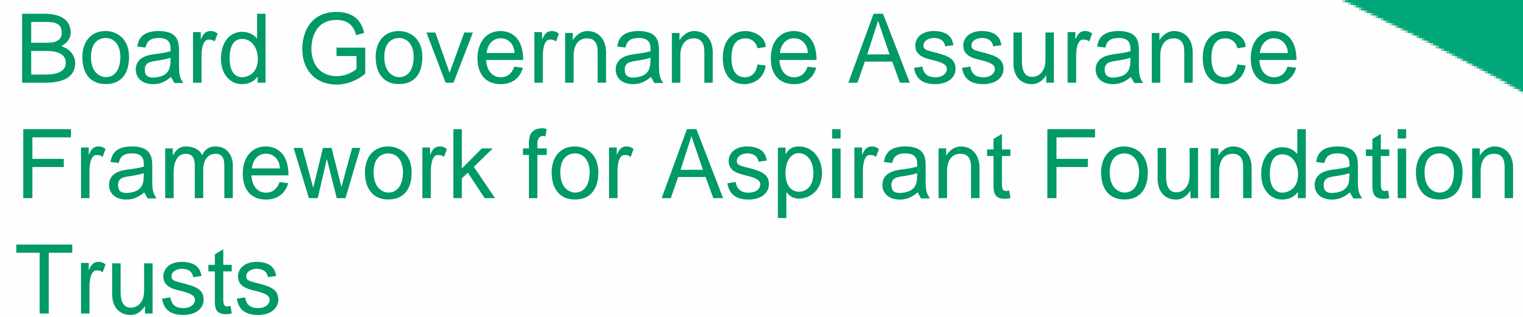
DH Department of Health



Board Governance Assurance Framework for Aspirant Foundation Trusts

Board Governance Memorandum

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Procedure - new
Gateway Reference	16884
Title	Board Governance Assurance Framework for Aspirant Foundation Trusts
Author	DH
Publication Date	15 December 2011
Target Audience	NHS Trust CEs, NHS Trust Board Chairs
Circulation List	SHA CEs, Directors of Provider Development, Strategic Health Authority Clusters
Description	This document sets out the structure, content and process for completing and independently validating a Board Governance Memorandum (BGM) for Aspirant NHS Foundation Trusts (AFTs).
Cross Ref	N/A
Superseded Docs	N/A
Action Required	NHS Trust chief executives are asked to note that the Board Governance Memorandum must be completed before they submit their FT application to DH.
Timing	**N/A**
Contact Details	Laura Roberts Head of Provider Leadership Development Floor 5, Richmond House 79 Whitehall, London SW1A 2NS email: Laura.Roberts@dh.gsi.gov.uk
For Recipient's Use	

Contents

Executive Summary	3
Introduction	5
Board Governance Memorandum (BGM) design principles	7
BGM overview	8
1.Board composition & commitment	15
2.Board evaluation, development & learning	20
3.Board insight and foresight	26
4.Board engagement and involvement	32
5.Board impact case studies	38
BGM Submission Document	43
Appendices	74

© Crown copyright 2011
First published December 2011
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

Executive Summary

Good governance is a hallmark of high performing organisations. We need NHS Boards that are primarily focused on care quality and excellent patient experience, are effective at understanding their business, can articulate and oversee the delivery of a strong strategic vision, and are able to demonstrate robust financial control.

The best Boards know how much quality matters to their patients, public and staff. They recognise that patients will choose services, and providers will compete on this basis. They understand how patients need healthcare services that are clinically and financially sustainable now and in the future.

To deliver this we will require strong leadership from NHS Boards. Boards who are prepared to ask probing questions and challenge mindsets. Boards who can take difficult decisions, working collaboratively across care pathways and beyond organisational boundaries. Boards who can radically challenge traditional models to deliver truly integrated services that patients tell us they want.

NHS Foundation Trust (FT) Boards are in the best shape to take up these challenges. This is because they have faced rigorous assessment of their capability and capacity by Monitor, the FT regulator. FT Boards also benefit from increased accountability for their decisions through the involvement of locally elected governors. This combination gives FT Boards the confidence and mandate to set the compass for a sustainable future, rooted in the needs of the local communities they serve.

For this reason, FTs remain at the heart of the Government's plans to modernise the NHS. At least 140 NHS bodies have now been authorised as FTs. The strong expectation is that remaining NHS trusts will achieve FT status by 2014, either on their own, as part of an existing FT, or in another organisational form under new management arrangements.

Each NHS Trust Board has made an explicit public commitment to achieve this by signing and publishing a Tripartite Formal Agreement (TFA). This sets out their trajectory towards becoming a FT, and the key milestones along the way.

Becoming a FT is not just a destination. The process of authorisation as an FT helps equip NHS Trust Boards more effectively to meet future challenges, by testing both clinical quality and financial viability.

Not all Boards pass these tests. Half of all aspirant NHS Trusts whose FT application is deferred during the authorisation process do so due to a failure of governance. More expressly, it means that there have been issues with capacity and capability of the Board.

In the past, to prepare for assessment by Monitor, many Trusts have undertaken Board development work. This work has varied in both cost and quality across the country. It has not always focused on the real governance challenges facing NHS Boards today.

Executive Summary (cont.)

In response, the Department of Health has commissioned the development of a **Board Governance Assurance Framework (BGAF)**, which will assist Boards through a combination of self and independent assessment processes to ensure that they are appropriately skilled, and prepared to achieve FT authorisation.

Using the Board Governance Assurance Framework means patients and the public can have confidence that their Trusts are undergoing a standardised, high quality process to help the Board build on their strengths and address any weaknesses.

All aspirant FTs are required to use the Board Governance Assurance Framework prior to submitting their FT application to the Department of Health. This is an important aspect of a Trust's application.

It is crucial to note that like other aspects of the TFAs, NHS Trusts must locally own the issues and solutions arising from the use of the framework. National support from the DH will only be available where needed.

Boards will therefore want to consider carefully the questions raised by the Board Assurance Framework, and the steps that they will take locally to address them.

The **BGAF** is structured on two key stages:

- **The Board Governance Memorandum** – where Boards self assess their current capacity and capability, which is supported by appropriate evidence and then externally validated by an independent supplier;
- **Development Modules** – where Boards can opt to gain a deeper level of assurance into the specific areas of Strategy, Quality and Finance.

This framework allows for flexibility in use and concentrates on the key elements of effective functioning for all board members. The delivery of the framework will be through a range of quality assured suppliers, at a nationally determined fixed price and met by the NHS Trust.

Co-design and Approach to development

The Department of Health (DH) commissioned Deloitte LLP to develop the Assurance Framework with key partners and stakeholders from across the NHS. The approach to co-design has consisted of:

- Forming a 'Network of Experts' from the NHS, academia, policy think tanks and beyond to provide insights and expertise and peer review the draft iterations of the Assurance Framework;
- A review of key Board effectiveness and governance good practice publications, including the *Intelligent Board* series, the *Healthy NHS Board,* and Monitor's *Governance Code;*
- Consultation and focus groups with Monitor, the Foundation Trust Network and Appointments Commission;
- Consultation with SHA Directors of Provider Development; and
- Working in partnership with six Foundation Trust Test Sites:

1. Central Manchester University Hospitals NHS FT
2. Chelsea and Westminster Hospitals NHS FT;
3. Derbyshire Mental Health NHS FT;
4. Northumberland, Tyne and Wear NHS FT;
5. South East Coast Ambulance Service NHS FT; and
6. The Royal Marsden NHS FT.

Introduction

The Board Governance Memorandum

This document sets out the structure, content and process for completing and independently validating a Board Governance Memorandum (BGM) for Aspirant NHS Foundation Trusts (AFTs).

The BGM should be completed by all AFT Boards and requires them to self-assess their current Board capacity and capability supported by appropriate evidence which is then externally validated by an independent supplier. It is the first stage of a two stage Assurance Framework; the second being the application, where necessary, of one or more Development Modules (see overleaf).

The key design principles and process are outlined in more detail on pages 7-10 inclusive, with the role of the independent external supplier covered in pages 11- 14 inclusive.

Application of the BGM (Stage 1)

It is recommended that all Board members of AFTs familiarise themselves with the structure, content and process for completing the BGM.

