Delivering the NHS Foundation Trust Pipeline: Single Operating Model

Part 1: SHA Development and FT Assurance

February 8th 2012

DH INFORMATION READER BOX

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Description	To support the delivery of the Foundation Trust (FT) pipeline, the next year will be a crucial phase in maintaining the momentum established following the signing of Tripartite Formal Agreements (TFAs) with all NHS Trusts in September 2011. Building on best practice, the Single Operating Model underpins the way in which SHA clusters will support the delivery of an all FT landscape
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For Recipient's Use	

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Foreword

To support the delivery of the Foundation Trust (FT) pipeline, the next year will be a crucial phase in maintaining the momentum established following the signing of Tripartite Formal Agreements (TFAs) in September 2011.

A crucial plank of this will be having a robust single operating model (SOM) to support this delivery.

Previously there have been different models used by Strategic Health Authorities (SHAs) to support and assess NHS Trusts for readiness to proceed to assessment for FT status.

These regional functions will eventually move to the NHS Trust Development Authority (NTDA) (formally from April 2013), but in agreement with SHA Clusters, we have developed a SOM to support the transition to this change in accountability in the system as soon as possible.

More specifically this model will:

- support a more consistent approach to the development and assurance of aspirant FTs drawing on best practice from across all SHAs;
- further enhance the delivery of the FT pipeline during 2012/13 when 50 per cent of the remaining NHS Trusts are due to apply; and
- improve processes to support timely and successful FT applications.

This document launches the first part of the roll-out of the SOM and is focussed on the processes used in SHA development and assurance against FT-readiness requirements in NHS Trusts.

This will be built upon with further dimensions added to cover the ongoing over-sight of NHS Trusts in relation to progress towards FT-readiness, the Department of Health's FT assurance process, consistency of decision making and approaches to supporting major transactions.

The over-sight process, in particular, will be key to the effective roll-out of the SOM. This will include regular self-certification from NHS Trust Boards, a key part of preparing them for operating as autonomous FTs.

We will release information about these further dimensions over the next few months.

The over-sight process, in particular, will be key to the effective roll-out of the SOM. This will include regular self-certification from NHS Trust Boards, a key part of preparing them for operating as autonomous FTs.

The development of the SOM has been led by SHA colleagues to ensure the relevant knowledge and experience has informed the detail that will be crucial to its effective implementation. We will continue to work with you all as the model is reviewed and refined to ensure it delivers against the objectives.

Thank you for all your help so far and I look forward to working with you as we implement this key element of our collective work on the FT pipeline.

Matthew Kershaw
Director of Provider Delivery
Department of Health

Introduction

1. This document describes the first element of the Single Operating Model (SOM) that the four Strategic Health Authority (SHA) Clusters will adopt from early 2012. The first element of the model focuses on the development and assurance of Foundation Trust (FT) applications.

2. The development of the SOM has been SHA-led with DH and other stakeholder involvement as necessary. This document indicates the beginning of the roll-out of this approach which will be supplemented over the coming months as further dimensions are developed. The further aspects of the model will focus on the DH assurance process for FT applications, the SHA over-sight of NHS Trusts, mechanisms to drive consistency of judgement and the assurance processes for major transactions.

3. This guidance provides information about why the model is being implemented, the approach to implementation and details the model that will be adopted as part of this initial roll-out.

Rationale

4. The rationale behind the introduction of the SOM is to:

    - Draw on best practice to develop a consistent approach to the development and assurance of aspirant FTs;
    - Enhance the processes underpinning the delivery of the FT pipeline across the country;
    - Support the transition from SHA accountability for delivery of the FT pipeline to the NHS Trust Development Authority (NTDA) in April 2013.

5. The delivery of an all FT landscape will become the responsibility of the NTDA from April 2013 upon abolition of the SHAs. In the interim, SHAs will continue to have responsibility for the delivery of the FT pipeline.

6. The four SHA Clusters have inherited assurance processes from the previous SHAs that vary in approach though many have similar content, timelines, documents and performance management arrangements.

7. The SOM is designed to build on best practice, encourage greater consistency with Monitor's authorisation approach, improve and develop processes where needed, make full use of best practice tools and to enable a smoother organisational transition to the NTDA.

8. The SOM is therefore about improving each NHS Trusts journey to achievement of FT status alongside enhancing the SHA assurance processes that enable this.

Principles

9. The delivery of the SOM is predicated on the following seven principles agreed by the Provider Development Steering Group in November 2011:

Table 1: Principles underpinning the Single Operating Model

	Principle
1	There is a requirement in transition to the NTDA to move to a single approach.
2	The model will be based around the eight domains of assurance against which DH considers FT applications for SofS support
3	The model will be designed around Monitor's criteria and assessment methodology
4	The model must promote consistency of judgement on equivalent issues in different applications.
5	The performance management of actions and milestones in Tripartite Formal Agreements (TFA) must be integrated
6	The model should remove unnecessary duplication of activity across all stages of the applications process.
7	The model should enable transparency of decision making.

10. The SOM enables NHS Trusts to undertake key activities and demonstrate key behaviours that will be crucial to them when they become Foundation Trusts. This includes self-certification and self-assessment against performance and governance requirements that will support the assurance of the NHS Trust and its ability to operate effectively as an autonomous FT.

Clinical Quality

11. The SOM details the approach that will build on and strengthen local approaches to developing FT applications and support the transition to the NTDA, the organisation that will have responsibility for maintaining the clinical quality standards and clinical outcomes in the remaining NHS Trusts. It is important therefore to be explicit that the continuing delivery of clinical quality standards and clinical outcomes remain the focus in this transitional period, alongside the actions directed to establishing a sustainable provider sector, with all NHS Trusts achieving FT status.

