

Liverpool Heart and Chest Hospital
NHS
Foundation Trust
Well-led Governance Review -
Summary Report

Final Report
March 2017



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Contacts

This review has been completed by MIAA.

Key Contacts:-

Tim Crowley

Managing Director, MIAA

Tel 07768 131789

Email tim.crowley@miaa.nhs.uk

Sandra Cudlip

Associate, MIAA

Tel 07879487555

Email Sandra.cudlip@miaa.nhs.uk

Steve Connor

Commercial Director

Tel 07768 131785

Email: steve.connor@miaa.nhs.uk

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1. Introduction

1.1 Introduction

We have carried out an independent review of governance arrangements at the Trust in accordance with NHS Improvement's (NHSI), formerly Monitor's publication '*Well-led framework for governance reviews: guidance for NHS foundation Trust's Updated April 2015*'.

NHSI's Single Oversight Framework (SOF) provides guidance to Trusts on five areas in which providers will be monitored and rated. One of the five themes in the SOF relates to Leadership and Improvement Capability and within this theme there is an expectation that trusts will have an independent Well-led assessment. Using the information from the five themes in the SOF NHSI places providers into one of four segments to identify support requirements

NHSI strongly encourages all NHS foundation Trust Boards to carry out these Well-led reviews for a number of reasons:

- Good governance is essential in addressing the challenges the sector faces.
- Oversight of governance systems is the responsibility of NHS foundation Trust Boards.
- Governance issues are increasing across the sector.
- Regular reviews can provide assurance that governance systems are fit for purpose.

Our review acknowledges the impact of the *Use of Resources and Well Led Assessment Consultation* issued by NHSI, which continues to recognise the importance of the Well-led review principles. Key areas of the current Well-led guidance will be strengthened with additional focus on areas such as system leadership. An objective of the Well-led review process is that NHS providers will be confident that there is a shared and consistent view forming the basis of regulatory judgements on the concept of Well-led. For example, CQC will ask providers how they have assured their governance arrangements. This may include asking for information about any independent reviews and how they have been acted on. The expectation is that a completed Well-led review, with prioritised actions, will be the preferred evidence to be shared.

The Trust has taken an innovative approach to delivering the Well-led Review through an enhanced Internal Audit Programme that integrates and builds on the current programme of governance activity. The work has been delivered over an extended time frame to enable tracking of strategy through to outcomes.

The detailed methodology applied in the review is provided in Appendix A.

We would like to thank all parties for their engagement with this review.

1.2 Report Structure

This summary report highlights the key findings and recommendations resulting from our Well-led review. The review links to the four areas defined in the 'Well-led Framework for Governance Review' guidance; Figure 1 overleaf provides an 'overview of the review structure' applied. Section 2 includes the Executive Summary together with a comparison of the ratings within your self-assessment and the ratings we have applied following our independent review. A glossary of terms used throughout the report is provided in Appendix B. A summary of all recommendations is provided in Appendix C.

By its nature this summary report concentrates on the key points and is not comprehensive in the way the final detailed report is.

Our findings in this report are based upon the views expressed by Board members, senior staff, governors and external stakeholders. We have assumed that the information provided to us and management's representations are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness or reliability.