The BGM is designed to provide assurance in relation to various leading indicators of Board governance. The BGM covers 4 key stages:

1. Complete the BGM self-assessment

2. Approval of the BGM by the AFT Board and signed-off by the AFT Chair;

3. BGM tested by an independent supplier;

4. Independent report produced.

Complete the BGM: It is recommended that responsibility for completing the self-assessment BGM sits with the Company/Trust Secretary and is completed section by section with identification of any key risks and good practice that the AFT Board can evidence. A submission document is provided (page 43) for the Board to record its responses and evidence, and to capture its self-assessment rating . Refer to the scoring criteria identified on page 9 to calculate self assessment ratings.

Approval of the BGM by AFT Board and signed off by the AFT Chair: The BGM is designed to mirror the self-certification process used by Monitor. Therefore, AFT Board's RAG ratings on the memorandum should be debated and agreed at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and ultimately signed off by the AFT Chair on behalf of the Board.

Introduction (cont.)

BGM tested by an independent supplier: All Board approved BGMs should be independently verified by an external and independent supplier. This will be done through a robust process including 1:1 interviews with Board members, Board meeting observation, staff focus groups as well as reviewing and analysing the evidence submitted by the Trust to support the BGM rating.

Independent report produced: The independent supplier will provide a report back to the AFT Board, the SHA cluster and the DH/NHS Trust Development Authority (NTDA). This report will include their independent view on the accuracy of the BGM ratings reached by the AFT Board and, where necessary, provide recommendations for improvement, including the application of various development modules if appropriate (see below).

The use of the independent supplier is at a fixed national price for the research, analysis and subsequent production of their final report. Further details on this are set out in BGM section of the tool.

Application of the Development Modules (Stage 2)

Three Development Modules have been created in the following areas:

1. Organisational Strategy & Values;

2. Quality Governance;

3. Financial Governance.

The modules have been designed to be developmental and support improvements in Board governance of an AFT following completion of the BGM and the independent report. The modules should be used where the independent report has identified the need for further work or used at local discretion of the AFT Board.

Each module sets out a series of key activities which are then broken down into specific sections. Against each section, there are a series of 'Red Flags' which suggest poor Board governance on a particular activity and "Good Practice" criteria. Where development is required, an AFT can focus on the areas of 'Good Practice' to support them in their development journey. Potential sources of evidence to demonstrate good practice are also provided.

Further details on the three Development Modules can be found on the Department of Health website **www.dh.gov.uk/publications**

BGM design principles

Principle	As demonstrated through...
1. **Respect:** Respect the work that has already be undertaken by aspirant FTs, SHAs and others and build on the Tri-Partite agreement	The BGM will require AFTs to submit evidence against each of the criteria. This evidence will enable them to showcase what they have achieved to date.
2. **Co-creation:** Co-created with the DH, NHS, Monitor & Deloitte	• We have created a Network of Experts that contains key NHS Leaders from all types of provider, both AFT and FT. • We have engaged with Monitor, SHA Provider Development Leads, FTN, and the Appointments Commission.
3. **Aligned:** Consistent with key features of the Monitor assessment process (e.g. Self-certification)	The BGM is based upon the principle of self-certification and is required to be approved by the whole Board.
4. **Good practice:** Utilise global good practice research and expertise from the public and private sectors	• We have engaged with key experts from Deloitte, NHS, and the private sector. • We have created an Academic and Practitioner Network of Experts. • We have referenced key NHS publications in the development of the BGM .
5. **Value for money:** Minimise cost and increase efficiency by using and/or adapting existing tools and limiting the need for expensive resources.	• We have utilised existing tools and products wherever possible.

BGM overview

The BGM is designed to provide assurance in relation to various leading indicators of effective Board governance. These indicators are:

1.Board composition and commitment (e.g. Balance of skills, knowledge and experience);

2.Board evaluation, development and learning (e.g. The Board has a development programme in place);

3.Board insight and foresight (e.g. Performance Reporting);

4.Board engagement and involvement (e.g. Communicating priorities and expectations);

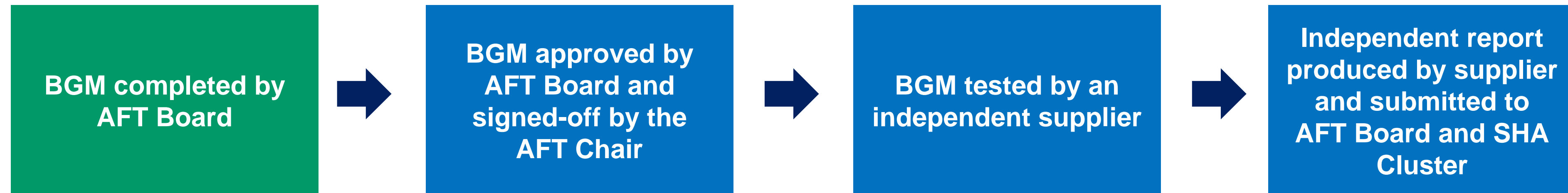
5.Board impact case studies (e.g. a case study that describes how the Board has responded to a recent financial issue).

Each indicator is divided into various sections. For example, 'Board composition and commitment' is divided into 3 sections: (1) Board positions and size; (2) Balance of skills, knowledge and experience; and (3) Board member commitment. Each section contains Board governance good practice statements and risks.

The AFT Board is required to complete the BGM Submission Document (see page 43). The AFT Board should RAG rate each section on a 'comply or explain' basis. That is, the Board should RAG rate each section based on the criteria outlined below. In addition, the Board should provide evidence and/or explanation to support their rating. Evidence can be in the form of documentation that demonstrates that they comply with the good practice or Actions Plans that describe how and when they will comply with the good practice. In a small number of instances, it is possible that an AFT Board either cannot or may have decided not to adopt a particular practice. In cases like these the Board should explain why they have not adopted the practice or cannot adopt the practice.

In addition to the RAG rating and evidence described above, the AFT Board is required to submit 4 mini case studies. These case studies are described in further detail in the Board Impact section.

BGM overview (cont.)



The scoring criteria for each section is as follows:

Green if the following applies:

- All good practices are in place unless the Board is able to explain why it is unable or has chosen not to adopt a particular good practice.
- No Red Flags identified.

Amber/ Green if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved, there are either:
  - robust Action Plans in place that are on track to achieve good practice; or
  - the Board is able to explain why it is unable or has chosen not to adopt a good practice and is controlling the risks created by non-compliance.
- One Red Flag identified but a robust Action Plan is in place and is on track to remove the Red Flag or mitigate it.

Amber/ Red if the following applies:

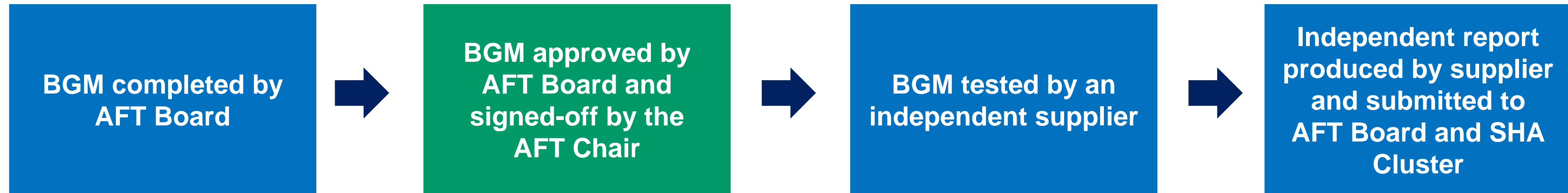
- Some elements of good practice in place.
- Where good practice is currently not being achieved:
  - Action Plans are not in place, not robust or not on track;
  - the Board is not able to explain why it is unable or has chosen not to adopt a good practice; or
  - the Board is not controlling the risks created by non-compliance.
- Two or more Red Flags identified but robust Action Plans are in place to remove the Red Flags or mitigate them.