12. There is now crucial momentum in the system to deliver an all FT sector and this will only continue with continued focus and delivery of quality clinical services for patients.

Overview

13. The following diagram provides a summary of the first part of the SOM beginning with an initial discussion between the aspirant FT and their SHA Cluster through to an application being submitted to the DH:

Figure: Overview of first part of Single Operating Model: FT Development and Assurance

FT application development

- Introductory meeting with Chair & CE and FT director of the applicant Trust
- Undertake self-assessments and begin production of key documents
- Initial Board interviews
- Initial Board observation
- As part of the ongoing approach to oversight Trusts to begin completing self-assessments against key FT requirements and self-certifying against Compliance Framework questions and to submit these to SHAs
- Initial interviews with Commissioner(s) and other purchasing- organisations e.g. Local Authorities.
- Third party review of Trust self assessment of Board Governance Assurance Framework (BGAF)
- Independent third party review of Trust self assessment against Monitor Quality Governance assessment framework requirements
- Trust undertakes HDD stage 1
- Formal submission of key FT application documents to SHA to inform FT readiness review meeting
- Trust go to public consultation
- Readiness review meeting will be held with the Trust Board after the introductory meeting with Chair & CE and FT Director.

FT application assurance and sign-off

- The Trust will develop further iterations of key documents
- Delivery of FT action plans by the Trust with updates to the SHA and ongoing updates of self-assessment and self-certifications
- Observation of Board and Trust Board sub-committees
- SHA agree to HDD2 commencing
- Trusts make final submissions of key products to inform SHA Cluster sign-off of FT application
- SHA review of final assurance documents
- Gain view of CQC
- Interview with HDD lead reviewer
- Interview with Commissioners
- Board-to-Board meeting between SHA Cluster and NHS Trust
- FT application submitted to DH

Single Operating Model: SHA development and assurance of FT applications

14. To support the implementation of the model, the development of the FT application/assessment process has been broken down into two phases:

    - FT development
    - Assurance and sign-off

Phase 1 - FT development

15. The following tables describe the actions required of trusts and SHAs to support the development of an FT application, ensure equity of approach and enable consistency of decision making.

Table 2: Actions to be taken in FT development

Action	Requirements/other information	Practices/tools to be used	Output
Introductory meeting with Chair & CE and FT director of the applicant Trust	- Discussion to include top level/key milestones that underpin the TFA - Minimum of SHA exec lead and SHA FT lead to be present		- Agreed set of detailed milestones including draft timetable and plans for IBP/LTFM submissions - Agree any external support requirements
Undertake self-assessments and begin production of key documents	- Undertake self-assessments against: o Board Governance Assurance Framework (BGAF) including development of case studies; and o Monitors Quality Governance Framework o Quality indicator dashboard - Begin production of IBPs/LTFMs including initial CIP plans	- BGAF processes and documentation to be used. (Link provided at Annex H) - Latest Monitor Quality Governance Framework to form basis of self-assessment - Standard quality indicator dashboards to be used as basis of self-assessment and review. - Standard template at Annex A to be	- Completed self-assessments against BGAF and Monitors Quality Governance Framework in place. - Clear understanding of Trusts quality dashboard profile. Action plans put into place where necessary - Initial drafts of IBPs/LTFMs including initial CIP plans in

		used for reviewing and providing feed back on IBPs. - Draft IBPs and LTFMs submitted to SHA Clusters will be reviewed: - by the SHA within a maximum of 4 weeks of receipt - In addition, a feedback meeting with Trust Chair and CEO following review of key drafts will be by the SHA.	place.

Initial Board interviews	- To be undertaken in pairs
	- Interviews conducted with voting members only
	- To test the understanding of the key issues in the organisation and the ability to respond appropriately to these.
	- For both Executive and Non-Executive Directors, the interviews need to focus on:
	  - corporate objectives
	  - portfolio relevant/specific issues to role on board
		- Minimum of issues to be covered as detailed at Annex B.
		- Headings for written feedback to Chair at Annex B.
			- Written feedback to Chair covering broad themes.

Initial Board observation	- To be undertaken in pairs or more dependent on issues - One of the pair should have experience of working at Board level or with Boards - Verbal and written feedback to Chair & CE including actions - SHA to have reviewed papers ahead of Board.	- Template at Annex C to be completed after Board observation.	- Written feedback to Chair (within 3 weeks of Board) and option to follow up with verbal feedback
As part of the ongoing approach to oversight Trusts to begin completing self-	- Testing the ability of Trusts to self-assess and self-certify as part of wider FT development process.	- Monitor Compliance Framework requirements to form basis of self-assessment and self-certification	- Monthly self-assessment and self-certifications to SHAs. - Action plans to be produced by Trusts if they

assessments against key FT requirements and self-certifying against Compliance Framework questions and to submit these to SHAs		requirements.	cannot provide any particular aspect of the self-assessment or self-certification requirements.
Initial interviews with Commissioner(s) and other purchasing-organisations e.g. Local Authorities.	- Discussions to understand commissioner perspective on Trust alongside commissioners own performance. - To be undertaken by SHA Provider Development team with Commissioner Executive representation. - Commissioners who represent 25% or more of income of Trust must be interviewed. Other commissioners can be interviewed in line with local requirements e.g. national centres may need to interview wider range of commissioners.	- Minimum of issues to be covered as detailed at Annex D.	- SHA to have clear understanding of Commissioner perspective of Trusts journey to FT status, in particular the alignment of clinical strategies and activity assumptions.
Third party review of Trust self assessment of Board Governance Assurance Framework (BGAF)	- Independent view given against BGAF. - SHA to review and provide feedback on responsive plan.	- BGAF processes and documentation to be used. (Link provided at Annex H) - SHAs to triangulate evidence provided in BGAF report with own assessment to inform consolidated action plan.	- Third party report. - Action plan against findings of report.
Independent third party review of Trust self assessment against Monitor Quality	- Independent third party review of Trust self certification and assessment of Monitor Quality Governance Framework. - Trust and SHA to agree Independent third party reviewer.	- Needs to occur towards the ends of the development phase.	- Third party report. - Trust action plan against findings of report.