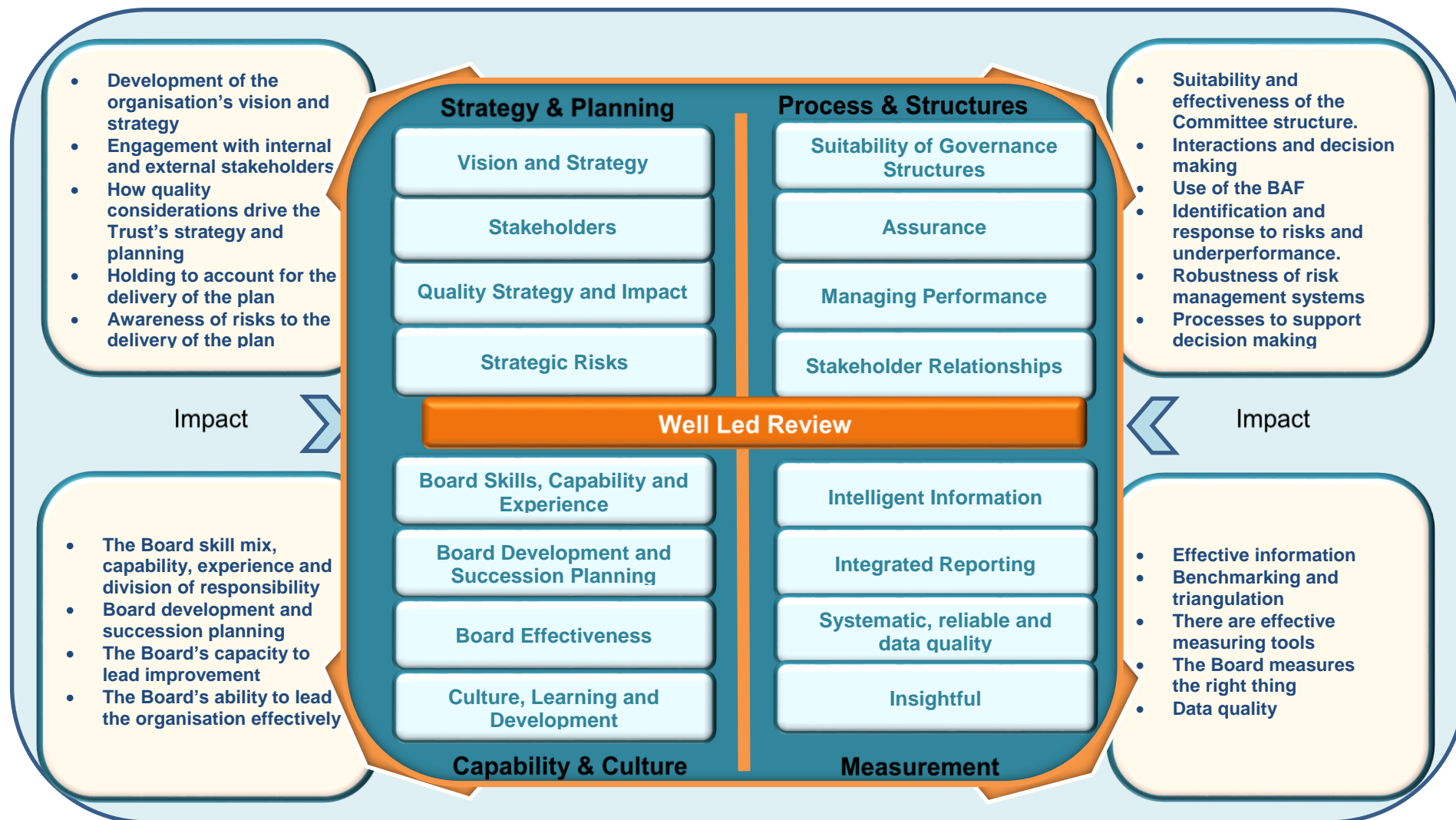


Figure 1 – Overview of Review Structure

2. Executive Summary

2.1 Overview

The overall conclusion from our review is that the Trust is well-led. Across all four domains of the Well-led Framework we encountered examples of outstanding practice in terms of strategic grip, system participation and leadership, focus on quality, patient safety and patient experience, Council of Governors (CoG) and patient engagement and governance process. Also, examples of a commitment to improvement and good leadership behaviours and values were evident in a range of settings.

The areas for development that have been highlighted by the review include completing the work underway to formalise the underpinning strategies, widening Board level metrics in relation to research, reflecting on future Board development needs, embedding learning and development across the Trust, strengthening the role and impact of business partners, extending the Board commitment to continuous learning and development to divisions, increasing divisional accountability, avoiding duplication across meetings and ensuring there is a formal record of appropriate scrutiny.

In carrying out our assessment over a four month period we have been able to observe the flow of information across Board, Assurance and Operational meetings. Overall the Board commits and delivers on actions raised by Board Members. We have observed how issues have been identified and action taken to make improvements, particularly in raising the profile of the recurrent CIP requirements in Divisions.

In reporting our findings we have taken into account the Trust's self-assessment (dated October 2016), the areas where the Trust believes improvements can be made and our advice on additional improvement. There are two differences between the ratings in the Trust's assessment and our independent ratings. For the key question relating to escalating and resolving issues the Trust self-assessed as green and our assessment was amber green. For another question relating to data quality the Trust

assessment was amber green and our assessment was green. Further detail is set out in Section 2.7.