Red if the following applies:

- Action Plans to remove or mitigate the risk(s) presented by one or more Red Flags are either not in place, not robust or not on track

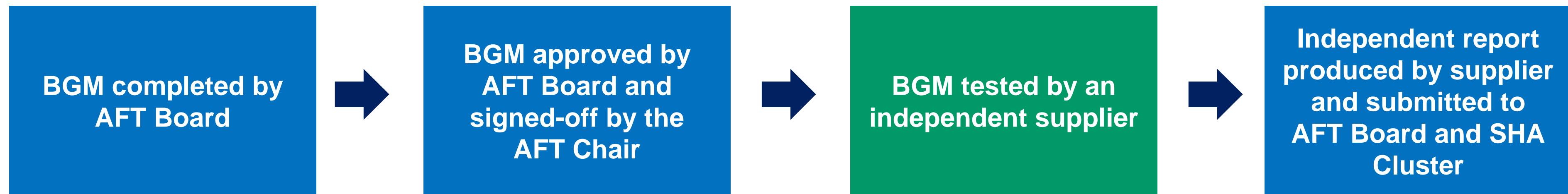
Please note: the various Red Flags included throughout this document are designed to highlight governance risks and are not intended to be a barrier to the Board's FT application. Where Red Flags are indicated, the AFT Board should describe the actions that are either in place to remove the Red Flags (e.g. a recruitment timetable where an AFT currently has an interim Chair) or mitigate the risk presented by the Red Flags (e.g. where Board members are new to the organisation there is evidence of robust induction programmes in place).

BGM overview (cont.)



The BGM is designed to mirror the self-certification process used by Monitor. Therefore, the AFT Board's RAG ratings on the BGM should be debated and agreed by the AFT Board at a formal Board meeting, a note of the discussion should be formally recorded in the Board minutes and then signed-off by the Trust Chair on behalf of the AFT Board.

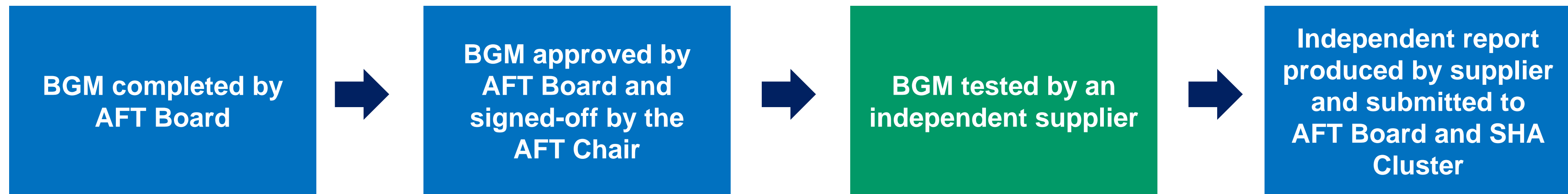
BGM overview (cont.)



The content of the BGM will be independently verified by an independent supplier. It is envisaged that the supplier will spend a number of days on site at the AFT, independently reviewing the evidence provided by the Board to support their BGM. An overview of the process is outlined below. The supplier will observe a Board meeting, interview Board members, and interview internal and external stakeholders. The site visit will culminate in a feedback session with the AFT Chair and CEO where the supplier will share their findings and advise on next steps.

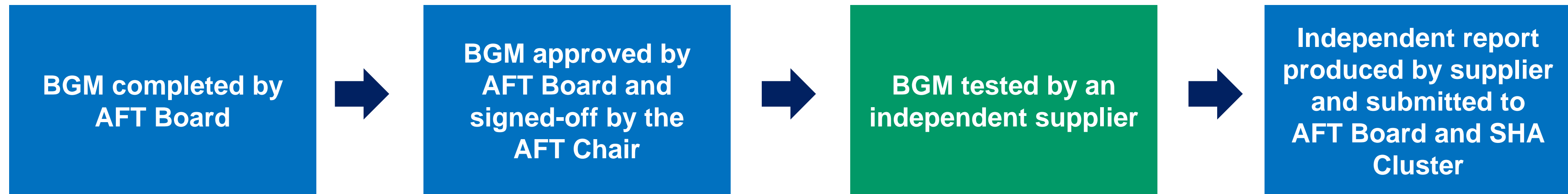
	Activity	Purpose
Information gathering (Off-site)	• Desktop review of evidence supplied by the AFT Board; • Generate a list of questions and areas to probe once on site.	Review of all the evidence supplied by the Board to support their BGM submission and compilation of a list of areas to investigate further during on-site visit.
	• Calls with external stakeholders. To include: main commissioners, SHA Cluster lead, Chair of the local Overview and Scrutiny Committee, external auditors, MPs and, if appropriate, other providers.	Ascertain an external stakeholder perspective on the capability of the Board and their suitability to govern an NHS FT.
Information gathering (On-site)	• Introductory meeting with Chair, CEO and Company Secretary (or equivalent);	To introduce the process and answer any immediate questions.
	• A focus group with patients, service users, carers and Trust volunteers.	Understand how patients, service users, carers and volunteers perceive the Board's commitment to quality.

BGM overview (cont.)



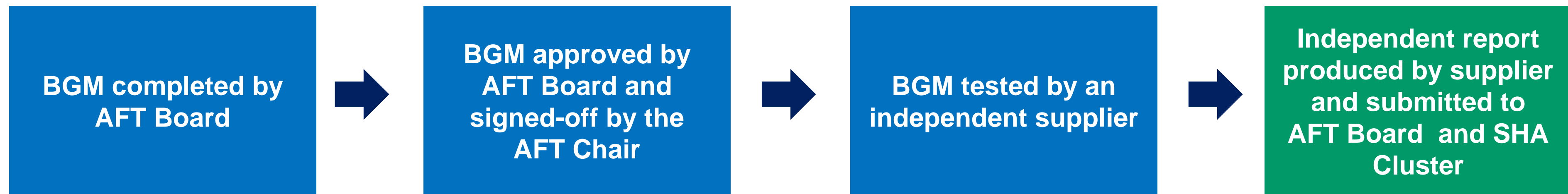
	Activity	Purpose
Information gathering (On-site) (cont.)	• Observe a Board meeting.	To assess how effective the Board is at holding the executive to account, whether Board challenge is appropriately balanced with support, the level of strategic discussion, focus on quality etc.
	• Conduct a Board-to-Board	To explore and test aspects of the BGM submission directly with Board members.
	• Interview with Company Secretary (or equivalent)	To answer any questions arising from the desktop review.
	• Interviews with every member of the Board (1 hr each).	To assure the independent supplier that the Board member understands the IBP, LTFM, major risks etc. and test aspects of the Board's BGM submission. The supplier will discuss with the Senior Independent Director the effectiveness of the Chair.
	• Conduct 2 staff focus groups (1.5 hrs and between 15 and 25 staff per focus group). Attendees should be randomised but include: senior and junior medical; registered nurses; nursing assistants; support staff; staff side/ LMC.	Consider the impact that the Board is having on the organisation and assess the extent to which staff understand the Trust's vision and strategy (as detailed in the IBP).

BGM overview (cont.)



	Activity	Purpose
Analysis of themes and 'Confirm and Challenge' session with the Chair and CEO. (On/off-site)	• Session to analyse the information received on-site.	Collation of various sources of information to determine whether the RAG ratings provided by the Board can be substantiated or require challenge.
	• Initial meeting with Chair in the first instance as leader of the Board and then joined by CEO.	'Confirm and Challenge' session to confirm which areas of the BGM have been substantiated by the independent supplier and challenge the areas where they do not believe the evidence provided supports the Board's RAG rating.
Report writing. (Off-site)	• Production of a report documenting the findings from the desktop and on-site review. • Final liaison with the Board (possible presentation to the Board).	The report will highlight areas where the independent supplier corroborates the ratings of the Board and where they believe the ratings should be reviewed. Improvement suggestions will be provided (see next page).

BGM overview (cont.)



The independent supplier will produce a summary report for the AFT, SHA cluster and DH outlining:

1.Where their independent findings are consistent with the AFT Board's findings;

2.Where they believe there is insufficient evidence to support the ratings provided by the AFT (i.e. either the evidence given is insufficient, the rationale provided as to why a good practice has not been adopted is unsatisfactory and/or action/ mitigation plans are deficient);

3.Recommendations to improve the AFT Board's ratings and/or areas where they believe additional assurance is required;

4.An indication of whether or not there are any major risks from a Board governance perspective with the AFT achieving the timeline as outlined in their Tripartite Formal Agreement.

In relation to 3 there are various services and products available (either through the NHS or Board Development suppliers) to help support the development of the AFT Board and individual Board members. In some instances, it may be necessary for the independent supplier to recommend deeper levels of assurance in certain areas. For example, concerns in relation to the quality of care provided by the AFT may emerge throughout the independent review and it may, therefore, in this instance be necessary for the supplier to recommend a review of the AFT Board's quality governance arrangements.