Governance assessment framework requirements			
Trust undertakes Historical Due Diligence (HDD) stage 1	- Review of Trust undertaken by independent accounting firm.	The purpose and scope of HDD 1 is for a preliminary review and financial reporting procedures report covering business planning, financial reporting procedures and specification of analysis required for the HDD at stage 2.	- HDD 1 report delivered. - Trust action plan - Indicative date set for HDD 2.
Formal submission of key FT application documents to SHA to inform FT readiness review meeting	- The SHA will require the following documentation to be provided by the Trust one month in advance of readiness review meeting: o Full draft IBP & LTFM including CIPs (and including initial downside modelling) o Clinical Strategy o Underpinning strategies: ▪ Workforce ▪ Estates ▪ IT ▪ Membership o Independent third party reports: ▪ BGAF ▪ Quality Governance Framework ▪ HDD 1 o Final draft public consultation document (including Governance rationale) and associated communications plans etc as agreed by the Trust board o Self-certifications o FT programme risk register including Board Assurance Framework		- All documents in place for readiness review meeting
Trust go to	- SHA agree to Trust going to		- Public

public consultation	consultation including signing-off documentation - Documentation and go ahead to be signed-off by SHA Provider Development Board - Consultation can be carried out in parallel with the readiness review meeting – i.e. one is not a gateway for the other. Final public consultation document (including Governance rationale) and associated communications plans as agreed by the Trust Board		consultation launched.
Readiness review meeting will be held with the Trust Board after the introductory meeting with Chair & CE and FT Director.	- To undertake formal review of progress made since introductory meeting - Developmental B2B experience for Trust Board - The whole voting Trust board is required at the meeting. From the SHA Cluster a minimum of at least 1 NED and 1 exec. - Signal move to the assurance phase of the process.	- Standard assurance report at Annex E to be completed to form basis of meeting. - Template for readiness review questions at Annex F to be used.	- Review of key documents including IBP/LTFM and underpinning strategies. - Written feedback to Trust on meeting. - IBP/LTFM aligned - Demonstration of viability under downside conditions, including meeting authorisation criteria. - Quality, finance and governance integrated throughout IBPs/LTFMs. - Confirm the Trust is ready to move to Assurance and sign-off phase OR Trust deemed not ready to move forward and action plans and escalation activities agreed. - Confirm the date for HDD 2.

Phase 2 - Assurance and sign-off

16. The assurance and sign-off phase of the model will provide SHA Clusters with assurance against the plans and activities commenced in phase 1, the development phase, and enable the sign-off of the application for submission to DH. The table below details the actions required to deliver this phase of the single model.

Table 3: Actions to be taken in Assurance and sign-off

Action	Requirements/other information	Practices/tools to be used	Output
The Trust will develop further iterations of key documents	- Further iterations of key documents to be submitted to SHA Cluster including: o Full draft IBP & LTFM including CIPs (and including initial downside modelling) o Clinical Strategy o Underpinning strategies: ▪ Workforce ▪ Estates ▪ IT ▪ Membership o Independent third party reports: ▪ BGAF ▪ Quality Governance Framework ▪ HDD 1 o Self-certifications o FT programme risk register including Board Assurance Framework	- Standard template at Annex A to be used for reviewing and providing feed back on IBPs.	- Feedback to the Trust using best practice tools. - SHA to triangulate and test assurances provided.
Delivery of FT action plans by the Trust with updates to the SHA and ongoing updates of self-assessment and self-certifications	- Continued updates of self-assessment and self-certifications as commenced in development stage - Updates on action plans including from BGAF, HDD 1, Quality Governance Framewor, Monitor risk ratings and Quality Indicators. - On-going review of the development of a rolling two-year (minimum) detailed programme of CIPs. - The detail of the above to be developed as part of SHA over-sight of NHS Trusts.	- Monitor/Audit Commission CIP guidance to inform CIP development. (Link provided at Annex H)	- Continued submissions of self-assessments and self-certification - Feedback to Trusts as necessary. - Inform assurance of FT against FT programme deliverables.
Observation	- To be undertaken in pairs or	- Template at	- Written

of Board and Trust Board sub-committees	more dependent on issues - One of the pair should have experience of working at Board level or with Boards - Verbal and written feedback to Chair & CE including actions - SHA to have reviewed papers ahead of Board.	Annex A to be completed after Board observations.	feedback to Chair (within 3 weeks of Board) and option to follow up with verbal feedback - To inform B2B meeting and decision to submit FT application to DH.
SHA agree to HDD2 commencing	- SHA to approve for Trust to commence HDD2. - SHA Cluster Provider Development Director to take decision.	- HDD2 needs to be arranged in advance (provisional date set after HDD 1). - The purpose and scope of HDD 2 is that prior to Secretary of State support, production of a historical due diligence report including an update on financial reporting procedures and business plan assumptions.	- HDD2 report delivered. - Action plan from Trust
Trusts make final submissions of key products to inform SHA Cluster sign-off of FT application	- Following products to be submitted to SHA Cluster: o IBP/LTFM and other appendices (including updated downside scenarios and mitigations) and including minimum 2 years detailed CIP plans. o Commissioner support letters o Evidence of delivery against actions plans on HDD, BGAF and quality governance. (SHA may ask for external assurance of evidence) o Letter from Trust solicitors confirming constitution in line with FT legislative		- Information in place to populate pack for final SHA Cluster-Trust B2B.

