a programme of implementation including communication and training to support reinforcement of the rationale and desired outcomes.

As part of the consideration of standardisation, thought should be given to the following aspects:

- Standard terms of reference format and content insofar as is appropriate. This should include ‘minimum’ Trust wide requirements in relation to meeting duties whilst also allowing an element of local determination in addition to Trust wide expectations.
- The terms of reference should be strengthened with greater emphasis on ensuring each division seeks triangulated assurance of operational, quality, financial and workforce performance including mitigations and recovery plans where performance is off trajectory and risk management. In addition, regular and ongoing CQC readiness reporting includes oversight of CQC

mandated improvement plans.

- Standard agendas in terms of format, minimum coverage and standard opening and closing meeting administration expectations.
- Mandated attendance expectations including non-clinical business partners (or representatives in their absence).
- Having a nominated chair which is consistently applied as opposed to alternate or rotating chairs.
- Clear and consistent quoracy requirements, including minimum attendance expectations throughout the year, which should be monitored and reported as part of the annual review of meeting effectiveness.
- Increased standardisation of standing agenda items wherever possible to support 'do minimum' information requirements including financial and workforce reporting along with operational performance and quality scorecards and exception reporting from each division's quality governance meeting. Possible standardised template agenda has been included as **Appendix 2.**
- Reinforcement of good practice and expectations that meeting documentation should be circulated at least 5 working days in advance of the meeting with attendees ensuring that they are well prepared for the meeting having read the papers in advance of the meeting.
- Reporting requirements should also be reviewed with a view to the Trust setting minimum expectations in relation to both format and content across all domains including workforce, quality, operation, financial and risk areas. Consideration should also be given to how triangulation of data can be enhanced to support more informed and rounded discussions.
- Terms of reference should refer to, and standardised agendas should support, an annual review of the terms of reference and meeting effectiveness against the terms of reference as part of the meetings' cycle of business. The meeting effectiveness reports should be discussed at divisional management boards and also reported into TEB.
- Each divisional management board terms of reference should be supported by an agreed cycle of business which is reviewed each year. This cycle of business should explicitly align with each board's duties and ensure an appropriate frequency of oversight across each duty (not necessarily monthly).
- The terms of reference should also set out any regular reporting from sub-groups established under each divisional management board and how escalation of risks and significant matters occurs between sub-groups and divisional management boards and onward into TEB or other relevant forum.
- The terms of reference should also set out the processes to support cross-divisional learning and how this should occur as part of the forum's duties.

We noted an inconsistent approach to reporting across all domains including financial, workforce, operational performance and quality and consequent impact on the scrutiny and discussions within DMBs. This extended to expectations regarding attendance of Finance and HR Business Partners at DMB meetings. Given current workforce and financial challenges both of which are inextricably linked to the delivery of high quality, and safe services thought should be given to whether further benefits can be derived from introducing consistent and strengthened reporting arrangements as well as reviewing the adequacy of resource distribution which supports divisional leadership.

Recommendation B2: The Trust should consider reviewing the approach to divisional reporting and support in regard to centralised support functions supporting divisional leadership.

Beyond the above overarching view of divisional governance, we have set out within **Appendix 3** our detailed findings by division.

Divisional level quality governance arrangements

Summary overview of Divisional quality governance arrangements

Key: Substantial assurance | Reasonable assurance | Needs improvement | Limited assurance | No assurance

Division	Governance Structure	Specialty-Level Governance	QI & Learning	Data & BI Support	Risk Management	Escalation & Communication
DTC	G - Stable structure with clear accountability and regular meetings.	A - Variable quality of governance across specialties.	G - Improvement huddles embedded and adopted Trust-wide.	A - Access to real-time data limited, relies on requests.	AG - Proactive risk management with regular scrutiny.	G - Multiple formal and informal escalation routes used effectively.
GS-ACT	AG - Stable but with some gaps in specialty reporting.	A - Inconsistent specialty engagement in governance.	G - Ad-hoc QI efforts, limited systematic learning.	AR - Reasonable access but lacks systematic interpretation.	A - Daily Datix reviews effective, formal risk scrutiny in place.	A - Duplication across meetings reduces efficiency.
GSM	A - Fragmented links between governance forums and DMB.	R - Limited specialty representation at key meetings.	A - Some structured learning but variable between specialties.	R - Overloaded data provision without useful analysis.	A - Inconsistent oversight and incomplete risk registers.	A - Unclear escalation and communication pathways.
SSMiMSK	A - Inconsistent specialty input, Orthopaedics stronger than others.	AR - Patchy specialty input, strong in Orthopaedics.	A - Limited cross-divisional learning beyond local specialty meetings.	R - Corporate BI capacity limited, delays in data provision.	AR - Duplication across meetings and inconsistent specialty input.	A - Professional lines used inconsistently for escalation.
Specialist Surgery	A - Underdeveloped governance with limited engagement.	R - Low incident reporting suggests weak specialty governance.	A - Limited formal learning forums.	R - Data access insufficient for specialty needs.	A - Underreporting of incidents, needs strengthening.	A - Weak escalation routes, lacking clarity.
UEC	G - Well-established structure with embedded daily huddles.	AG - Good specialty-led forums with active consultant involvement.	G - Active improvement huddles with multidisciplinary input.	A - Good real-time data and dashboard access.	A - Regular risk meetings and active review of Datix incidents.	G - Strong daily huddles and feedback loops.
WHP	A - New team still embedding governance arrangements.	R - Gynaecology lacks formal governance oversight.	A - Maternity leads on QI, other services less engaged.	R - BI support good for Maternity, less so elsewhere.	A - Risk quality variable across services.	AR - Fragmented communication across teams.