Accordingly, the DH has commissioned 3 'development modules' in the areas of strategy, quality and finance that can be used where deeper levels of assurance are sought. It is envisaged that these modules will be delivered by an independent supplier working in collaboration with the AFT and culminate in a 'confirm and challenge' event with the whole AFT Board.

1. Board composition and commitment

1. Board composition and commitment

Overview

This section focuses on Board composition and commitment, and specifically the following areas:

1. Board positions and size

2. Balance and calibre of Board members

3. Board member commitment

1. Board composition and commitment

1.1 Board positions and size

Red Flag	Good Practice
1. The Chair and/or CEO are currently interim or the position(s) vacant. 2. There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago). 3. The number of people who routinely attend Board meetings is unwieldy compared to other NHS Provider Trusts.	1. The size of the Board (including voting and non-voting members of the Board) is appropriate for the requirements of the business. 2. All voting positions are substantively filled. 3. The Board has a Senior Independent Director (SID) in place. 4. The Board has a Foundation Trust Secretary (or equivalent) in place. 5. It is clear who on the Board is entitled to vote. 6. At least half the Board of Directors, excluding the Chair, comprise NEDs determined by the Board to be independent (refer A3.2 and C2.2 in the Monitor NHS Foundation Trust Code of Governance). 7. Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or leave the Board within a short space of time.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Biographical information on each member of the Board. • The Board's structure. • Job Descriptions/ Role Specifications for FT Secretary, SID, and NEDs. • Evidence of potential conflicts of interest of Board members being declared and managed.

1. Board composition and commitment

1.2 Balance and calibre of Board members

Red Flag	Good Practice
1. There are no NEDs with a recent and relevant financial background. 2. There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector. 3. The majority of Board members are in their first Board position. 4. The majority of Board members are new to the organisation (i.e. within their first 18 months).	1. The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the Trust over the next 5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the Trust's IBP. 2. In selecting Board members, the Chair and CEO have given due consideration to various qualities that are essential for the person to be effective in their Board role (e.g. effective at working in teams, independence of thought, well developed political/ influencing skills, sound judgement, ability to build trusting and respectful relationships, ability to listen first and then assert their view). 3. The Board has an appropriate blend of NEDs from the public, private and voluntary sectors. 4. The Board has given due consideration to the diversity of its composition in terms of the protected characteristic groups in the Equality Act 2010. 5. There is at least one NED with a clinical healthcare background (e.g. a doctor, nurse or allied health professional who is not conflicted). 6. There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer. 7. The majority of the Board are experienced Board members. 8. The Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment. 9. The Chair of the Board has previous non-executive experience. 10. At least one member of the Audit Committee has recent and relevant financial experience.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Biographical information on each member of the Board. • The Board's structure. • Board skills audit. • Board and Committee Terms of Office for NEDs. • Example NED role descriptions.

1. Board composition and commitment

1.3 Board member commitment

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. There is a record of Board and Committee meetings not being quorate.
2. There is regular non-attendance by one or more Board members at Board or Committee meetings.
3. Attendance at one or more Committees is inconsistent (i.e. the same Board members do not consistently attend the same Committee meetings).
4. There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved.</td><td>1. Board members have a good attendance record at all formal Board and Committee meetings and at Board events (e.g. workshops; quality walks etc).
2. The Board has discussed the time commitment required of the FT process and Board members have committed to set aside this time.
3. The Board has an explicit ‘Code of Conduct’ which clearly describes the behaviours expected of Board members. These behaviours are aligned to the values of the Trust and the 7 Nolan Principles of Public Life. Compliance with the code is routinely monitored by the Chair and included as part of each Board member’s annual appraisal.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board’s RAG rating.</td><td>• Board attendance record.
• Attendance at Sub-Committee meetings.
• Induction programme.</td></tr>
</table>

2. Board evaluation, development and learning

2. Board evaluation, development and learning

Overview

This section focuses on Board evaluation, development and learning, and specifically the following areas:

1.Effective Board-level evaluation;

2.Whole Board Development Programme;

3.Board induction, succession and contingency planning;

4.Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

Red Flag	Good Practice

1. No formal Board evaluation has been undertaken within the last 12 months.
2. The Board has not undertaken an independent evaluation of its effectiveness within the last 2 years.
3. Where the Board has undertaken an evaluation, only the perspectives of Trust Board members were considered and not those outside the Board (e.g. staff, commissioners etc).
4. Where the Board has undertaken an evaluation, only one evaluation method was used (e.g. only a survey of Board members was undertaken).
	1. Formal evaluations of the Board and Committees have been undertaken within the previous 12 months consistent with the NHS Foundation Trust Code of Governance. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal evaluations that have been undertaken.
	2. The Board has had an independent evaluation of its effectiveness and committee structure within the last 2 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations.
	3. In undertaking its formal evaluation, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners and/or patients) on whether or not they perceive the Board to be effective.
	4. The focus of the evaluation included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum:
	    1. The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this;
	    2. How effectively meetings of the Board are chaired;
	    3. The effectiveness of challenge provided by Board members;
	    4. Role clarity between the Chair and CEO, Executive Directors and NEDs, between the Board and management and between the Board and its various sub-committees;
	    5. Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session.
	    6. The quality of relationships between Board members, including the Chair and CEO. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.

Examples of evidence that could be submitted to support the Board's RAG rating.	• Report on the outcomes of the most recent Board evaluation and examples of changes/ improvements made in the Board and Committees as a result of an evaluation. • The Board Scheme of Delegation/ Reservation of Powers.

2. Board evaluation, development and learning

2.2 Whole Board development programme

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. The Board does not currently have a Board development programme in place.
2. The Board Development Programme is not aligned to helping the Board achieve FT status.</td><td>1. The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual evaluation (see previous section) and contains the following elements: understanding what FT status means; development specific to the Trust's FT application; and reflecting on the effectiveness of the Board and its supporting governance arrangements.
2. Understanding what FT status means - Board members have an appreciation of how they will be regulated as an NHS FT and the role of the Board and NEDs in an FT environment.
3. Development specific to the Trust's FT application – the Board is or has been engaged in the development of the IBP and LTFM and self-assessing the Trust's quality governance arrangements against Monitor's Quality Governance Framework.
4. Reflecting on the effectiveness of the Board and its supporting governance arrangements - The development programme includes time for the Board as a whole to reflect upon, and where necessary improve:
    1. The focus and balance of Board time;
    2. The quality and value of the Board's contribution and added value to the AFT;
    3. How the Board responded to any service or financial failures;
    4. Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board;
    5. The robustness of the Trust's risk management processes;
    6. The reliability, validity and comprehensiveness of information received by the Board.
5. Time is 'protected' for undertaking this programme and it is well attended.
6. The Board has considered, at a high-level, the potential development needs of the Board post authorisation as an FT.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board's RAG rating.</td><td>• The Board Development Programme.
• Attendance record at the Board Development Programme.</td></tr>
</table>

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Red Flag	Good Practice
1. There is no formal induction for new members of the Board. 2. Deputy Chair and Deputy CEO positions have not been formally designated and noted in Board minutes. 3. NED appointment terms are not sufficiently staggered.	1. All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, and the statutory duties of Board members in FTs. 2. Induction for Board members is conducted on a timely basis. 3. Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the Trust, the organisation's structure, Trust values and meetings with key leaders. 4. Deputy positions for the Chair and CEO have been formally designated and minuted. 5. The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions (Executive and Non Executive) not withstanding the requirement to market test applicants and, where appropriate, recruit externally.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Succession plans. • Sample induction programmes.

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Red Flag	Good Practice
1. There is not a robust performance appraisal process in place at Board level that evaluates the Board contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received. 2. Individual Board members have not received any formal training or professional development relating to their Board role.	1. The effectiveness of each Board member's contribution to the Board, including the Board contribution of Executive Directors, is formally evaluated on an annual basis by the Chair (in the case of Executive Directors, this appraisal may form part of a wider annual appraisal process and therefore fed back via the CEO). The evaluation process includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. 360 degree appraisal) and how they have performed against their objectives. 2. There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the Senior Independent Director. 3. Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis by the Chair. 4. Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role. In particular, each Board member has reflected upon their personal development needs in relation to helping the Trust successfully achieve FT authorisation and, where appropriate, has included these needs within their Personal Development Plan. 5. There are processes in place to ensure the development of Executive Directors as Corporate Directors. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level. 7. The involvement of Governors in the Chair and NED appraisal process once the Trust is an FT has been considered.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Performance appraisal process used by the Board. • Sample Personal Development Plans. • Sample Board member objectives. • Evidence of attendance at training events and conferences. • Board minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors.