	requirements		
SHA review of final assurance documents	- Review of documentation submitted ahead of final Board to Board meeting - Test documentation against the eight DH FT domains and triangulate with interviews with Trust and stakeholders.		- Information in place to populate pack for final SHA Cluster-Trust B2B - Review to inform questions at the Board to Board meeting
Gain view of CQC	- SHA Cluster to meet with CQC assessor for NHS Trust to fully understand regulator position on NHS Trust. - Explicit clarification on readiness to be presented to the DH for Secretary of State support. View to be included in Board to Board pack. - Need confirmation of current compliance against Monitor Quality Performance authorisation criteria, or equivalent.	- SHA to review QRP in advance of CQC interview. - Option to interview CQC assessor as necessary. - Draw in other SHA colleagues as necessary	- Information in place to populate pack for final SHA Cluster-Trust B2B - Information to inform Medical/Nursing Director report - Inform Board to Board questions
Interview with HDD lead reviewer	- SHA Cluster to meet with HDD lead partner to consider issues raised in reports and progress made. - Explicit clarification on readiness to be presented to the DH for Secretary of State support. View to be included in Board to Board pack.	- Draw in other SHA colleagues as necessary	- Information in place to populate pack for final SHA Cluster-Trust B2B. - Inform Board to Board questions
Interview with Commissioners	- Commissioners who represent 25% or more of income of Trust must be interviewed. Other commissioners are in line with local requirements e.g. national centres may need to interview wider range of commissioners. - Discussions to understand commissioner perspective on Trust alongside commissioners own performance. - Explicit clarification on readiness to be presented to the DH for Secretary of State support. View to be included in Board to Board	- Minimum of issues to be covered as detailed at annex D. - Draw in other SHA colleagues as necessary	- Information in place to populate pack for final SHA Cluster-Trust B2B. - Inform Board to Board questions

	pack. - Discuss the commissioner support letter that is provided.		
Board-to-Board meeting between SHA Cluster and NHS Trust	- Whole voting Trust Board required - Minimum of SHA Cluster Chair and one NED. Relevant Exec Directors to include Director of Finance, Director of Provider Development and Medical and/or Nursing Director. - Where governance structures allow, SHA Cluster team who undertakes the Board to Board meeting to have delegated authority to take decision for Trust to submit FT application to DH (or to make a decision to defer to the relevant committee with the delegated authority) - Approval needs to be in line with SHA Cluster governance arrangements.	- Standard assurance report at annex E to be completed to form basis of meeting. Proportionate focus on areas of risk within assurance evidence needs to be made. - Template for Board-to-Board questions at Annex F to be used.	- Feedback letter to the Trust

FT application submitted to DH	- Under cover of a supporting letter from the SHA Cluster CEO or Director of Provider Development. This letter must indicate assurance that the Trust is a credible candidate at that stage, i.e. is meeting Monitor's key authorisation criteria and are assured will continue to do so going forward, and does not know of any reason why this trust should not be authorised as an FT at the earliest possible opportunity. Alongside this the following information to be submitted to DH:
	  - IBP plus appendices
	  - LTFM
	  - Commissioner support letters
	  - SHA Medical Director/Nursing Director report
	  - Independent BGAF report
	  - Independent third party Quality Governance Framework report
	- SHA support form including all relevant further evidence. (Plan is to that the SHA support form will be superseded by the SHA FT Assurance Report (As per Annex E) in due course)
			- FT application and all other relevant information as per SHA support form requirements submitted to DH

Indicative timeline

17. An indicative timeline for the implementation of the SOM described in this document is provided at Annex G.

18. The time take for each application will vary dependent on the complexity of each case and this indicative timeline provides a starting position for the timetabling of SOM actions.

Summary and next steps

19. This document provides the information and tools SHA Clusters need to begin the implementation of the first part of the SOM.

20. Further guidance and additional phases of the SOM will follow which focus on SHA over-sight of trusts, the DH FT review process, consistency of decision making and the transactions process.

21. SHA over-sight will be based on Monitor's self-certification approach to regulatory over-sight and FT application assessment. It will also consider self-certification against Monitors risk ratings and progress against TFA milestones and focus on the on-going review of finance, quality and service performance. Over-sight will also focus on the delivery of action plans linked to HDD assessments, BGAF, the Quality Governance Framework and the achievement of necessary Monitor risk ratings.

22. The ethos of both the FT application process and Trust over-sight is to ask Trust Boards to commit to becoming a FT and for the SHA to hold the Trust Board to account for the delivery of those commitments including the achievement of TFA milestones.

23. Establishing a standard approach to the FT development and SHA assurance processes is key to ensuring the effective roll-out of the single model in its entirety.

24. The use of a single process and a single set of best practice tools will promote consistency and prepare for the establishment of the NTDA.

25. Links to key documents relevant to the implementation of the SOM are provided at Annex H.

ANNEX A- IBP REVIEW AND FEEDBACK FORM

The following table provides a 'checklist' of the suggested evidence (not exhaustive) that needs to be included within the IBP.