Our observations in this report are grouped under the areas of the Framework.

- Strategy and Planning.
- Capability and culture
- Processes and structures
- Measurement

Our review recognises that the Trust has been included in Segment 1 under the SOF which allows the maximum autonomy. In addition we note that the Trust has been rated as outstanding in the recent CQC assessment. We have considered the results of these assessments in our work.

Clearly the challenges that the Trust are facing now, and in the period ahead, will test the resilience of all aspects of the Trust's governance arrangements. It is in that context that the areas for improvement have been prepared.

The headlines from each domain and key questions are set out below and more detailed context to support these is provided in section 3.

2.2 Strategy and Planning

Q1

- The Board is strategically focussed, forward looking and able to respond quickly to changes in the local health economy. NEDs are engaged and have an input into strategy development which is exceptional when compared to other trusts we have reviewed.
- There is a demonstrated commitment to pro-active, system-wide collaboration and leadership. External stakeholders told us that Trust leaders are making a positive and significant contribution to the Cheshire and Merseyside Sustainability and Transformation Plans (STP).
- There is a very well structured planning process to develop both the operational plan and the strategy built upon regular engagement with internal and external stakeholders.
- While there are supporting strategies in key areas eg Quality and Workforce, there are other underpinning strategies eg clinical

strategies that need to be formally agreed and completed as a priority to support the achievement of the vision and strategy.

Q2

- Board members have a consistent understanding of the top risks to the Trust. There is a clear route for escalating risks from “ward to board”.
- The Board Assurance Framework (BAF) is used as a dynamic tool with risk ratings changing over the year to prioritise the Board’s time and give confidence in achievement of each strategic objective at any given point in time.
- The Operational Board (OB) could be better sighted on risks across the corporate departments. This change would need the Risk Management and Corporate Governance Committee (RMCGC) to operate differently.
- Service developments and efficiency changes are developed and assessed with input from clinicians. There needs to be a sustained focus on increasing clinical engagement and ensuring a more pro-active and timely approach to Quality Impact Assessment (QIA) preparation and post implementation reviews.
- A Head of the Programme Management Office (PMO) has now been appointed but the PMO is in its early stages and there is more work to do to ensure the function is fully effective.
- Staff did feed back to us that there are emerging concerns that the reputation that the Trust has for placing quality over finance is not sustainable and “transformation” simply equates to cost-cutting. As such the Board has an important role in signalling a consistent message and consistent set of behaviours in all the settings where quality and financial sustainability are being balanced.

2.3 Capability and Culture

Q3

- The Board has stable membership, is well balanced and comprises high calibre individuals who bring a range of skills and experience. The responses in the Board survey were the most positive that we have experienced compared to the cohort of trusts we are reviewing.

- The Chairman is known and seen across the Trust. He has a distinctive and unique profile in the system leadership setting which is a great asset for the Trust.
- The Chief Executive’s leadership style for promoting an open and continuous improvement culture has been positively referred to both internally and externally.
- The Medical Director has been commended by board members for his leadership in involving consultants more in achieving the Trust’s objectives as well as their own clinical goals via improving job planning. Future challenges include addressing inconsistencies in consultant productivity levels.
- The NEDs demonstrate a deep understanding of the external and internal context in which they operate and provide a high level of rigorous independent challenge, particularly through the Assurance Committees.
- Over time strategic challenges facing boards give rise to the need for specific skills and it is important that this requirement is kept under review in a systematic way to ensure the Board is “future-proofed”. The skills mix assessment can be used to scope Board development sessions.
- The People Committee is leading the drive to improve learning and development. This needs to be a continued area of focus for the Trust as initial results from the 2016 Staff Survey indicate that the Trust has not made the progress intended.

Q4

- There is a commitment to create a culture where staff feel confident to raise concerns, where staff are listened to, and actions are taken. The Board is sighted on the need to address inappropriate consultant behaviours with evidence of improvements being made.
- The Trust has introduced divisional business partners for Information, Human Resources (HR) and Finance. However, business partners have not delivered the benefits expected and the Trust needs to act with pace to develop, strengthen and embed the business partners so they

are able to support and advise the divisions in their strategic and operational decision making.