3. Board insight and foresight

3. Board insight and foresight

Overview

This section focuses on Board information, and specifically the following areas:

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. Significant unplanned variances in performance have occurred
2. Performance failures were brought to the Board's attention by an external party and/or not in a timely manner.
3. Finance and Quality reports are considered in isolation from one another.
4. The Board does not receive 12 month rolling cash flow forecast information.
5. The Board only receives minutes of Committee meetings and does not tend to discuss them.
6. The Board does not have an action log.
7. Key risks are not reported / escalated up to the Trust Board.</td><td>1. The Board has debated and agreed a set of quality and financial metrics outside the national and regionally agreed metrics that are relevant to the Board given the context within which it is operating and what it is trying to achieve.
2. The Board receives a performance report which includes:
  1. A fully integrated performance dashboard which enables the Board to consider the performance of the Trust against a range of metrics including quality, performance, activity and finance and enables links to be made (e.g. financial variances are linked to activity);
  2. Variances from plan are clearly highlighted and explained;
  3. Key trends and findings are outlined and commented on;
  4. Future performance is projected with associated risks and mitigations provided where appropriate (e.g. forecast outturn);
  5. Key quality information is triangulated (e.g. complaints, claims, incidents, Rule 43 issues, key HR metrics, and audit findings) so that Board members can accurately describe where problematic service lines are;
  6. Benchmarking of performance to comparable organisations is included where possible;
  7. Supporting performance detail is broken down by Service Line so members can understand which services are high and low performing from a financial and quality perspective.
3. The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made.
4. The Board regularly discusses the key risks facing the AFT and plans to manage or mitigate them.
5. An action log is taken at Board meetings. Accountable individuals and challenging / demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board's RAG rating.</td><td>• Board Performance Report.
• Board Action Log.
• Example Board agendas and minutes highlighting sub-committee discussions by the Board.</td></tr>
</table>

3. Board insight and foresight

3.2 Efficiency and Productivity

Red Flag	Good Practice
1. The Board does not receive performance information relating to progress against CIPs and QIPP targets and plans. 2. There is no process currently in place to prospectively assess the risk(s) to care quality presented by CIPs.	1. The Board is assured that there is a robust process for prospectively assessing the risk(s) to care quality and the potential knock-on impact on the wider health and social care community of implementing CIPs. This process requires the Medical, Nursing and Operations Directors to all sign-off each major CIP to ensure that patient safety is not compromised. 2. The Board can provide examples of CIPs that have been rejected or significantly modified due to their potential impact on patient safety. 3. The Board receives information on all major CIPs/ QIPP plans on a regular basis, including how other organisations in the local health economy are performing against QIPP. Schemes are allocated to lead Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement of each major CIP is clearly stated and contingency measures are articulated. 4. There is a process in place to monitor the ongoing risks to care quality for each scheme once a scheme has been implemented, including a programme of formal post implementation reviews. Change(s) to working practice(s) due to major CIPs are supported by a programme of organisation development.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Quality assurance process for signing-off and monitoring CIPs. • Examples of CIPs that have been rejected on the basis of quality. • Board reporting pack that documents CIP progress. • Example post implementation review.

3. Board insight and foresight

3.3 Environmental and strategic focus

Red Flag	Good Practice
1. The Board does not receive an update on developments within the external environment at each Board meeting. 2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the Trust and downside scenario planning. 3. The Board does not formally review progress towards delivering its strategy.	1. The CEO presents a report to every Board detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks in the health economy, PBR new tariffs etc.). The impact on strategic direction is debated and, where relevant, updates are made to the Trust's risk registers and BAF. 2. The Board has reviewed lessons learned from enquires and has considered the impact upon themselves. Actions arising from this exercise are captured and progress is followed up. 3. The Board has conducted or updated an external stakeholder mapping exercise, market analysis and/or PESTELI analysis within the last year to inform the development of the IBP. 4. In developing the IBP, the Board as a whole has explored market opportunities and threats in relation to the services it provides, discussed its appetite for risk and has considered various alternative futures (e.g. scenario planning). 5. The Board has agreed a set of corporate objectives and associated KPIs/ milestones that enable the Board to monitor progress against implementing its vision and strategy for the Trust. Performance against these corporate objectives and KPIs/ milestones are reported to the Board on a quarterly basis. 6. The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the Trust and downside scenario planning (e.g. the risks presented by PBR, commissioning intentions and efficiency requirements). Specifically, the Board can demonstrate that it has sufficiently discussed the downside scenarios that underpin the LTFM, including key mitigation plans and trigger points for deploying these plans. 7. Strategic risks to the Trust are actively monitored through the Board Assurance Framework (BAF).
Examples of evidence that could be submitted to support the Board's RAG rating.	• CEO report. • Evidence of the Board reviewing lessons learnt in relation to enquiries. • Outcomes of an external stakeholder mapping exercise. • Corporate objectives and associated KPIs/ milestones and how these are monitored. • Board Annual programme of work. • BAF.

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Red Flag	Good Practice
1. Reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. 2. Board discussions are focused on understanding the Board papers as opposed to making decisions. 3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting.	1. The Board can demonstrate that it has actively considered the timing of Board and committee meetings and the presentation of Board and committee papers in relation to month and year end procedures and key dates (e.g. submissions to CQC) to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. 2. A timetable for sending out papers to members is in place and adhered to. 3. Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, discussion). 4. Board members have access to in-month flash reports to demonstrate performance against key metrics and there is a defined procedure for bringing significant issues to the Board's attention outside of formal monthly meetings. 5. Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported, where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has already been through. 6. The Board is routinely provided with data quality updates (e.g. Information Governance Toolkit scores). These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place. 7. The Board can provide examples of where it has explored the underlying data quality of performance metrics that have been RAG rated green.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board meeting timetable. • Process for submitting and issuing Board papers. • In-month flash reports. • Sample Board papers. • Data Quality updates.

4. Board engagement and involvement

4. Board engagement and involvement

Overview

This section focuses on Board engagement and involvement, and specifically the following areas:

1. External stakeholders

2. Internal stakeholders

3. Board profile and visibility

4. Future engagement with FT Governors

4. Board engagement and involvement

4.1 External stakeholders

Red Flag	Good Practice
1. The development of the IBP and LTFM has only involved the Board and a limited number of Trust staff. 2. The Trust has poor relationships with its commissioners. 3. The Trust's latest patient survey results are poor. 4. The Trust has received adverse negative publicity in relation to the services it provides in the last 12 months.	1. The Board has an External Stakeholder Engagement Plan that clearly describes the Trust's key existing and emerging external stakeholders, their relative priority and the tailored methods used to involve each stakeholder group (stakeholders include PCT Cluster, Clinical Commissioning Groups, Local Authorities and Wellbeing Boards). 2. A variety of methods are used by the Trust to enable the Board and senior management to listen to the views of patients, carers, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 3. The Board can evidence how key external stakeholder groups (e.g. patients, carers, commissioners and MPs) have been engaged in the development of their 5 year strategy for the Trust and provide examples of where their views have been included and not included in the IBP. 4. The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the IBP (e.g. campaigns in community vantage points, shopping centres, leisure centres; close links with academic institutions and schools; visits to 'hard to reach 'groups etc.). 5. The Trust has constructive and effective relationships with its key stakeholders, especially Lead Commissioners.
Examples of evidence that could be submitted to support the Board's RAG rating.	• External Stakeholder Engagement Plan. • Organisational/ management structure. • Clinical Commissioning Group Strategy. • Description of disputes with Commissioners and how they have been resolved.