Trust name:	
SHA name:	
Date due:	
Date received:	
Reviewed by:	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
1. Executive Summary:	The executive summary is a short, sharp, focussed summary of the key elements of the integrated business plan. It should provide the reader with a high-level overview of the trust, its vision, the market it operates within and the performance of the trust, both historic and future projections. It should also explain why the trust is applying for NHS foundation trust status and how becoming an NHS foundation trust will help the trust deliver its vision. This section should link to the detail within the later sections of the integrated business plan.	
Vision and strategy	• Overview of the trust vision statement and strategy	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Rationale for NHS foundation trust status	• Why does the trust wish to be an NHS FT? • How will the trust exploit the freedoms? • Culture and environment to be created	
Market assessment – overview of local health economy, covering:	• Demographics and demand; • Competitive factors, e.g. impact of private providers, independent sector and NHS competitors; • Impact of choice; and • Analysis and impact assessment of the marketplace, including core and non-core business.	
Performance overview – summary table covering historical and projected:	• Financial performance; and • Non-financial performance (e.g. standards and targets)	
SWOT analysis	• Summary SWOT (strengths, weaknesses, opportunities, threats) analysis	
Key risks	• The financial impact on the organisation • Any mitigating actions proposed • Assessment of likelihood for each risk	
Leadership and Management	• Skills and experience profile • Board capability and capacity • Board development • BGAF alignment	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Quality	• Approach taken to quality, safeguarding service users and effectiveness • Set out the "golden thread" running through and underpinning all sections of the plan	
2. Profile:	In this section, assume the reader knows nothing about the organisation. This section will cover the basic details of what the trust is and the type of services it provides to the local population. It should inform the reader of how these services are provided, and provide an overview of the key achievements in recent years. It is expected that this section will be completed at an early stage, as applicants should be aware of, or have access to, all of the information required and be able to present it without difficulty. It is important to remember within this section that this document presents a profile of the business. Avoid being too clinically biased in the information provided, or concentrating on service delivery in isolation.	
Overview should contain:	• The basic details of the trust, e.g. facts on size of population served, the type of trust and the number of sites the trust operates from; • Main commissioners • Staff numbers (whole-time equivalents) and the number of beds; and • Organisational structure.	
Range of services and activity summary table detailing**:**	• Services and relative size of each service	
Finance summary table providing**:**	• High-level financial information (i.e. turnover, asset base, reference cost index, etc.)	
Performance – summary describing: .	• Historical performance against key healthcare targets	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Contractual information	• Should provide information on any current significant contracts including anticipated value/cost and expiry date	
Other procurement arrangements – details of:	• Shared service centres, national contracts, etc	
Joint venture information if relevant . Include details:	• The roles and responsibilities of the parties to the joint venture or partnership arrangement; • Key financial terms of the joint venture agreement; and • Governance arrangements of the joint venture.	
3. Strategy:	This section should describe what the organisation will look like in five years time, and provide the reader with an understanding of the trust's strategies for the lifetime of the integrated business plan and how it intends to deliver them. For each element of the strategy, please provide rationale behind it, details of likely timeframes for realisation and an indication of how success will be measured. The trust also needs to be able to articulate how NHS foundation trust status will make a difference.	
Vision – Trust vision statement		