Whilst we have noted that divisional management board meetings should incorporate quality governance related matters as part of the overarching role and responsibility of divisional management, we would support the viewpoint that given the volume and scope of clinical matters, and the desirability of inviting a wide spectrum of clinical colleagues, that all divisions hold separate divisional quality governance meetings but that these are formed as a formal sub-group of divisional management boards and report in to them. Currently there is a mixed economy of some divisions having separate quality governance meetings and some not. Equally, where these do occur, some routinely report into divisional management board as part of a holistic approach whilst some don't. As examples, WHP currently have a separate quality governance meeting whereas UEC do not. In addition, we note that whilst GSM do hold a separate quality governance meeting, this does not routinely report into DMB.

Recommendation B3: The Trust should consider introducing a requirement for each divisional management board to have a divisional quality governance sub-group that reports into it and include Trust-wide expectations regarding duties, membership, attendance and reporting.

The divisional quality governance meetings should have a broader range of metrics and greater detail than the quality scorecards currently included in the divisional management scorecard and be supported in producing these by business intelligence. As part of this, the divisional quality governance meetings should receive reports by exception from all specialties where performance is off track and conduct deep dives, led by their clinical lead/director, into each specialty on a rotational basis. In keeping with the divisional management board meetings, divisional quality governance meetings would also benefit from having Trust-wide standardised agendas and terms of reference picking up on many of the good practice principles referenced above.

Recommendation B4: The Trust should consider the 'do minimum' information/reporting requirements for divisional quality governance meetings and issue a template terms of reference incorporating Trust-wide minimum requirements in keeping with the good practice outlined within the divisional management board terms of reference.

Attendance, particularly from clinical staff, was poor at most of the clinical governance meetings we observed, be they specialty or divisional level with meetings either proceeding without being quorate or being cancelled, sometimes repeatedly. Operational pressures should not absolve clinical staff from

maintaining the requirements of their professional registration and revalidation. We recommend that expectations in this regard are made clear from the professional leads within the organisation. For doctors, who had the lowest representation overall, these expectations would typically be agreed through job planning and core SPA allocation. Minimum annual attendance thresholds should be set for specialty quality governance meetings and for those required to attend divisional quality governance meetings.

Recommendation B5: The Trust should consider setting out minimum attendance expectations and how it will monitor, report and reinforce the importance of attendance at such meetings.

Except for the GSM quality governance meeting, there was a lack of recognition and alignment across divisions with corporate quality priorities. Alignment could be improved by explicit reference to the Trust annual quality priorities (reflected in the annual Quality Report) and PSIRP priorities with divisional agendas.

Recommendation B6: The Trust should consider ways in which it can improve alignment and focus of divisional quality governance meetings with Trust-wide priorities and improvement plans in addition to any 'do minimum' bottom up requirements.

All Divisions recognise PDSA cycles as the Trust-wide QI methodology. Improvement huddles and divisional QI projects are widespread, with what was described generally as good engagement from divisional clinical staff. We were told that there is a mix of staff-generated, and Trust directed projects.

However, whilst QI enthusiasm exists, structured oversight and central support from the Trust's QI team is described as being stretched. Given the required level of future transformation and service improvement to support Trust sustainability there may be a need to strengthen mechanisms to balance enthusiast-generated and Trust-required, larger scale QI projects that support the Trust's clinical priorities and PSIRP. Additionally, we heard that currently it was difficult to measure the impact of improvement schemes with a consequent need to also strengthen this area.

We found widespread evidence of inconsistent or in some instances absent Trust-wide learning. While some structured forums exist e.g., QASH, broader knowledge-sharing remains ad hoc although we heard that PSIRF has encouraged greater ownership and co-operation in incident investigation across divisions as has the introduction of 'learning events'. However, there appears to be opportunities to further strengthen Trust-wide learning.

Recommendation B7: The Trust should consider ways in which it can strengthen the sharing of best practice and learning across divisions to further promote continuous improvement.

The Patient Safety Incident Response Framework (PSIRF) is a key element in strengthening patient safety and governance within the organisation. PSIRF is recognised as a revolutionary shift in incident management and one which encourages a system-wide learning approach. Divisions have embedded PSIRF to varying degrees, with maternity services in particular standing out in terms of understanding and maturity of approach. Other services across divisions appear to be in variable states of implementation and maturity. We heard that challenges exist in staff engagement and training uptake, in part owing to the lengthy training requirements.

Recommendation B8: The Trust should consider ways in which it can refresh PSIRF implementation and training by addressing training gaps and strengthen a consistent Trust-wide rollout of PSIRF. This may include the provision of targeted training to enhance staff understanding and engagement with the

framework to ensure that staff are aware of, aligned to and report against PSIRP identified Trust-wide priorities.

Several divisions described a significant deterioration in performance in regard to closing complaints since the introduction of a change in executive sign off process. If this is the case, which it appears to be from our limited review of DMB documentation, the Trust should review the revised complaint sign-off process with a view to reducing bottlenecks while maintaining quality and improving performance against the Trust target.

Recommendation B9: The Trust should review the revised complaint sign-off process with a view to reducing bottlenecks while maintaining quality and improving performance against the Trust target.