Q5

- The Board has set the tone of learning and development and supported the implementation of an Organisational Learning Policy which is relatively new and has not yet had the chance to become embedded. In particular there are opportunities to drive the continuous learning and development agenda more formally in divisional meetings.
- Systems are in place to review and monitor performance and quality of care through performance dashboards at ward, divisional and Board level with a wide range of information available across the Trust.
- The encouraging and inclusive style of the Director of Nursing and Quality (DoN) in driving improvements in patient safety, engagement and leading on the preparation for the CQC has been referred to very positively by many stakeholders. The DoN is taking action to ensure the Trust maintains the momentum generated by the CQC inspection.

2.4 Process and Structures

Q6

- The governance structure facilitates a clear distinction between assurance (non-executive led) and performance management (executive led).
- The partnership setting is complex and fast-moving and given those conditions the Board is reasonably assured that initial governance and management arrangements are set out and understood. It is important that those arrangements are now strengthened and kept under review as partnerships and collaborations evolve.
- There is a clear focus on quality at both Board and Committee level.
- Committees of the Board are well chaired with appropriate attendance and good levels of scrutiny, challenge and support. There is an effective relationship between the work of the Committees and the Board.

Q7

- At Board level the Director of Corporate Affairs provides effective support and leadership to ensure governance arrangements are proactively reviewed and reflect best practice.
- The Board and senior management are committed to good financial management but there is more to do to embed a culture of good financial management throughout the Trust.
- The new Chief Finance Officer (CFO) has had an immediate and positive impact, delivering more transparency and clarity on the financial position. She is driving forward improvements on SLR, forecasting and understanding of costs.
- The OB is very well regarded across divisions and the Board members. The OB has a very wide remit and meetings can last for several hours (albeit with regular breaks). There is a view among many of the staff we interviewed that the agenda can have more items than the meeting can reasonably consider in the time allowed. In addition, there are opportunities to make better use of time in the OB to ensure everyone is fully engaged throughout the meeting and all key dimensions of the Trust get sufficient coverage in the meeting.
- The revised divisional arrangements have resulted in improved clinical engagement and performance improvements in many key operational areas such as Referral to Treatment (RTT) and agency spend. The next challenge for divisions is to identify and drive forward plans to ensure financial sustainability.
- Whilst acknowledging progress in achieving “hard” targets in the Operational Plan, the Divisions need to broaden their focus and be accountable for performance across all aspects of the Trust’s business. This includes more robust divisional committee meetings which can be relied upon to address for example financial performance.

Q8

- The Trust is continually taking action to improve the patient experience and the success of this is borne out in the outstanding results in the National Patient Survey.

- The Trust has a good system for engaging with the workforce and acting on feedback.
- The Trust has demonstrated a commitment to creating an open and honest culture where reporting concerns and incidents is actively encouraged and supported.
- The Trust has provided evidence that there is a focus on stakeholder engagement. The Chief Operating Officer (COO) in particular, has had a positive impact on developing external stakeholder relations. Non-NHS leaders told us that they would value greater engagement with the Board.
- Interviews with stakeholders revealed a generally positive set of relationships. However some have said they remain concerned that the Trust can be too inward looking rather than focussing on what is important for the whole economy.
- Whilst recognising improvements in communication some external stakeholders would welcome improved engagement with clinicians at the Trust.

2.5 Measurement

Q9

- The Board reviews metrics in a performance dashboard designed around the strategic objectives. Board members triangulate the data with reference to other channels of information.
- There are limited Key Performance Indicators (KPIs) for research which is a key objective. Other than a planned 6 monthly update, research does not feature much in other months and there can be limited or no discussion on this topic.
- The quality of the Board reports and cover sheets in practice is variable and in particular the executive summary does not always guide debate or outline the key issues and risks for the reader.
- The Trust is aware that the range and depth of information can be developed in particular in relation to SLR which is a key priority for the Trust. Without reliable SLR information it will be difficult for example to assess consultant productivity.

- The demand for performance information is likely to increase and there are temporary capacity issues within the informatics function which is having an effect on the timeliness of reporting, the pace of developmental work and the progress on integration with divisions.
- Although accepting improvements are being made, clinicians remain frustrated with many aspects of the Electronic Patient Record (EPR) system which can lead to inefficiencies and impact on productivity.
- It is evident that the Executive team has a grip on operational performance across the Trust. We have observed at times limited debate in the OB on underperforming areas on the dashboard. At times presentations can be information giving rather than decision making as the issues have been discussed in other forums or action has already been taken when an issue has arisen eg CIP performance.