4. Board engagement and involvement

4.2 Internal stakeholders

Red Flag	Good Practice
1. The Trust's latest staff survey results are poor. 2. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence' by the clinical community, the Trust does not have productive relationships with staff side/ trade unions etc.). 3. There are significant unresolved quality issues.	1. A variety of methods are used by the Trust to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 2. The Board can evidence how staff have been engaged in the development of their 5 year strategy for the Trust and provide examples of where their views have been included and not included in the IBP. 3. The Board ensures that staff understand the Trust's key priorities and how they contribute as individual staff members to delivering these priorities. 4. The Trust uses various ways to celebrate services that have an excellent reputation and acknowledge staff who have made an outstanding contribution to patient care and the running of the Trust. 5. The Board has communicated a clear set of values/ behaviours and how staff that do not behave consistent with these values will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the Trust's stated values/ behaviours. 6. There are processes in place to ensure that staff are informed about major risks that might impact on patients, staff and the Trust's reputation and understand their personal responsibilities in relation to minimising and managing these key risks. 7. The Board can demonstrate that clinicians play a key role in management and decision-making within the Trust.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Internal engagement or communications strategy/ plan. • Organisational values. • Dignity at Work policy.

4. Board engagement and involvement

4.3 Board profile and visibility

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board.
2. Attendance by Board members is poor at events/ meetings that enable the Board to engage with staff (e.g. quality/ leadership walks; staff awards, drop in sessions).</td><td>1. There is a structured programme of events/ meetings that enable NEDs to engage with staff (e.g. quality/ leadership walks; staff awards, drop-in sessions) that is well attended by Board members and has led to improvements being made.
2. There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and CEO, amongst external stakeholders.
3. Board members attend and/or present at high profile events.
4. NEDs routinely meet patients and carers.
5. The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board’s RAG rating.</td><td>• Board programme of events/ quality walkabouts with evidence of improvements made.
• Active participation at high-profile events.
• Evidence that Board minutes are publicly available and summary reports are provided from private Board meetings.</td></tr>
</table>

4. Board engagement and involvement

4.4 Future engagement with FT Governors

Red Flag	Good Practice
1. The Board has not yet considered the roles and responsibilities of the Council of Governors. 2. The Board has not yet considered how best to communicate with and engage the Council of Governors. 3. The Board has not yet considered how to elect, induct and develop governors.	1. The Board has a plan in place to form a Council of Governors which is representative of the staff and community served by the Trust and partner organisations. The Board has considered the size of the Council of Governors to ensure it is not unwieldy and how the Council will be structured in order to discharge its statutory duties. 2. There is a statement in place that sets out the roles and responsibilities of the Council of Governors and how these are distinct from, but complementary to, the roles and responsibilities of the Board. The statement also considers the role of specific groups of governors (e.g. staff governors) and how they will be used to best effect. 3. There are robust plans in place to elect, induct and develop governors once the Trust is authorised. 4. There are robust plans in place to show how the Board will communicate with and engage governors, in particular, in the areas of strategy development, service change and quality issues. 5. The Board has a Membership Strategy that describes the number of members required, how that target will be reached, how the Trust will ensure that its membership is representative and how the membership will be maintained going forward. 6. The Board has a strategy for engaging with its membership, including describing the kinds of issues it will consult with members on and how the views of hard-to-reach groups in the community will be represented.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Council of Governors Development Plan. • Membership Recruitment Strategy. • Membership Engagement Strategy. • Statement on the roles and responsibilities of the Council of Governors. • Governor election timetable and plan.

5. Board impact case studies

5. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the Trust and considers recent case studies in the following areas:

1. Performance failures in the areas of quality;

2. Performance failures in the areas of finance;

3. Organisational culture change; and

4. Organisational strategy.

5. Board impact case studies

5.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the Trust, patients, carers and the public. To support this section of the BGM, the Board is required to submit four brief case studies:

1.A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality (examples of potential quality issues are provided in section 5.2.). In putting together the case study, the Board should describe:

1. Whether or not the issue was brought to the Board's attention in a timely manner;
2. The Board's understanding of the issue and how it came to that understanding;
3. The challenge/ scrutiny process around plans to resolve the issue;
4. The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

2.A recent case study briefly outlining how the Board has responded to a performance failure in the area of finance (examples of potential financial issues are provided in section 5.3.). In putting together the case study, the Board should describe:

1. Whether or not the issue was brought to the Board's attention in a timely manner;
2. The Board's understanding of the issue and how it came to that understanding;
3. The challenge/ scrutiny process around plans to resolve the issue;
4. The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

3. A recent case study on the Board's role in bringing about a change of culture within the AFT. This case study should clearly identify:

1. The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
2. The reasons why the Board wanted to focus on this area;
3. How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
4. Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.

4.A recent case study that describes how the Board has positively shaped the vision and strategy of the Trust. This should include how the NEDs were involved in particular in shaping the strategy.

Note: Recent refers to any appropriate case study that has occurred within the past 18 months.

5. Board impact case studies

5.2 Examples of quality issues to explore in a case study

- Key quality standards not being achieved;
- One or more Never Events in the last 24 months (example 10x medication errors, suicides);
- There are concerns or sanctions raised by the CQC or consistent red-flags on the CQC QRP;
- Adverse commentary from other key regulators including the HSE, NPSA, local media or MPs;
- One or more Rule 43 issue in the last 24 months;
- A high reporting rate on NRLS with a high proportionate incidence of ‘serious harm’;
- NHSLA level 1 without reasonable delays or NHSLA reduced level;
- Same or similar causal factor incidents;
- There is significant adverse local or national media coverage in relation to quality or evidence of poor reputation (patient choices etc);
- Feedback significantly below the average on National Patient Surveys;
- Repeated significant issues on PEAT inspections;
- Incidents or root causes associated with failing to identify and monitor the deteriorating patient (MEWS etc);
- Poor staff survey results
- Quality issues arising from the remote working of clinical staff.

5. Board impact case studies

5.3 Examples of financial issues to explore in a case study

- The Trust has not achieved a break even position in each of the last 3 years.
- In the previous year the actual financial outturn performance was >10% variance of the original planned budget.
- Contracts with key commissioners were not signed by the end of the first quarter of the financial year
- In the previous year the Trust did not meet its CIP plan and the variance between outturn and plan was > 15%
- The Trust met its CIP target in the previous year, although this was predominantly through the use of non-recurrent schemes which accounted for > 20% of plan
- There has been significant slippage in the performance against the capital plan and the Trust has failed to meet it's CRL in each of the last 3 years.
- The current FRR is < 3.
- Significant backlog maintenance without an affordable capital plan.

[Insert name of Aspirant Foundation Trust]

BGM Submission Document

[Insert date of BGM submission]

[Insert planned date to enter DH process as per TFA]

Contents

		Page
Board context		45
Summary results		47
1.	Board composition & commitment	50
2.	Board evaluation, development & learning	54
3.	Board insight and foresight	59
4.	Board engagement and involvement	64
5.	Board impact case studies	69

Board context

Board context

This section should set the overall context for the AFT and should include a brief overview of the Trust together with a summary of the Trust's key strategic objectives and how it is performing against them. This overview links into section 3.3 of the Board Memorandum under good practice point 5 which covers the Board's strategic focus. It provides the Board with an opportunity to summarise what is important to the organisation, how it performs against KPIs and what patients think of the services provided.

In this section please provide a brief overview of:

1.Your organisation in terms of income, staff and key services provided;
2.Your organisation's key strategic objectives
3.Summary of the KPIs the Board uses to track performance against these objectives ands how the Trust is currently performing
4.Summary of the trust position with regards patient feedback

Summary results

Summary results

Overview of BGM sections 1 to 3 inclusive

1. Board composition and commitment			
Ref	**Area**	**Self-Assessment rating**	**Any additional notes**
1.1	Board positions and size		
1.2	Balance and calibre of Board members		
1.3	Board member commitment		
2. Board evaluation, development and learning			
2.1	Effective Board-level evaluation		
2.2	Whole Board development programme		
2.3	Board induction, succession and contingency planning		
2.4	Board member appraisal and personal development		
3. Board insight and foresight			
3.1	Board performance reporting		
3.2	Efficiency and Productivity		
3.3	Environmental and strategic focus		
3.4	Quality of Board papers and timeliness of information		

Summary results

Overview of BGM sections 4 and 5 inclusive

4. Board engagement and involvement			
Ref	**Area**	**Self-Assessment rating**	**Any additional notes**
4.1	External stakeholders		
4.2	Internal stakeholders		
4.3	Board profile and visibility		
4.4	Future engagement with FT Governors		

5. Board impact case studies		
Key points to highlight		
5.1	Performance issues in the areas of quality	
5.2	Performance issues in the areas of finance	
5.3	Organisational culture change	
5.4	Organisational strategy	

1. Board composition and commitment

1. Board composition and commitment

1.1 Board positions and size

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

1. Board composition and commitment

1.2 Balance and calibre of Board members

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

1. Board composition and commitment

1.3 Board member commitment

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

2. Board evaluation, development and learning

2. Board evaluation, development & learning

Section RAG rating:

2.1. Effective Board level evaluation

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

2. Board evaluation, development & learning

2.2 Whole Board Development Programme

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	**Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)**	**Explanation if not complying with good practice**
e.g. GP 1...		