As part of our review of divisional quality governance arrangements we noted the following elements of good practice:

- **Governance Structures:** All divisions have formal governance structures. DTC, GSM, and UEC show consistent use of escalation routes (Safety & Quality Committees, Trust Board).
- **Risk & Incident Management:** Divisions including GSM, UEC, and DTC conduct regular risk reviews and incident meetings (daily/weekly in some cases). Several divisions are embedding PSIRF or equivalent frameworks.
- **Patient Safety:** Reduction of serious incidents and improved incident reporting in some areas (e.g., falls, pressure ulcers in iMSK). Specific improvements include MRSA outbreak control (WHP) and mental health patient management (GSM).
- **Performance Improvements:** RTT and waiting times are reducing in several divisions (iMSK, Specialist Surgery, WHP). Investment in pathway redesign and theatre capacity noted.
- **QI Culture:** Active QI structures noted in UEC, GSM, and DTC, supported by PDSA cycles and improvement huddles. We understand that DTC's improvement huddles are being adopted Trust-wide.
- **Communication:** Nursing communication tends to be structured and effective. Several divisions are using improvement newsletters, forums, or learning huddles to disseminate learning e.g., GSM, DTC, WHP.
- **Leadership Stability:** Divisions such as GSM and DTC benefit from stable and cohesive triumvirates, with apparent good working relationships identified.

In addition, we noted areas for improvement in relation to divisional quality governance:

- **Governance Reporting:** Inconsistent or unclear governance reporting routes in GSM, GS-ACT, and SSMiMSK. Multiple divisions report duplication of reporting e.g., WHP, GSM or are missing formal links to their respective divisional management board.
- **Risk Management:** Risks do not appear to be appropriately and/or routinely escalated or recorded e.g., GSM, WHP, with some risk registers appearing out-of-date or incomplete. Risk deep dives were viewed by the divisions as inconsistent or bureaucratic e.g., SSMiMSK, WHP.
- **Complaints Handling:** We noted severe delays across divisions e.g., iMSK drop from 91% to 9% closure rate, GSM consistently reporting at 20%. New Trust-level processes were cited as contributing to the backlog.
- **Performance Reporting:** Poor data interpretation was noted across divisions e.g., GSM, GS-ACT, SSMiMSK) with business intelligence teams providing raw data but limited analysis.
- **Cross-Divisional Learning:** Largely informal or missing across all divisions with a lack of formal processes in place.
- **Clinical Engagement:** Limited clinical representation in key governance forums e.g., GSM, WHP including specialties missing from meetings leading to non-discussions and missed opportunities for oversight e.g., Specialist Surgery and WHP.

- **Policy Governance:** Trust intranet and policy navigation was reported by the divisions as being difficult to navigate. Some divisions referenced outdated policies and inconsistent cascade to frontline teams.
- **IT & Systems:** Multiple divisions reported to us persistent Cerner challenges, including training gaps and functionality limitations. We have not tested or triangulated this feedback but included for completeness.

Beyond the above overarching view of quality governance, we have set out within **Appendix 3** our detailed findings by division.

Specialty level quality governance arrangements

A limited sample basis examination of speciality quality governance was conducted, including a sample of specialty governance meeting agendas and minutes uploaded and attendance at four specialty quality governance meetings. Even from this limited sample, it is clear that there is variation in how specialties manage their quality governance.

Of the observed speciality level meetings, some were combined with business meetings and some are separate. As with divisional level meetings there were inconsistencies with nomenclature with some naming conventions difficult to understand. For example, the Acute Medicine Business Meeting also covers clinical governance matters.

All meetings show a shared commitment to patient safety and governance with evidence of active incident discussions. We also noted a willingness to improve, which is a positive platform to build upon. However, poor documentation, time management, inconsistent escalation of risks, a backlog of complaints and variable clinical representation appear widespread.

To help combat this and support improved specialty governance arrangements we would recommend setting out standardised agenda and terms of reference incorporating Trust-wide ‘do minimum’ expectations which allow for some additional local flexibility as required for all specialty governance meetings. In addition, there needs to be clear reporting by exception into divisional management board meetings.

In examining whether a so-called 'golden thread' is in place between wards and Board, we acknowledge that our examination of those connections at corporate level is limited by the scope of this review and to the corporate papers available to us. We did have access to the terms of reference for the Quality of Care Committee and noted that divisional chief nurses and ADO's can be co-opted to the meeting whilst divisional directors have an open invitation but are only required to attend annually when presenting their divisional report, which appears to be a weakness.

We also note that the divisions report in turn to the Quality of Care Committee which results in each division submitting a report annually. Although the dashboards presented at Quality of Care Committee helpfully contain the same domains for each division, which aids comparison, we noted that these same domains are not consistently reflected in divisional dashboards thereby appearing to disconnect the ‘golden thread’.

In common with our comments in relation to corporate governance arrangements at divisional level, we experienced difficulty in establishing the escalation reporting routes for quality governance matters from divisional level upwards into the Trust. We were not provided with a structure diagram that shows how quality assurance flows through the Trust beyond the roadmap of the quality directorate meetings which does not indicate how or where the divisions fit in. When seeking this information from the triumvirates

there was a lack of clarity and understanding of the arrangements overall with apparent multiple reporting routes and duplication with the same papers going to multiple committees.

Similar to our approach at divisional quality governance level, we have set out below existing strengths and areas for improvement in relation to specialty level quality governance.