Q10

- The Director of Research and Informatics has led the development of a robust approach to assessing and improving the quality of the data used to support the metrics in the strategic and operational dashboards. The Trust is ahead of many organisations in relation to data quality and work is ongoing to embed the Data Quality Strategy.
- Board members have confidence in the robustness of data and the supporting base to statements and declarations.

2.6 Key Recommendations

Based on the findings we have identified a number of areas for Trust consideration that we believe can further improve or enhance current arrangements. Rather than create a detailed action plan we have split the areas into improvement opportunities (IO) and recommendations (R). The Trust response to the recommendations is included in Appendix C and the key recommendations are summarised below:

- Formally agree and complete the clinical strategies and other underpinning strategies to support the achievement of the vision and strategy.

- Reflect on future Board development needs eg through regular skills audits of current Board members comparing what exists now and what are needed in the future to inform/scope Board development sessions.
- Take prompt action to ensure that the aims of the Trust's L&D Strategy are being achieved on a timely basis. This will require the divisions to be fully engaged and progress should be monitored by the OB.
- Progress with pace the plans to develop, strengthen and embed business partners so they are able to support and advise the divisions in their strategic and operational decision making.
- Extend the Board commitment to continuous learning and development to divisions so that it becomes part of the business as usual.
- Improve the effective operation of the Divisional teams by communicating a formal accountability framework that clearly sets out the arrangements for devolved leadership.
- Get the balance between avoiding duplication in meetings and ensuring there is a record of appropriate scrutiny. Also ensure that there are mechanisms for obtaining assuring without the need for a minutiae of information.

2.7 Ratings Assessment

A key requirement of the Well Led review is to provide a summary assessment utilising the risk rating definitions provided in Monitor's Well Led framework (Table 2.7.1). The comparative assessment is provided in (Table 2.7.2).

Table 2.7.1 - Risk Rating scoring definitions

























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

Table 2.7.2 – Comparative Assessment (Trust's Self-Assessment: Well Led Review Rating)

Monitor Domain	Strategy and Planning (Section 3.1)		Capability and Culture (Section 3.2)			Process and Structures (Section 3.3)			Measurement (Section 3.4)	
Detailed Question	<u>credible strategy</u> and robust plan -high quality/sustainable	Aware of <u>risks</u> to the quality, sustainability and delivery of current /future services	<u>skills and capability</u> to lead the organisation	shape an open, transparent, <u>quality focused culture</u>	<u>continuous learning and development</u>	roles and accountability <u>quality governance</u>	<u>escalating and resolving issues</u> and managing performance	<u>stakeholders engaged</u> on quality, financial and operational performance	<u>appropriate information</u> on performance is analysed and challenged	<u>robustness of information</u>
Trust Rating										
Review Rating							 ①		 ②	

Two differences in the scores was identified:

①- The move to a Divisional structure has brought a number of benefits, eg significant improvement in performance on key indicators. There is scope to improve accountability for performance across all aspects of the Trust's business so that the Divisions can support the Trust in achieving all its objectives eg working with business partners on business plans to drive