Red Flags	**Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)**	**Notes/ comments**

2. Board evaluation, development & learning

Section RAG rating:

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

2. Board evaluation, development & learning

2.4 Board member appraisal and personal development

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

3. Board insight and foresight

3. Board insight and foresight

3.1 Board Performance Reporting

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

3. Board insight and foresight

3.2 Efficiency and productivity

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

3. Board insight and foresight

3.3 Environmental and strategic focus

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

4. Board engagement and involvement

4. Board engagement and involvement

4.1 External stakeholders

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

4. Board engagement and involvement

4.2 Internal stakeholders

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

4. Board engagement and involvement

4.3 Board profile and visibility

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1…		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

4. Board engagement and involvement

4.4 Future engagement with FT Governors

Section RAG rating:

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
e.g. GP 1...		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

5. Board impact case studies

5. Board impact case studies

5.1 Case Study 1

Performance Issues in the area of quality	**Title:**
Brief description of issue	
Outline Board's understanding of the issue and how it arrived at this	
Outline the challenge / scrutiny process involved	
Outline how the issue was resolved	
Summarise the key learning points	
Summarise the key improvements made to the Trust's governance arrangements directly as a result of the above	

5. Board impact case studies

5.2 Case Study 2

Performance issues in the area of finance	**Title:**
Brief description of issue	
Outline Board's understanding of the issue and how it arrived at this	
Outline the challenge / scrutiny process involved	
Outline how the issue was resolved	
Summarise the key learning points	
Summarise the key improvements made to the Trust's governance arrangements directly as a result of the above	

5. Board impact case studies

5.3 Case Study 3

Organisational culture change	**Title:**
Brief description of area of focus	
Outline reasons / rationale for why the Board wanted to focus on this area	
Outline the Board was assured that the plan/(s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	

5. Board impact case studies

5.4 Case Study 4

Organisational strategy	**Title:**
Brief description of area of focus	
Outline reasons / rationale for why the Board wanted to focus on this area	
Outline the Board was assured that the plan/(s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	
Specifically explain how the NEDs were involved	

Department of Health

Board Assurance Framework for Aspiring Foundation Trusts

Appendices

Contents

Appendix 1: Glossary 76

Appendix 2: Individuals contributing to the development of the BGM 78

Appendix 3: Foundation Trusts contributing to the development of the BGM 82

Appendix 4: Bibliography 83

Appendix 1

Glossary

Abbreviation and full term	
AFT	Aspirant Foundation Trust
BAF	Board Assurance Framework
BGM	Board Governance Memorandum
CRL	Capital Resource Limit
CQC	Care Quality Commission
CEO	Chief Executive Officer
CIP	Cost Improvement Plan
DH	Department of Health
ED/NED	Executive Director / Non-Executive Director
FGM	Financial Governance Module
FRR	Financial Risk Rating
FT/N	Foundation Trust/ Foundation Trust Network
HSE	Health and Safety Executive
HR	Human Resources
IM&T	Information Management and Technology
IBP	Integrated Business plan
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LMC	Local Medical Council
LTFM	Long Term Financial Model
MP	Member of Parliament

Abbreviation and full term	
NICE	National Institute of Clinical Excellence
NHS / NHSLA	NHS Litigation Authority
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
NoE	Network of Experts
OSVM	Organisational Strategy and Values Module
PEAT	Patient Environment Action Team
PBR	Payment by Results
PESTELI	Political, Environmental, Social, Technological, Environmental, Legal, Industry
PCT	Primary Care Trust
PMO	Programme Management Office
QGM	Quality Governance Module
QIPP	Quality, Innovation, Productivity, Prevention
QRP	Quality and Risk Profile
RAG	Red Amber Green
REID	Risk Evaluation for Investment Decisions
SIC	Statement of Internal Control
SID	Senior Independent Director
SLM/R	Service Line Management/Reporting
SMART	Specific, Measurable, Achievable, Relevant, Time-framed
SHA	Strategic Health Authority
SWOT	Strengths, Weaknesses, Opportunities, Threats
USP	Unique Selling Points

Appendix 2

Individuals contributing to the development of the BGM

Individuals from the following organisations contributed to the development of the BGM:

- Appointments Commission
- AQuA (Advancing Quality Alliance)
- Deloitte LLP
- Department of Health
- Foundation Trust Network
- Monitor
- North West Leadership Academy
- SHA Provider Development Leads from the 10 former SHAs
- The Leadership Academy
- The National Leadership Council

In addition, contributions were sought from a Network of Experts drawn from across the NHS and leading academics in the field of Board and Leadership Development. These individuals are summarised below and on the next pages:

Name	Position and organisation	Reason for inviting them to be part of the network
Tracey Allen	CEO, Derbyshire Community Services NHS Trust	Provide advice from an aspirant Community FT perspective.
Amanda Rawlings	Director of HR and OD, Derbyshire Community Services NHS Trust	Provide advice from an aspirant Community FT and HR perspective.
Jackie Daniel	CEO, Manchester Mental Health and Social Care Trust	Provide advice from an aspirant Mental Health FT perspective.
Simon Featherstone	CEO, North East Ambulance Service NHS Trust	Provide advice from an Ambulance FT perspective and FTN Board member.
Suzanne Hinchliffe	Chief Operating Officer and Chief Nurse	Provide advice on quality governance and CIPs.
Dr Umesh Patel	Medical Director, Wrightington, Wigan and Leigh NHS FT	Provide advice on quality governance and clinical engagement.

Appendix 2

Individuals contributing to the development of the BGM

Name	Position and organisation	Reason for inviting them to be part of the network
Jane Burns	Trust Secretary, Salford Royal NHS FT	Provide advice from a FT Company Secretary perspective. High-performing FT. Recently won an award for Board effectiveness.
David Dalton	CEO, Salford Royal NHS FT	High-performing FT. Recently won an award for Board effectiveness.
Jim Potter	Chairman, Salford Royal NHS FT	High-performing FT. Recently won an award for Board effectiveness.
Sir Hugh Taylor	Chairman, Guy's and St Thomas' NHS FT	Large acute FT. Previous DH Permanent Secretary.
Phil Morley	CEO, Hull and East Yorkshire NHS FT	Large acute aspirant FT.
Ian Baines	Finance Director, Dudley and Walsall Mental Health Partnership NHS FT	Financial governance advice.
Adrian Roberts	Finance Director, Central Manchester NHS FT	Financial governance advice.
Paul Olive	Audit Chair, Blackpool Teaching Hospitals NHS FT	Financial governance advice.
Simon Barber	CEO, 5 Boroughs Partnership NHS FT	High performing FT providing mental health and learning disability services.
Dr. Gillian Fairfield	CEO, Northumbria, Tyne and Wear NHS FT.	Taken 2 Trusts through to FT status.
Rob Webster	CEO, Leeds Community NHS Trust	Experience of Capability Reviews in Central Government.
Brian Stables	Chairman, Royal University Hospitals Bath	Chairman and Board Member on the FTN.
Steve Wilson	Finance Director, Wirral Community NHS Trust	Provide financial governance advice from aspirant FT.