Strengths

- **Risks** such as hidden follow-ups (iMSK, GSM) and colorectal cancer pathway concerns (Colorectal Surgery) were openly identified and discussed, showing a proactive approach.
- Evidence of **Quality Improvement** included a notable reduction in falls and pressure ulcers (iMSK), and improvements in safeguarding training compliance (GSM) indicate effective improvement work.
- **Collegial and supportive cultures** were noted (e.g., TADS and iMSK), with some services showing increased staff collaboration and ownership of patient safety.

Areas for improvement

- Several divisions (iMSK, GSM) have **significant complaint backlogs** and low complaint closure rates, partly due to clinician responsiveness and (we were informed) new corporate processes.
- **Risk registers** often lack scoring (Colorectal, TADS) or fail to include known risks discussed at meetings (GSM, TADS), undermining prioritisation and escalation.
- Several meetings (e.g., GSM, TADS) lacked **adequate representation** from clinical directors or senior specialty leads, limiting the quality of clinical challenge.
- **Patient feedback and staff experience** data were often presented but not sufficiently discussed or actioned across multiple meetings.
- In terms of **meeting administration**, we noted delays, poor documentation, incorrect agendas, and lack of pre-circulated papers were frequent issues, limiting meeting effectiveness (Colorectal, TADS, GSM).

Recommendation B10: The Trust should consider divisional directors attendance (not as members) at Quality of Care Committee meetings to increase clinical leadership representation or ways in which the Trust can increase engagement with senior clinicians e.g. increased frequency of divisional reporting.

Recommendation B11: The Trust should consider developing a clear 'wiring diagram' that maps governance reporting pathways from 'ward to Board'. This should help address existing duplication of reporting routes as well as ensure that there are no gaps in assurance flows.

Other divisional observations

In the beginning of the review, requested information was not readily forthcoming with the need for repeated requests and escalations to be made e.g., the quality reporting structure within and upwards from divisions. For any external reviewer, the efficiency of release and completeness of evidence provided creates an impression of the Trust. Equally, regulators/external reviewers will take evidence and reports at face value – if information is incomplete or minutes do not evidence challenge and scrutiny, we cannot assume that it occurred, even if the organisation believes a robust discussion was had at the time. Consideration should be given by the Trust in relation to the preparedness for external reviews, including communicating the presence and importance of these to support timely submission of information.

We witnessed inconsistent filepath naming standards across divisions, making it challenging to identify files saved. Equally, some meeting paperwork was inconsistently structured and collated. Good governance would be to ensure that meeting documents are separate standalone documents (with

naming conventions that correlate to the respective agenda items) to ensure that these can be provided to a range of stakeholders (including the CQC) upon request.

During our review, two of the six DMBs (UEC and WHP) were rescheduled due to the unavailability of staff. Diary conflicts and competing priorities will inevitably occur; however, this must be balanced against the need for timely oversight of assurances and the need for deputies to attend and be able to deputise where appropriate. We also noted elsewhere in the report that two divisions (IMSK and SSM) stood down their divisional management boards for some time in late 2024 due to poor attendance.

Recommendation B12: The Trust should ensure clear communications throughout the organisation ahead of future external reviews including designated contact points and having a central repository of structures, personnel and information.

Recommendation B13: The Trust should reinforce the importance of report/evidence completeness to evidence challenge, scrutiny, decisive actions and ultimately assurance within the minutes and documentation.

Recommendation B14: The Trust may wish to consider (or reiterate if applicable) file saving conventions across the Trust in accordance with its record management policy(ies). It may also wish to consider and implement meeting standards practice ensuring all meeting paperwork is filed separately and can be readily retrievable and accessible including ensuring legacy actions can be easily monitored.

It is acknowledged that the Trust is on a data maturity journey, and divisions report being well supported by performance colleagues to obtain reports and data, with ready access to divisional relevant information. We were informed that some divisions have taken the decision to appoint their own dedicated performance resources with it being clear that divisions appear generally competent in the understanding of the current issues within their immediate oversight enabling them to brief colleagues on current matters. However, within divisions we evidenced limited evidence of a triangulated and integrated approach to performance management. Information was largely presented in silos with limited connection being made between workforce data, financial impact, operational activity performance and quality of care. In many cases target information was absent from reports, information was presented as 'point in time' current month only with limited trend analysis and evidence of forward trajectories, with a lack of narrative setting out mitigating actions, timelines and ownership. Overall, across all divisions there was a consistent lack of articulation of the 'so what?' when issues were highlighted which led to discursive narrative based discussions which generally failed to focus on SMART management actions and accountability.

Recommendation B15: The Trust should consider its approach to data analysis and interpretation at divisional level and below including the potential use of SPC to aid improved focus on trends and identification of the need for management actions. Report formatting should encourage and support presentation of the 'what', the 'so what' and the 'what next' to improve focus on SMART actions i.e., specific, measurable, accountability, realistic and timelines.

In common with many Trusts, the Trust has a significant financial sustainability challenge. As such it will be necessary to ensure that divisions have the right support and tools to ensure appropriate financial oversight and risk management, including regular reporting and focused discussions at their divisional management board meetings and at specialty level. We noted variable focus on finance at divisional level and particularly limited focus on cost efficiencies in the evidence we reviewed and the meetings we observed. In particular we noted that CIP information was not presented alongside the overall divisional financial performance.

We noted that, also in common with many Trusts, the Trust has a significant pay related cost pressure which several divisions did reference within their divisional management board meetings. However, there was a lack of detail including workforce detail to describe the details of this and help focus discussions. Some central actions were acknowledged including the introduction of vacancy control panels and divisional director sign-off of bank and agency shifts but there was a lack of local ownership of the issue and understanding of the divisional detail and how local management can and should also be managing the issue.