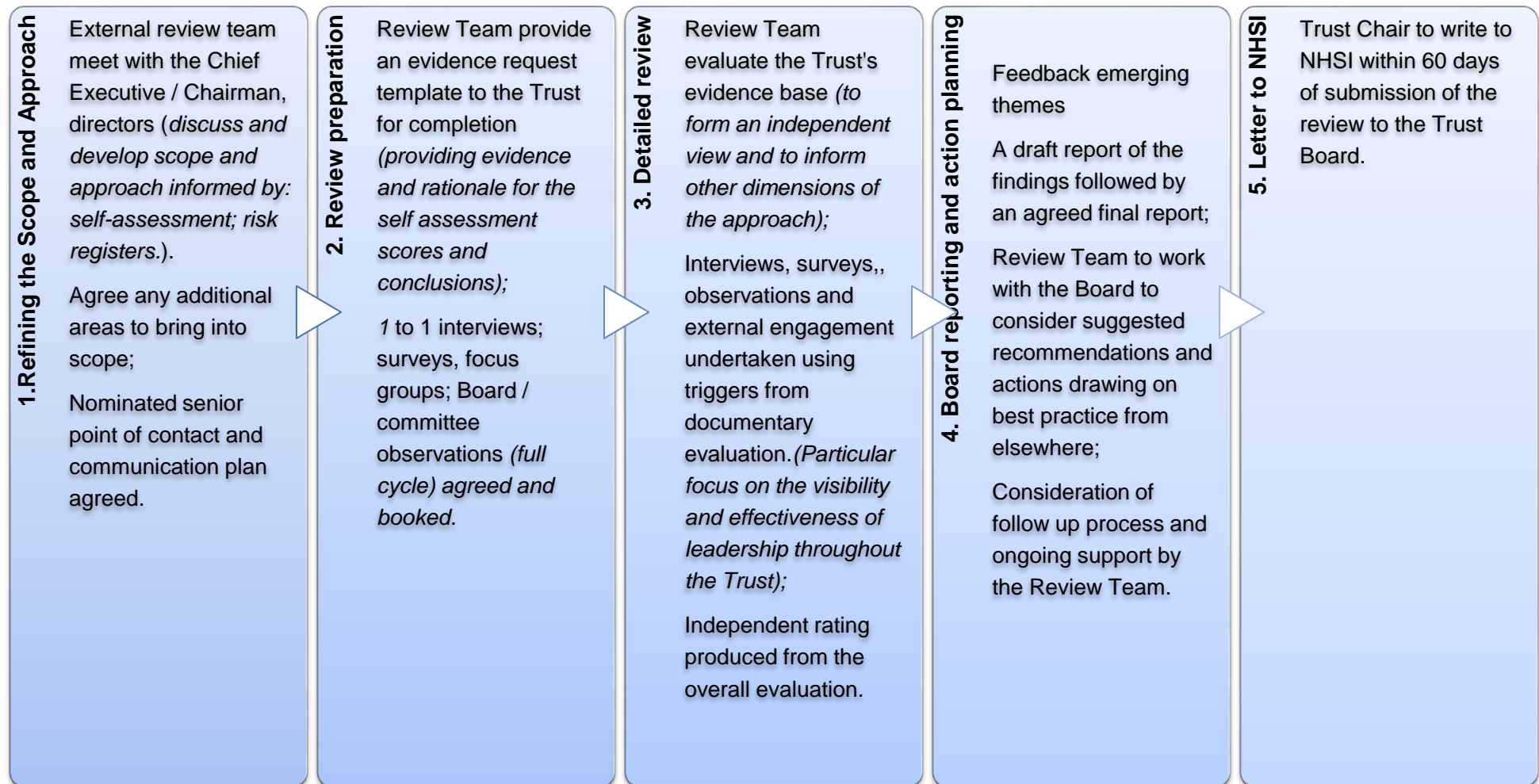
through improvements in more qualitative areas such as learning and development.

②The Trust has invested in innovative systems for generating robust information with plans to develop these further and is more advanced in this area than the other trusts we are reviewing

Appendices

Summary Approach

The approach applied is set out in **Figure 1** below. Supported by a self-assessment completed by the Trust.



Detailed Review Approach

		Date
Board Member Interviews	Neil Large - Chair	20 Dec 2016
	Jane Tomkinson - Chief Executive	12 Dec 2016
	David Bricknell - NED/ Deputy Chair/ SID	5 Dec 2016
	Lawrence Cotter - NED	5 Dec 2016
	Julian Farmer - NED	5 Dec 2016
	Debbie Herring (Director of Strategy and Organisational Development)	12 Dec 2016
	Mark Jones - NED	12 Dec 2016
	Sue Pemberton -Director of Nursing and Quality	9 Jan 2017
	Raphael Perry - Medical Director/Deputy Chief Executive	13 Jan 2017
	Marion Savill - NED	12 Dec 2016
	Claire Wilson –CFO	20 Dec 2016
	Mark Jackson Director of Research and Informatics	13 Jan 2017
	Lucy Lavan - Director of Corporate Affairs	19 Dec 2016
	Tony Wilding - Chief Operating Officer	9 Jan 2017
Other Internal Interviews	Tony Bennett - Divisional Head of Operations (Clinical Services)	26 Sept 2016
	Steven Colfar -Head of Nursing (Clinical Services)	26 Sept 2016
	Nigel Scawn - Associate Medical Director (Clinical Services)	26 Sept 2016
	Hayley Kendall - Divisional Head of Operations (Surgery)	13 Oct 2016
	Nike Cope Deputy Divisional Head of Operations (Surgery)	26 Sept 2016
	Robin Wiggs - Divisional Head of Operations (Medicine)	26 Sept 2016
	Clare Appleby – Consultant	3 Oct 2016