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Strategy	• Rationale and the timeline of each strategic objective • Clear understanding of how success will be measured • Relevant details of underpinning strategies • Major risks to achievement of strategy • Underpinning quality and patient safety strategy and strategic objectives	
Rationale for NHS foundation trust status	• Key reasons for application • What NHS foundation trust status will mean in terms of delivering the strategy and vision of the trust, including the cultural environment that will be created within the NHS foundation trust. • How the trust will utilise the freedoms given under NHS foundation trust status • What use will be made of the board of governors and the trust members	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Consultation process: should include details of:	• The outcome of the consultation process including the timeline; • The type of information provided, response received to date and how this has influenced the final strategy; • Any stakeholder analysis performed and how stakeholder relations are currently managed; • Stakeholder analysis – summary of representation i.e. special interest groups (can be provided as an appendix to document); and • Membership analysis – summary of representation i.e. analysis showing membership is reflective of constituencies served and actions to address under-representation.	
4. Market Assessment:	The market assessment section should cover a high-level analysis of the current health economy including details of clinical networks and other appropriate SHA-based commissioning intentions. It should incorporate information regarding the impact of Lord Darzi's Next Stage Review, and competitors (both NHS and independent sector), including patient choice statistics. Practice-based commissioning analysis can also be incorporated into this element of the business plan. In summary, this section is about describing how the trust is 'positioned' currently within the health care market and how this, coupled with evidence-based research, will inform the future positioning of the trust within the marketplace, i.e.: • Know your business; • Know the business you're in; and • Know the businesses you're in with. This section is an assessment, not just an analysis. It needs to be backed up throughout with data, information and the implications of the data sourced, rather than being based on presumptions or aspirations. Make good use of demographics, market share data, PEST analysis (an analysis of political, economic, social and technological factors), maps, charts, graphs and tables.	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Local health economy – provide details of:	• Assumption on future demand growth; • Any external factors impacting upon the current levels of demand within the local health economy; and • Factors such as demographics, ageing analysis and population migration statistics which provide a useful context in which to view the local health economy plans.	
Objectives of local health economy – describe:	• Commissioner(s) strategy and objectives • how the trust's strategy will contribute to the overall objectives of the local health economy; and • how the trust's activity assumptions are consistent with local health economy objectives.	
PEST – provide:	• Comprehensive PEST analysis.	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Competitive factors: provide details of: .	• Patient choice statistics to date and an overview of how patient choice is factored into the overall plans for the trust. It is important to link choice into the implementation of practice based commissioning; • Provide details of existing and future independent sector providers, their current proximity and the services they are currently offering. Explain impact on the trust; • Detail any known issues regarding independent sector capacity; and • Impact of other NHS foundation trusts and NHS trusts in the local health economy	
Market share and segmentation:	• Relevant segmentation analysis and impact of market share, including core and non-core services.	
Trust performance:	• Provide any benchmark data which is used by the trust to compare its performance with competitors, e.g. waiting times, average length of stay, capacity, readmissions rates, etc.	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
5. Service Development plans	This section of the integrated business plan is intended to cover any service development plans the trust anticipates will impact upon its "business as usual" over the next five years. A service development plan may cover: a) significantly altering the level of activity undertaken by the trust (up and/or down); b) significantly altering the type of activity undertaken by the trust (up and/or down); c) significantly altering the patient pathway by modernising existing facilities, undertaking extensive refurbishment, relocating/reducing the number of sites; or d) significantly altering any non-clinical capability of the trust, i.e. increasing the education/training facilities, building a pharmacy manufacturing unit, providing GP services. It should be possible to anticipate what is coming in this section. If the profile, market assessment, PEST analysis and SWOT analysis have been completed thoroughly, there should be no surprises, as the service developments will respond to the strategy and market assessment undertaken in sections three and four. Present service developments as mini business cases, and concentrate on the most significant five or six schemes, listing them in order of short-term, medium-term, and long-term developments. Service developments should be described in the context of the base case, ie 'business as usual', then go on to describe and build in the service developments to present the 'upside' case. Service plans should link back to the trust's strategy, and be properly reflected within the long-term financial model.	
SWOT analysis: Should cover:	the detailed SWOT analysis and how service development plans link to the outcomes of the SWOT analysis.	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Summary of future initiatives: For each service development plan, provide:	• A high-level analysis of the strategic drivers behind the plan, i.e. to deliver cost improvements, to increase the level of service quality, to improve staff morale, to enhance patient choice opportunities, to fit with local health economy objectives, etc.; • A high level cost/benefit analysis, indicating likely capital investment required, the duration of the service development plan and the likely benefits to be derived; • Quantitative benefits of the service development plan as well as the qualitative benefits; and • Details of public consultation if relevant to the success of the service development plan	
Activity projections: For each service development plan, provide:	• Information on the impact upon existing activity levels; • The type of activity likely to be affected; • Impact on achieving healthcare targets such as the 4 hour A&E target; and • Impact on quality of service delivery and user experience	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Resource implications: For each service development plan:	• How capital investment required will be funded; and • Describe the impact on staff resources and actions to be taken to ensure delivery	
6. Financial Evaluation:	This section tells the financial story, with focus given to the historic, present, and future performance. It describes the historical financial performance of the trust, with good narrative of the finance schedules required. It provides a clear narrative and analysis to the figures in the long-term financial model. This section goes on to demonstrate how this track record, along with the service developments in section five, translate into robust and viable financial projections in the short, medium and long term. These projections will enable you to demonstrate that delivery of your service plans in section five will result in the organisation satisfying the key financial criteria and ratios expected of a foundation trust. Section six should provide a clear understanding of the key assumptions behind the plans and the likely projections of the I&E, cash flow and balance sheet. Key items for inclusion will be the assumptions behind the service development plans and the cost improvement plans.	
Historical performance (including appropriate analysis to understand trends):	• Income and expenditure • Balance sheet • Cashflow • Cost improvement programmes – (recurrent/non-recurrent) • Capital expenditure • Normalised earnings (including details of adjustments) • Detailed bridge analysis – last historical year and current year • Public sector payment policy performance	
Current performance	• Ensure clear link to historical performance and to forecast • Including appropriate analysis to understand trends	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Future forecasts – Assumptions both for base case and for service developments:	• Activity • Prices • Income • Costs • Working capital	
Clear demonstration of implied efficiency within income and costs	Impact of service developments (may be in section five) • Business cases • Investment criteria Future forecasts (including appropriate analysis to understand trends) • Income and expenditure • Balance Sheet • Cashflow • Capital expenditures • Normalised earnings (including details of adjustments) Detailed bridge analysis – year by year • Public sector payment policy performance, including any actions to improve performance	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Cost improvement programmes	• Detailed for two years • Summary for all other years • Governance arrangements for delivery of cost improvement programmes, including the directorate owning each cost improvement programme initiative, prior-year budget, risk assessment of achievement and details of how success will be measured • Quality and safety impact assessment • Link to workforce changes/other enabling strategies • Link to service-line reporting/ management	