Recommendation B16: The Trust should consider developing Trust-wide minimum expectations in relation to financial reporting at divisional and specialty level to encourage greater understanding, local ownership and accountability over financial sustainability.

Operational performance information at divisional and specialty level was inconsistently presented and in some cases absent altogether. There appeared to be a reliance on oversight of performance via the separately held monthly Trust Performance Meetings (TPM). TPMs are coordinated by the Director of Performance (DoP) and attended by the COO, DoP and Associate Director of Operations. National and local operational metrics and other pertinent matters such as national and regional COO briefings are regularly discussed. There was evidence of performance charts being used to track actuals 'vs' target but due to the lack of minutes associated with the meeting it was unclear what assurance is taken regarding mitigating actions to ensure performance hits trajectory. We did however evidence prompt turnaround from actions following the meetings with clear asks of officers contained within the body of emails. However, legacy open actions from previous meetings and confirmation of progress/closure was less evident.

Recommendation B17: The trust should set out its expectations regarding oversight of operational performance at divisional management boards and at specialty level to increase local accountability.

Of a more minor, but no less important matter, there was evidence of inconsistency of minute taking across divisions and within the provided service line documentation, with some divisions providing structured and detailed minutes, and others providing more informal notes. The presentational style and professionalism of minuted evidence was also variable and included the lack of identification of chairmanship of meetings. It was also challenging to identify actions and resolutions clearly.

Recommendation B18: The Trust should consider training and/or educating divisional level minuted takers to improve the standard of minute taking, and general meeting administration practice (including agendas and action trackers), across divisions and within service lines.

We noted a number of documents that were out of date, with some referencing Clinical Commissioning Groups and previous divisional naming conventions (e.g. TASCC - Theatre, Anaesthetic, Surgery and Critical Care Division).

Recommendation B19: The Trust should develop or reinforce its existing records management policy including arrangements relating to the need for regular reviews to ensure not only that naming conventions are correct but more critically that documents reflect contemporary regulation, practice and requirements.

Trust-wide observations and opportunities for improvement

Strategy

Divisions reported being engaged in the recent development of the Clinical Strategy and of having positive connections with the newly appointed Chief Medical Officer. However, it was acknowledged by divisions that the wider organisational objectives was much less evident and that there is a disconnect between the Trust and divisions in this respect as well as a disconnect with the Trust's enabling strategies. The absence of such linkage between divisional plans and Trust wide strategies was evident at the divisional management board meetings. Divisions were unable to clearly articulate the 'Strategy Pyramid' and we experienced difficulty in trying to connect the overarching Trust strategy with divisional objectives other than in DTC. As one of the key enabling strategies, we noted a lack of understanding of the Trust's digital journey and how leveraging digitisation will support future efficiencies at divisional level.

Recommendation B20: In support of a digital strategy, the Trust should consider a visible digital roadmap to increase awareness, aid understanding and implementation as well as support the release of efficiencies via revised ways of working.

Recommendation B21: With the imminent appointment of a new Group Chair and appointment of a Group CEO there is an opportunity to consider strategy at both group and Trust level (which expires 2025) and its associated enabling strategies including digital. If developed in consultation with staff and divisional management this will enhance understanding, ownership and accountability. The Trust should also ensure that there is explicit alignment and connectivity between Group/Trust objectives and divisional plans.

Risk management

The establishment of an executive chaired Trust-wide Risk Scrutiny Committee (RSC), including rotational deep dives, indicates a good practice approach to risk oversight. The RSC appears well attended by representatives of the Executive Committee as well as corporate functions and divisions. From the review of documentation, meeting administration appears well-coordinated, with consistency of presentation of risk information from divisions and corporate partners which supports reader familiarity and ease of reference.

We were informed that the RSC is generally regarded by divisional leadership as a valuable forum for deep dives into key risks, though its perceived effectiveness appears to vary across divisions. While some referenced that they find it supportive, others perceive inconsistencies in its approach and impact including that deep dive exercises can feel excessive and repetitive rather than insightful. A common concern is the frequency of risk reviews, with some divisions feeling that scrutiny is too infrequent to provide timely assurance. Many divisions report duplication in risk reporting across multiple committees, creating duplication and perceived inefficiencies without having a clear understanding of why current reporting arrangements are such and what benefits/purpose is derived from the existing risk reporting architecture. We were informed that some risks are managed "in-house" without formal inclusion on the risk register, reducing visibility at Trust level. Whilst we were told that escalation processes to the RSC exist, there are concerns over a lack of timely follow-up or corporate-level response to significant risks.

Those we engaged felt that it would be beneficial to agree clear expectations regarding the risk deep dives and ensure a greater consistency of approach which better reflects existing guidance and templates.

Recommendation B22: The Trust should consider the purpose of the risk deep dive process and ensure that a consistent approach is adopted that supports alignment with the agreed desired outcomes.

We also noted that risk descriptions are variable by service and in some cases, actions lack specificity. We also noted a tendency to describe issues as opposed to presenting the risks that result from an issue occurring. Focussing on the issue can create ineffective risk management, duplication of performance management discussions and a focus on the wrong things.

Recommendation B23: The Trust should consider adopting a Trust-wide approach to risk articulation encompassing the cause(s), risk event and consequence(s) approach to risk articulation thus ensuring a more meaningful focus on controls and assurances over future risks as opposed to existing issues.