		Date
Stakeholder Interviews	Mark Pullan – Consultant	3 Oct 2016
	Jim Davies – Deputy CFO	3 Oct 2016
	Joan Matthews -	3 Oct 2016
	Lynda Robinson - PMO	13 Oct 2016
	Paula Pattullo (Lead Governor)	26 Sept 2016
	Catrin Hanks (BCUHB - North Wales Cardiac Network)	17 Oct 2016
	Dr Richard Cowell, Lead Cardiologist North Wales Network -	17 Oct 2016
	Louise Shepherd – CEO of Alder Hey and STP lead	17 Oct 2016
	Tom Jackson – CCG DoF	14 Nov 2016
	Andrew Bibby – Specialist Commissioning	24 Oct 2016
	Gary Masterson – Critical Care lead RLUBHT	7 Nov 2016
	Margaret Carney – Sefton Council CEO	14 Nov 2016
Document Review	Board Self Assessment	Not Applicable
	Conducted a desktop review of a sample of key Trust documentation including Board minutes, Committee minutes, terms of reference, BAF, risk registers	
Audit	Jackie Bellard – Grant Thornton --	7 Nov 2016
Surveys	National Staff Survey Results 2016	January 2016
	Board Member Survey	August 2016
Me eti ng	Board of Directors	27 July 2016
	People Committee	6 Sept 2016

Appendix A – Approach and Methodology

		Date
	Operational Plan Kick off meeting	26 Sept 2016
	COG	26 Sept 2016
	Board Observation	27 Sept 2016
	Operational Board	30 Sept 2016
	IP Committee	19 Oct 2016
	Quality Committee	25 Oct 2016
	Audit Committee	8 Nov 2016
	LiA Feedback	8 Nov 2016
	Divisional Governance Meetings	18 Nov 2016
	People Committee	6 Dec 2106
	Operational Board	25 Nov 2016
	Cardiology Big Conversation	1 Dec 2106
	Learning and Sharing Event	9 Dec 2106
	Board Observation	13 Dec 2106
	Business Transformation Group	15 Dec 2106
	RM and Corporate Governance Committee	19 Dec 2106

Methodology

The diagnostic tools and methods for carrying out the review were selected from those listed in the table below.

Tool	Suggested components	Purpose
Desktop document review	Board minutes, papers, and agendas; Board assurance framework; audit reports; strategic documents, e.g. the Trust's strategy and business plan, quality strategy and people strategy; and internal/external audit reports, annual governance and corporate governance statements, alongside any other relevant reviews.	To provide a view of: <ul style="list-style-type: none"> • how ongoing issues and risks within the NHS foundation Trust are communicated and managed; • the quality of information being produced to support decision-making; and, • how the Board prioritises issues at the Trust and divides its attention.
One-to-one interviews	All Board members, the Trust secretary, lead governor, clinicians, local stakeholders, including CCG/ Specialist Commissioning and patient representatives.	To gain individuals' views of the Trust's governance and to provide a 'safe' environment in which to explore issues and discuss sensitive information, as appropriate.
Board and sub-Committee observations	Observations of 3 Board meetings and relevant sub-Committees, including audit and quality.	To identify the dynamics of the Board, including agenda management, depth and breadth of the information used to make decisions and

Tool	Suggested components	Purpose
		progress priorities, and the way they challenge and hold each other to account for the leadership of the Trust.
Stakeholder surveys	Staff and patient groups, governors, commissioners and providers	To get internal and external parties' views of the Trust's governance to cross-reference with the Board's own views – to test the Board's awareness.