Service-line reporting/management	• Status within trust • Timetable • Link to strategy/service developments/ cost improvement programmes	
Impact of future changes to tariff/ contracting		
Compliance with key financial criteria	• Statutory breakeven (if appropriate) • Working capital loans and liquidity • Private patient income cap • Prudential borrowing code ratios	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Capital funding	• Rationale – debt/internal, core unavoidable capex (maintenance) and new developments linking to initiatives discussed in strategy • Sources of funding • Status of securing funding	
Assurance on non-recurrent income/ capital funds (public dividend capital)		
Risk ratings	Trust forecasts • Headroom and sensitivities	
Working capital facility	• Amount/rationale including debtor, creditor and stock days • Status of securing facility	
Key performance indicators	• Explanation in integrated business plan to understand modelled key performance indicators. For example, average length of stay, bed occupancy, theatre utilisation (acute), crisis resolution, early intervention, assertive outreach (MH)	
PFI	• Costs • Implications	
IFRS	• Implications	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
7. Risk:	This section should cover the high-level risk analysis performed by the trust, and builds on the issues identified with the PEST and SWOT analyses. It covers both financial and nonfinancial risks. High-level information should be provided on the existing risk management structure and systems linked to the overall risk management strategy of the trust described in section nine, and the key personnel involved in the risk management within the trust. This section articulates how the risks in the resultant downside case are to be mitigated, to ensure good financial performance over the lifetime of the integrated business plan and beyond.	
Risks: Summary of:	• Key risks impacting the trust's plans • Assessment of likelihood; • Mitigating actions to address the risks; and • Details of financial and non-financial impact	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Sensitivity analysis: include:	• A table of assumptions underpinning the base case (most likely case) e.g.: – Volumes (e.g. inpatient, day case, outpatient, etc.) – Capacity (e.g. bed days available, theatre sessions available, etc.) – Efficiency/productivity (e.g. staff/patient ratios, throughput, etc.) – Tariffs – Unit costs (e.g. salaries by staff type, drugs costs, consumables costs) – Inflation (e.g. tariff uplifts, wage inflation, drug costs inflation, etc.) – Balance sheet (e.g. accounting policies, creditor days, debtor days, etc) • A scenario analysis which describes the upside and downside for each of these assumptions. • The sensitivity analysis should assess the financial impact in income & expenditure and cash terms of the upside and downside scenarios against the base case; • The impact of controllable mitigating items in the downside case scenario; • And conclusion on financial position after a reasonable set of downside risks (after mitigation).	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
8. Leadership and Workforce	This section is intended to cover an overview of the leadership and the management structure of the trust and its employees. It should provide the reader with a high-level understanding of how the trust board operates and its attitude towards its workforce. In particular, this section should cover the leadership of the organisation and how it needs to develop to be fit for purpose, how the workforce strategy will underpin organisational change and development and how the trust will continue to engage with and involve its staff in the development of future service plans and HR arrangements. This section should demonstrate the links to the financial reports within the integrated business plan and the long-term financial model, including the implications of any changes to staffing policies e.g. use of agency staff, or staffing plans e.g. whole-time equivalents, grades, structures etc.	
Management arrangements. Provide:	• An overview of the board structure; and • The executive and non-executive director qualifications and experience, including a scanned photo within the document for each executive and non-executive director	
Workforce key performance indicators include details of:	Staff numbers; • turnover; • sickness; and • absence. Benchmarking data may be added	
Agency arrangements and recruitment hot-spots	• Provide an overview of how these issues impact the trust.	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Workforce and organisational development:	• Overview of agenda for change, the European working time directive, the consultant contract (level of sign-up). • Evidence of how staff engagement and involvement has been achieved and will continue to be effectively developed going forward. • How the workforce changes as indicated in the LTFM will be achieved.	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
HR strategy – integrated business plan should cover:	• How HR issues are integrated across the organisation's strategies; • HR's contribution from board level through the organisation and the opportunity NHS FT status brings for the workforce; • What opportunity will be created for the workforce as a result of securing NHS FT status; • Growing as an employer: • Staff involvement and/or social partnership • Illustrations within the integrated business plan (including highlighting and cross-referencing to the links to the governance arrangements), how the organisation's ongoing aspirations and plans to grow and develop further staff involvement, engagement and wider social partnership will be achieved.	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
9. Governance Arrangements:	This section of the integrated business plan is intended to cover how the applicant trust currently ensures it is sufficiently well governed. Special attention should be paid to the future governance arrangements of the trust and how the members and the board of governors will impact upon the governance arrangements of the trust. Corporate governance can be defined as the process whereby organisations make strategic decisions, determine who is involved and ensure accountability is maintained. This will encompass formal mechanisms such as the risk management strategy of the trust, and informal means. Trusts will also need to describe where and how they need to strengthen existing systems and processes to enable effective operation as an NHS foundation trust. Applicants need to make specific reference to the findings of the historical due diligence, detailing progress against any action plans identified.	
Stakeholder interests	• Summary of constituencies and • Board structure • Description of governors and constituencies and rationale, which complies with legislation • How the governors will be supported and inducted into the organisation and governor role, including the provision of tailored support where appropriate • How the membership will be utilised and exploited within the NHS foundation trust for the development of future service delivery • How the organisation will enable empowerment within a framework of accountability and managed risk.	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Corporate governance and management	• Overview of the committee structure employed by the trust, for example the audit committee and the risk management committee, how quality governance (and clinical governance) is to be enacted • Details should include the key members of each committee, terms of reference, how frequently they meet and the sources of information provided to the committee on a regular basis Refer to the *NHS Foundation Trust Code of Governance* for further guidance on this area	
Risk management	• Should provide a summary of how risks are managed throughout the organisation • Comment on NHS Litigation Authority Risk Management Standards achievement	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Performance management reporting framework: include details of:	• Which reports are sent to the board on a monthly/quarterly basis; • How quality is performance managed by the Board; • Changes made to reporting procedures in light of NHS foundation trust application; • Systems currently used by the trust to track financial and non-financial performance e.g. healthcare targets, clinical risk; and • When the systems were introduced, if benchmarking data is available, when information can be obtained/frequency of the reports and the access available to these systems throughout the organisation	
Financial controls and reporting: describe the financial controls and reporting procedures at the trust covering:	• Details of finance committee; • Controls over expenditure; and • Details of any significant controls • Weaknesses in Statement of Internal Control	
Audit: description of the audit arrangements covering: • .	• Internal audit – mention any adverse internal audit reports; • External audit – name of auditor, form of audit opinion for last two years, significant issues raised in management letter to the trust; and • Details of the audit committee	