We saw some evidence of read across from divisional risks highlighted at divisional management boards to the RSC indicating an appropriate flow of information and escalation. However, in common with a number of other forum minutes reviewed, there appears to be limited evidence of recorded challenge evidenced within the RSC.

In respect of clinical risks in particular, we observed considerable variation across divisions in the approach and frequency of risk reviews along with thresholds for divisional level review. Risks were generally RAG rated but the thresholds for these RAG ratings were not described and, in some instances, nor were the specific risk scores provided (likelihood x impact). Common across all divisions was the absence of mitigations, SMART actions and target risk scores within risk reports all of which are designed to focus on the management of risks as opposed to the mere capture and reporting of risks. We also noted instances of detailed discussions of new risks irrespective of the RAG rating whereby this time could have been spent more efficiently on discussing material risks.

Recommendation B24: The Trust should ensure a consistent approach is adopted to risk scoring, RAG rating and reporting of risks that focuses on the management of the risk. Risk focus should also be commensurate with the RAG rating.

We noted a number of risk themes from our review of RSC and divisional risk information including estate issues impacting on clinical delivery. It was not apparent from our review and from discussions where consideration of thematic risks occurs.

Recommendation B25: The Trust should ensure that there is a clear and understandable process for collating, reporting and focussing on Trust-wide risk themes. In doing so, the Trust should also ensure that there are aligned mechanisms in place to ensure risks inform capital prioritisation processes

We understand that the Risk Management Strategy is due for imminent review. From interviews held and enquiries made, there appears to be an imbalance between focus on clinical and non-clinical risk matters with scrutiny appearing to be predominately on clinical risks and divisionally focused.

Recommendation B26: Consideration should be given to regular scrutiny and reporting of corporate functional risks including regular deep dives including areas such as estates and capital works, workforce, and finance which impact patient care and span divisions.

Divisional Review Meetings (DRMs)

Those we engaged with spoke positively in relation to the divisional review meetings (DRMs) and we observed helpful and respectful interaction and challenge between the executive team and divisional representatives. In our view, these meetings could be further enhanced via the strengthening of a number of meeting hygiene factors including setting clear expectations with regards to DRMs including:

- Meeting format i.e., whether these are to be held in person, virtual or hybrid, and ensuring supporting technology is available if hybrid to allow full participation by all attendees irrespective

of mode of attendance.
- Completion of actions and updates prior to the meeting to aid meeting time efficiency.
- Clear attendance requirements and expectations including mandating Divisional Director attendance.
- Improving equity of contributions, from both Divisional leadership and executive team members which should better support equity of focus across all domains including quality.
- Ensuring divisions attend with validated data and have a full understanding of performance, together with clear actions, requests for support and recovery trajectories for underperforming areas.
- Ensuring adequate overlap of UEC and GSM sessions to discuss common matters.

Recommendation B27: Consideration should be given to adopting the above meeting effectiveness improvements as part of setting minimum expectations of divisional DMB meetings.

Other process improvement opportunities

We noted potential opportunities for wider Trust-wide strengthening of a number of processes including:

- Quality impact assessments and associated approval processes of cost improvement plans.
- Consistency of implementation (including expectations, process and templates) for divisional recruitment control panels.
- Improved commercial rigour and governance in relation to business case development and approval processes along with evaluation of pilot schemes.
- More regular cascading of key Trust wide messages (e.g. financial challenges), via a variety of mechanisms, to support divisional awareness and understanding of Trust-wide matters.

Corporate governance / administration

We note that corporate committee administration coordination sits within respective executive portfolios e.g., the workforce team service the People Committee as opposed to a central corporate governance team. The centralisation of corporate governance resources coupled with a review of requirements, would, in our view better support the implementation and ongoing adherence to standardised governance arrangements and working practices potentially including within divisions dependent upon the structure and make-up of the centralised resource.

Recommendation B28: The Trust should review its current structure, approach and capacity of its corporate governance resource in order to ensure adequate support for its corporate governance requirements including capacity to roll out a more standardised approach and support ongoing adherence to Trust agreed standards.

It is understood that the Policy on Policies is currently under review and that there is some confusion with regards to overarching policy governance, the templates to be used and approval routes. Those we spoke to also commented that it can be challenging to locate and access policies and standard operating procedures via the intranet especially for staff unused to the system. This would be particularly problematic for bank and agency staff needing urgent access to clinical policies.

As policy governance is currently under review it is timely for us to recommend that the following be considered as part of the review process:

- The overarching policy should provide clarity for the overarching process and standards for the development, review and approval of policies.
- There should be clear mechanisms for the centralisation of policy governance and oversight.

- Consideration could be given to the establishment of a Policy Steering Group (or equivalent) with multidisciplinary membership including Divisional and HR/Union representation.
- Ensure that divisions are involved in the development, review and consultation of policy development as appropriate.
- As part of the review, consideration should be given to the ease of navigating the intranet to locate policies.

Recommendation B29: The Trust should consider the inclusion of the above points as part of its review of policy governance and processes.

We witnessed inconsistent naming of groups, meetings and use of terms during our review. For example, the term 'Business Meeting' being used to describe meetings that were fully, or predominantly clinical governance focused, and the term ‘governance’ meeting used interchangeably between corporate and clinical governance forums. Equally, many divisional leaders referred to their DMB meetings as divisional boards.

Recommendation B30: The Trust should set out a defined meeting taxonomy and classifications to better describe meeting purpose, avoid confusion, support understanding and consistent application.