The terms used within the report

Ref.		Ref.	
AC	Audit Committee	HR and OD	Human Resources and Organisational Development
AMD	Associate Medical Director	IPC	Integrated Performance Committee
BAF	Board Assurance Framework	IPR	Integrated Performance Report
BTSG	Business Transformation Steering Group	LiA	Listening into Action
CCG	Clinical Commissioning Group	L&D	Learning and Development
CEO	Chief Executive Officer	NED	Non-Executive Director
CFO	Chief Finance Officer	NHSI	NHS Improvement
CIP	Cost Improvement Programme	OB	Operational Board
CoG	Council of Governors	OD	Organisational Development
COO	Chief Operating Officer	PMO	Project Management Office
CQC	Care Quality Commission	QIA	Quality Impact Assessment
CRR	Corporate Risk Register	RMCGC	Risk Management and Corporate Governance Committee
CVD	Cardio Vascular Disease	RTT	Referral to Treatment
DDoP	Deputy Director of Operations	SLA	Service Line Agreement
DHOO	Divisional Head of Operations	SLR	Service Line Reporting
DoF	Director of Finance & Performance	SoF	Single Oversight Framework
DoN	Director of Nursing & Quality	SMART	Specific, Measurable, Achievable, Realistic and Time - Based
DQ	Data Quality	STP	Sustainability and Transformation Plans
DRR	Divisional Risk Register	SUIs	Serious and Untoward Incidents
E&I	Equality and Inclusion	RLUBHT	Royal Liverpool University and Broadgreen Hospital NHS Trust
EPR	Electronic Patient Record	ToR	Terms of Reference
FFT	Friends and Family Test	Trust	Liverpool Heart and Chest NHSFT
HoN	Head of Nursing		

Appendix B.1 – Glossary

The table below provides a summary of the recommendations.

No	Section	Recommendation	Management Response	Timescale/Lead Officer
1	3.1.2	The Trust needs to formally complete the Divisional and other underpinning strategies to support the Trust's strategic plan.		
2	3.1.2 and 3.4.2	In defining what it means to be the "best for delivery of care and research" the Trust should identify measures (including a wider range of metrics relating to research) that will allow the Trust to determine whether or not it is on track. This should include the key milestones on the route to achieving this status. In designing metrics and information needs of the Board the Trust should ensure that they are aligned to all priority areas including research. The Board should consider rescheduling the planned Board session on Research and Innovation		
3	3.1.3	Revisit the Terms of Reference for the RMCGC to recognise the work that goes on in other forums in relation to Divisional Risk Registers. This would allow time to focus on the identification, monitoring and management of risks in corporate areas. In addition to minutes the RMCG should also provide a BAF key issues report to the OB		
4	3.2.2 and 3.2.4	The Trust should have a Board Development programme linked to development themes and outcomes from the skill mix assessment which will equip the Board with the skills for implementing systems wide transformational change at scale and pace. There may be opportunities for the Board to work with AQUA to explore ways of taking forward and embedding continuous learning and improvement across the Trust.		
5	3.2.3	Part of the corporate objectives for 2017/18 is to "educate and develop our people" and this has been an area of focus in the Trust. The Trust will need to reflect on the staff survey results in the section on learning and development and ensure it continues its focus on this area to ensure that the aims of its Education and Development Plan are being achieved on a timely basis. This will require the divisions to be fully engaged and progress should be monitored by the OB.		
6	3.2.3	Progress with pace the plans to develop, strengthen and embed business partners so they are able to support and advise the divisions in their strategic and operational decision making.		

Appendix C.1 – Recommendations

7	3.3.3 and 3.2.4	Improve the effective operation of the Divisional teams eg by communicating a formal accountability framework that clearly sets out the arrangements for devolved leadership and communicates the parameters by which performance will be assessed. Divisional leaders should have SMART objectives that reflect wider corporate responsibilities, values and behaviours as well as operational and professional related objectives eg the commitment to continuous improvement and learning at Board level needs to be extended to divisions and become part of the business as usual in the divisions.		
8	3.3.3	Terms of Reference for the Divisional Governance and Performance Committees should be updated in line with the agreed accountabilities framework. All members should be aware of their responsibilities including the need to attend regularly. Meetings should be held so that business partners are able to attend		
9	3.4.2	The Trust needs to get the balance between avoiding duplication in meetings and ensuring there is evidence of where the robust scrutiny of performance has taken place eg at the Operational Board the reference could be made to discussions at the BTSG.		