Appendix 2

Individuals contributing to the development of the BGM

Name	Position and organisation	Reason for inviting them to be part of the network
Dr Tracey Long	Founder, Boardroom review	Established Board development consultant providing services to the FTSE 100 and 250.
Professor Andrew Kakabadse	Cranfield University	Leading academic in the field of corporate governance and effective chairs.
Professor Bob Garrett	Cass Business School	Leading academic in the field of Board effectiveness.
Professor Paul Stanton	Northumbria University	NHS Governance expert.
Professor Stuart Emslie	Birkbeck	NHS Governance expert.
Dame Sue Street	Strategic Advisor to Deloitte LLP.	Significant experience of central government Boards and governance.
Lord Philip Hunt	Chairman, Heart of England NHS FT	Large acute FT. Previous junior health minister.
Peter Mount	Chairman, Central Manchester NHS FT	Large high performing FT. Previous Chairman of the NHS Confederation.
Steve Bundred	Strategic Advisor to Deloitte LLP.	Ex-CEO of the Audit Commission, significant experience of NHS and Local Authority regulation and corporate governance.
Robin Staveley	Partner, Gatenby Sanderson (Recruitment consultants)	Significant experience of recruiting to NHS Board-level positions in both FTs and non-FTs.
Andrew Foster	CEO, Wrightington, Wigan and Leigh NHS FT	Existing FT and previous HR Director for the DH.
Julian Hartley	CEO, University Hospital South Manchester NHS FT	Existing FT with large flow of specialist tertiary services. Chair of NWLA.

Appendix 2

Individuals contributing to the development of the BGM

Name	Position and organisation	Reason for inviting them to be part of the network
Andy Chittenden	Trust Secretary, University Hospital South Manchester NHS FT	Provide advice from a FT Company Secretary perspective.
Gary Graham	CEO, Dudley and Walsall Mental Health Partnership NHS FT	Mental health and learning disabilities aspirant FT.
Glyn Shaw	Chairman, Dudley and Walsall Mental Health Partnership NHS FT	Mental health and learning disabilities aspirant FT.
Professor Naomi Chambers	Head of Health Policy and Management, Strategy Research, Manchester Business School, University of Manchester	Leading health academic.

Steering Group Member	Programme Role	Organisation
Matthew Kershaw	Director of Provider Delivery	Department of Health
Miranda Carter	Monitor Engagement Lead	Monitor
Steve Phoenix	Engagement Lead	NHS South East Coast
Deborah Chafer	Engagement Lead	North West Leadership Academy
Laura Roberts	Programme Sponsor	Department of Health
David Barron	Programme Lead	Department of Health
Dr Jay Bevington	Deloitte Engagement Partner	Deloitte LLP
Claire Heaney	Deloitte Engagement Lead	Deloitte LLP

Appendix 3

Foundation Trusts contributing to the development of the BGM

Ref	Name
1	Central Manchester University Hospitals NHS Foundation Trust
2	Chelsea and Westminster Hospital NHS Foundation Trust
3	Derbyshire Healthcare NHS Foundation Trust
4	Northumberland, Tyne and Wear NHS Foundation Trust
5	South East Coast Ambulance Service NHS Foundation Trust
6	The Royal Marsden NHS Foundation Trust

Appendix 4

Bibliography

Ref	Details
1	**A review of corporate governance in UK banks and other financial industry entities: final recommendations** Walker, David (2009)
2	**Achieving first-class financial management in the NHS**, Audit Commission (April 2004)
3	**Adding Insult to Injury: Failure to Implement Patient Safety Alerts**, AVMA (February 2010)
4	**An Organisation with a Memory**, Department of Health (2000)
5	**Audit Committee self-assessment checklist**, National Audit Office (November 2009)
6	**Boardroom Behaviours: a report prepared for Sir David Walker by the Institute of Chartered Secretaries and Administrators** ICSA (June 2009)
7	**Building better National Health Service boards** Clinician in Management, 13, 69-75 Jay Bevington, Paul Stanton, Aidan Halligan, Ron Cullen & Liam Donaldson (2005)
8	**Code of Conduct and Code of Accountability,** Appointments Commission (2004)
9	**Compliance Framework 2011/12,** NHS Confederation (2004)
10	**Corporate Governance and the Credit Crunch**, ACCA (2008)
11	**Corporate Governance in Health Organisations**, Audit Commission (2007)
12	**Criteria for Assessing Core Standards** CQC (2009)
13	**Exploring the association between board and organisational performance in NHS foundation trusts,** Journal of the British Association of Medical Management. Emslie, S V (2008)
14	**Effective Boards in the NHS?** NHS Confederation (2004)
15	**Figures you can Trust,** Audit Commission (2009)
16	**Financial Aspects of Corporate Governance (The),** The Cadbury Report (December 1992)
17	**From Ward to Board: Identifying good practice in the business of caring,** King's Fund (2009)
18	**Getting on board.** In View, 3, p18-22 Jay Bevington, Paul Stanton, Aidan Halligan & Ron Cullen (September 2004)
19	**Getting the Measure of Quality – Opportunities and Challenges** The Kings Fund Raleigh / Foot (2009)

Appendix 4

Bibliography

Ref	Details
20	**Governance Challenge for the NHS Executive Director (The)** ICSA Guidance Note (2009)
21	**Governing the NHS**, Department of Health (2002)
22	**Guidance on Audit Committees**, Financial Reporting Council (2010)
23	**Guidance on Board Effectiveness,** Financial Reporting Council (March 2011)
24	**Healthy Boards for a Healthy London,** NHS London/ Deloitte (October 2010)
25	**Healthy NHS Board: principles for good governance** (The) NHS Leadership Council (February 2010) *www.nhsleadership.org.uk/workstreams-top-nhshealthyboard.asp*
26	**HM Treasury Audit Committee Handbook,** HM Treasury (March 2007)
27	**How safe is your Hospital?** Dr Foster (2009)
28	**Independent Enquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 –** Chaired by Robert Francis QC (March 2009)
29	**Indicators for Quality Improvement**, NHS Information Centre (2009)
30	**Induction of NHS Foundation Trust Governors,** ICSA Guidance Note (2004) *www.icsaglobal.com/resources/guidance#text[]tag[]cat[GUidance_notes]page[8]*
31	**Integrated Governance Handbook**, Department of Health (2006)
32	**Intelligent Board (The),** Appointments Commission / Dr Foster (2006)
33	**Leadership under the microscope**, by John H. Zenger, Kurt W. Sandholtz, and Joseph R. Folkman (2007)
34	**Lessons learned from recent NHS foundation trust applications**, Monitor (January 2011)
35	**Making Patients a Priority:** Service users' perspectives on NHS Boards, NHSIII/ Deloitte (May 2010)
36	**Mapping the Gap:** Highlighting the disconnect between governance best practice and reality in the NHS, ICSA (July 2011)
37	**Model Conflicts of Interest Policy for NHS Trust Board Members,** ICSA Guidance Note (2010) *www.icsaglobal.com/resources/guidance#text[]tag[]cat[Guidance_notes]page[2]*
38	**Monitor Compliance Framework 2011/12,** Monitor (2011)
39	**National Enquiry into Fit-for-Purpose Governance**, Centre for the Innovation in Health Management (2009)

Appendix 4

Bibliography

Ref	Details
40	**NHS Foundation Trust Code of Governance** Monitor (March 2010)
41	**NHS trust boards and organisational performance. Health Care Risk Report**, Emslie, S V (2007)
42	**"Knowing what you know and don't know" – A practical guide to reviewing effectiveness at Board-level** NWLA/ Deloitte (June 2010)
43	**Putting Quality First in the Boardroom: Improving the business of caring,** King's Fund (March 2010)
44	**Quality and Patient Safety – Understanding the Role of the Board**, Ontario Hospitals Association / Governance Centre of Excellence (2010)
45	**Quality Governance in the NHS** National Quality Board (March 2011)
46	**Quality reporting in 2008/09 Annual Reports** Monitor (2009)
47	**Reviewing your contribution and capability as a NHS Board member**, NWLA/ Deloitte (May 2010)
48	**Reviewing Board Effectiveness in NHS Foundation Trusts**, NHSIII/ Deloitte (February 2011)
49	**Risk Management Standards for Acute Trusts** NHSLA (2010/11)
50	**Seven Principles of Public Life (The)** *www.public-standards.org.uk/index.html*
51	**Taking it on Trust – A review of how boards of NHS trusts and foundation trusts get their assurance** Audit Commission (April 2009)
52	**The Foundations of Good Governance: A Compendium of Best Practice**. Foundation Trust Network/ Beachcroft (2011)
53	**The National Health Service Constitution**, Department of Health (2009)
54	**The Productive Ward, Learning and Impact Review,** Kings College London (2010)
55	**The Verita Brief**, Verita (2008)
56	**UK Code of Corporate Governance** Financial Reporting Council (June 2010)