Appendix 1 – Recommendations

Part A - Board, Committee and Executive level

Ref	Recommendation
A1.	The Trust should update the constitution to reflect statutory changes and identified good practice.
A2.	The Trust should update the standing orders to reflect the proposed changes as detailed on pages 6 and 7 of the report.
A3.	The Trust should update the SoRD to reflect the proposed changes as detailed on page 7 of the report.
A4.	The Trust should clarify responsibility for approving the fundraising policy and either revise the SoD or approve the policy in accordance with SoD.
A5.	The Trust should consider whether the role of the Charitable Funds Committee should include delegated responsibility for authorising expenditure.
A6.	The Trust should update the SFIs to reflect changes as described om page 8 of the report.
A7.	The Trust should ensure that the outstanding FPPT evidence is obtained, and the Chair should undertake the assessment and present a report to a Board meeting and to the Council of Governors.
A8.	The Trust should arrange for internal audit to undertake an audit of the FPPT process.
A9.	The Trust should undertake a formal and more objective board skills assessment to inform the board development programme and future board appointments.
A10.	The Trust should ensure all powers that are reserved to the Board are included, where appropriate, in the board work programme.
A11.	The Trust should review the board work programme to ensure that it is comprehensive, aligns with meeting agendas and will enable oversight by the Board of all its responsibilities.
A12.	The Trust should revise the ARC ToR to ensure comprehensive oversight of risk management across all strategic risks, not just quality/clinical, and its relationship in this respect with the other Board committees.
A13.	The Trust should review the work programme for ARC to ensure it includes all items relevant to its ToR.
A14.	The Trust should revise the 0CC ToR to reflect membership by Board members and attendance by others.
A15.	The Trust should determine the arrangements for oversight of its digital arrangements and reflect within the ToR and work programme of the relevant forum(s).
A16.	The Trust should update the committee work programme to ensure that it reflects all the responsibilities of the 0CC.
A17.	The Trust should consider membership by the Chief Medical Officer and the Chief Nursing Officer and how this is reflected in the ToR alongside the benefits/disbenefits of the requirement for rotational attendance.
A18.	The Trust should ensure that there is a consistent approach to oversight and involvement in internal audit reports across the assurance committees.
A19.	The Trust should clarify responsibility for overseeing quality and continuous improvement and reflect within the appropriate committee ToRs.
A20.	The Trust should ensure that the work programme is comprehensive and reflects reporting from all linked sub-groups.
A21.	The Trust should ensure that reporting groups which report to TEB (for management accountability) and to committees (for assurance purposes) are

	consistently reflected in the relevant ToRs and the governance structure document.
A22.	The Trust should review the work programme to ensure that all responsibilities from the PC ToR are reported into it and on an appropriate frequency.
A23.	The Trust should review and standardise oversight of the BAF by the Board committees.
A24.	The Trust should revise the ToR to ensure that the role and responsibility of the TEB is delegated by the Chief Executive.
A25.	The Trust should ensure the ToR for all committees and sub committees/reporting groups are aligned and reflected on the governance structure diagram.
A26.	The Trust should review the TEB work programme plan to ensure that it is comprehensive and includes all priorities as agreed.
A27.	The Trust should ensure that there is an agreed understanding of items that should be escalated to TEB.
A28:	The Trust should revise the SoRD to include delegation of responsibilities to all committees.
A29:	The Trust should consider developing a ToR for CoG.
A30.	The Trust should revise the standing orders for the CoG as described on page 20 of the report.
A31.	The Trust should revise the work programme for the CoG to include FPPT, the annual plan and a chair's report from ARC.
A32.	The Trust should as part of the next evaluation of the CoG consider whether the information needs of the CoG are being met and consider opportunities to strengthen.
A33.	The Trust should review the Managing conflicts of interest policy and the SoRD to ensure that all decision making groups are appropriately reflected in the governance documents and are aligned.
A34.	The Trust should update the risk management strategy and policy and remove any areas of duplication.
A35.	The Trust should continue to develop the IGPAF ensuring clarity of roles and responsibilities including the recommendations as set out within this report. The Trust should also better define escalation of risk and issues between the different forums.

Part B – Divisional level governance arrangements

Ref	Recommendation
B1.	The Trust should revisit the rationale for implementing a consistent approach to divisional governance arrangements and reinvigorate a programme of implementation including communication and training to support reinforcement of the rationale and desired outcomes.
B2.	The Trust should consider reviewing the approach to divisional reporting and support in regard to centralised support functions supporting divisional leadership.
B3.	The Trust should consider introducing a requirement for each divisional management board to have a divisional quality governance sub-group that reports into it and include Trust-wide expectations regarding duties, membership, attendance and reporting.
B4.	The Trust should consider the 'do minimum' information/reporting requirements for divisional quality governance meetings and issue a template terms of reference incorporating Trust-wide minimum requirements in keeping with the good practice outlined within the divisional management board terms of reference.
B5.	The Trust should consider setting out minimum attendance expectations and how it will monitor, report and reinforce the importance of attendance at such meetings.

B6.	The Trust should consider ways in which it can improve alignment and focus of divisional quality governance meetings with Trust-wide priorities and improvement plans in addition to any 'do minimum' bottom up requirements.
B7.	The Trust should consider ways in which it can strengthen the sharing of best practice and learning across divisions to further promote continuous improvement.
B8.	The Trust should consider ways in which it can refresh PSIRF implementation and training by addressing training gaps and strengthen a consistent Trust-wide rollout of PSIRF. This may include the provision of targeted training to enhance staff understanding and engagement with the framework to ensure that staff are aware of, aligned to and report against PSIRP identified Trust-wide priorities.
B9.	The Trust should review the revised complaint sign-off process with a view to reducing bottlenecks while maintaining quality and improving performance against the Trust target.
B10.	The Trust should consider divisional directors attendance (not as members) at Quality of Care Committee meetings to increase clinical leadership representation or ways in which the Trust can increase engagement with senior clinicians e.g. increased frequency of divisional reporting.
B11.	The Trust should consider developing a clear 'wiring diagram' that maps governance reporting pathways from 'ward to Board'. This should help address existing duplication of reporting routes as well as ensure that there are no gaps in assurance flows.
B12.	The Trust should ensure clear communications throughout the organisation ahead of future external reviews including designated contact points and having a central repository of structures, personnel and information.
B13.	The Trust should reinforce the importance of report/evidence completeness to evidence challenge, scrutiny, decisive actions and ultimately assurance within the minutes and documentation.
B14.	The Trust may wish to consider (or reiterate if applicable) file saving conventions across the Trust in accordance with its record management policy(ies). It may also wish to consider and implement meeting standards practice ensuring all meeting paperwork is filed separately and can be readily retrievable and accessible, including ensuring legacy actions can be easily monitored.
B15.	The Trust should consider its approach to data analysis and interpretation at divisional level and below including the potential use of SPC to aid improved focus on trends and identification of the need for management actions. Report formatting should encourage and support presentation of the 'what', the 'so what' and the 'what next' to improve focus on SMART actions i.e., specific, measurable, accountability, realistic and timelines.
B16.	The Trust should consider developing Trust-wide minimum expectations in relation to financial reporting at divisional and specialty level to encourage greater understanding, local ownership and accountability over financial sustainability.
B17.	The trust should set out its expectations regarding oversight of operational performance at divisional management boards and at specialty level to increase local accountability.
B18.	The Trust should consider training and/or educating divisional level minuted takers to improve the standard of minute taking, and general meeting administration practice (including agendas and action trackers), across divisions and within service lines.
B19.	The Trust should develop or reinforce its existing records management policy including arrangements relating to the need for regular reviews to ensure not only that naming conventions are correct but more critically that documents reflect contemporary regulation, practice and requirements.
B20.	In support of a digital strategy, the Trust should consider a visible digital roadmap to increase awareness, aid understanding and implementation as well as support

	the release of efficiencies via revised ways of working.
B21.	With the imminent appointment of a new Group Chair and appointment of a Group CEO there is an opportunity to consider strategy at both group and Trust level (which expires 2025) and its associated enabling strategies including digital. If developed in consultation with staff and divisional management this will enhance understanding, ownership and accountability. The Trust should also ensure that there is explicit alignment and connectivity between Group/Trust objectives and divisional plans.
B22.	The Trust should consider the purpose of the risk deep dive process and ensure that a consistent approach is adopted that supports alignment with the agreed desired outcomes.
B23.	The Trust should consider adopting a Trust-wide approach to risk articulation encompassing the cause(s), risk event and consequence(s) approach to risk articulation thus ensuring a more meaningful focus on controls and assurances over future risks as opposed to existing issues.
B24.	The Trust should ensure a consistent approach is adopted to risk scoring, RAG rating and reporting of risks that focuses on the management of the risk. Risk focus should also be commensurate with the RAG rating.
B25.	The Trust should ensure that there is a clear and understandable process for collating, reporting and focussing on Trust-wide risk themes. In doing so, the Trust should also ensure that there are aligned mechanisms in place to ensure risks inform capital prioritisation processes
B26.	Consideration should be given to regular scrutiny and reporting of corporate functional risks including regular deep dives including areas such as estates and capital works, workforce, and finance which impact patient care and span divisions.
B27.	Consideration should be given to adopting the meeting effectiveness improvements as referenced on page 37 as part of setting minimum expectations of divisional DMB meetings.
B28.	The Trust should review its current structure, approach and capacity of its corporate governance resource in order to ensure adequate support for its corporate governance requirements including capacity to roll out a more standardised approach and support ongoing adherence to Trust agreed standards.
B29.	The Trust should consider the inclusion of the above points as part of its review of policy governance and processes.
B30.	The Trust should set out a defined meeting taxonomy and classifications to better describe meeting purpose, avoid confusion, support understanding and consistent application.

Appendix 2 – Possible example standardised DMB agenda

Building on the current template for DMB, it is recommended that this be expanded to include at the following matters.

Time	No.	Item	Lead	Requirement
		Opening governance •Welcome and apologies • Confirmation that the meeting is quorate. *No business will be conducted unless the following are present [xxxx]* •Declarations of interest		To receive
		Minutes of the last meeting and action tracker		To approve
		Trust Executive Board/ Divisional Review Feedback and corporate strategic matters		To receive
		Matters for approval •xxx •xxx		To approve
		Directorate Level Review ○ Strategic Matters - [to include here progress against any strategic and transformational workplans] ○ Operational Oversight Scorecard presentation and exceptions including • Quality matters • Operational performance • Finance – inc. CIP • Workforce • Risk • Digital matters • Estates matters • AOB		To receive
		(Rotational) Service level Review - [Service X] Scorecard presentation and exceptions including • (as above)		To receive
		Exceptions from other services •xxx •xxx		To receive
		Reports from Divisional governance/Divisional meetings •xxx •xxx		To receive
		Closing governance •Matters to escalate •Matters to cascade •Reflections on values •Date of next meeting [xx/xx/xx]		To agree To agree To discuss