Measurable Standard	Evidence	Comments or Findings (reviewers to initial comments)
Compliance Framework: Overview providing details of: .	• How the trust will ensure compliance with the monitoring regime; and • The financial risk rating at authorisation and year 1 of the projected period	
IT systems: Overview of systems including:	• Readiness for national initiatives such as choose and book, electronic staff records, Connecting for Health, etc	
Supporting strategies: • Clinical • Estates • IT • Workforce	• Strategies in place and up to date • Appropriate read-across with other supporting strategies • Linked to overall strategy of organisation	

Appendices:

I – Long Term Financial Model. The most recent iteration of the model, as supplied by the SHA, needs to be populated and submitted as part of the FT application. PDF files, containing a small number of the output sheets do not provide sufficient data for effective scrutiny and challenge.

II – Governance Rationale. This needs to explain why the trust has chosen to adopt the governance arrangements that have been consulted upon. It should map directly across to the Constitution.

III – Model Core Constitution. Trusts need to ensure that the Constitution is compliant with the legislation.

IV – Consultation Response and Staff Engagement. Trusts need to articulate how feedback from the public consultation has been considered, including where changes to the governance arrangements have been made.

V – Membership Strategy. Trusts need to demonstrate effective representation of the membership base, and articulate how membership will be grow, develop and be maintained over the lifetime of the IBP. Suggestions that the Council of Governors will develop the strategy further once appointed, whilst understandable to some degree, creates the impression that FT status, public accountability and active membership participation has not been carefully thought through.

ANNEX B – BOARD MEMBER INTERVIEWS: ISSUES TO BE COVERED/HEADINGS FOR FEEDBACK

Table: Board member Interviews: Suggested areas to be covered/Indicative questions

Trust Profile
1. Can you give a brief profile of your Trust – population served, services provided, the opportunities and some of the challenges you face serving this community? (an understanding of the business of the Trust and customers they serve).
Strategy
2. How has the Trust developed its strategy? (approach to strategy development including environmental and internal assessment, stakeholder engagement etc)
3. What are the strategic objectives of the Trust and how will the board measure progress towards its achievement?
4. What will the Trust look like in 5 years? And what will be the implication for services, staff and estates.(what services and how delivered, staffing numbers, estates).
Resources to deliver the Strategy - Financial & IT Systems
5. How has the board assured itself it's IT (clinical) and financial systems and processes are and will continue to be fit for purpose to deliver the strategy?
Finance
6. What is the Trust's current financial position and end of year forecast (as per last board paper) and progress with CIP delivery?
Governance
7. Can you explain the governance framework associated with your CIP delivery? (programme management arrangement, programme plan, how developed, monitoring, reporting, improvement, implications of adverse performance)
8. How does the board actively encourage robust clinical debate? Can you give an example?

Quality Governance
9. How does quality drive the Trust's strategy? (Quality strategy in place, how communicated, SMART objectives linked to it and how progress monitored? Also Board awareness of potential risks to quality and mitigation action)
Workforce
10. What are the key elements of your workforce strategy and how will it help you to deliver the Trust vision?
Risk
11. What are the three biggest risks facing the Trust over the next 18months? What plans do the Trust have in place to mitigate them?

HEADINGS FOR FEEDBACK

Following the Board interviews being carried out, feedback will be provided to the Trust Chair based around the following headings, as a minimum:

- Introduction
- Background
- Approach
- General Remarks
- Key Findings/Observations
- Actions/Recommedations
- Next Steps

ANNEX C – BOARD OBSERVATION FEEDBACK TEMPLATE

Introduction – Trust Board Observation

- This document contains the resources to undertake a Board observation and provide a report of that observation. It does not represent information about the principles of how a good board discharges its responsibilities.

- The Board observation will be used by the SHA as part of the FT development and assurance process.

- This Trust Board observation assesses the Board against a wide range of criteria including:

  - Governance Arrangements
    - Accessibility of venue and papers, Agenda, Keeping to time, quality and content of papers, etc.

  - The Level of Challenge and Assurance
    - Individual contributions, detail of the discussion, forward/strategic vs. operational/historic focus, decisions made, actions agreed , follow up etc.

  - Board Behaviour
    - Composition, commitment , collective decision making, engagement

  - Coverage of Topics
    - Strategic, quality, risk, financial, workforce, clinical etc.

Trust name:	
SHA name:	
Date of observation:	
SHA representatives:	

The following table provides a template for providing feedback following Board observations:

Executive Summary

Key Areas of good practice:	Key areas for further development

Board Observation - Attendance

Date:		Venue:	
Attendee name	**Attendee role**	**Apologies name**	**Apologies role**

Observations – Governance Arrangements

Area	Areas of Good Practice	Areas for Further Development
Meeting arrangements Inclusive (i.e. Hearing loop, wheelchair access etc) Convenient location and room size		
Public welcomed		
Attendance Record: 6 Previous board meetings.		
Name tags easy to see, seating arrangements, appropriate breaks, well organised.		
Board Papers Board papers circulated in advance. Available in accessible formats if required		
Do the Board minutes provide sufficient detail on prior discussions re: previous decisions and actions with owners and timescales and reporting arrangements		
There is a clear timed agenda, with balance across the relevant issues. Are the agenda timings realistic. Is the agenda followed		
Are the documents fit for purpose Are the functions of each paper clear i.e. information/decision/discussion/other. Clearly presented options/ recommendations and decisions in each paper/item? Clear assessment of risks and how these can be mitigated. Clear link to relevant strategy/strategic objective.		
For performance data How clearly is the data presented, are dashboards used effectively to easily highlight problems.		

Clear narratives and action plans where performance is not on target are presented or reports from board committees where these issues discussed. Is data benchmarked Is performance data comprehensive i.e. Quality, finance, performance targets workforce etc.		

Observations – Challenge, assurance, individual contributions, level of discussion, forward focus, decision making

Area	Areas of Good Practice	Areas for Further Development
<u>Chair contribution:</u> • Chair ensuring effective contribution from relevant parties • Chair ensures each item is given appropriate time. • Chair demonstrates grip of the business • Chair ensures each item sufficiently explored, brought to a clear conclusion and that clearly identifiable decisions are made. • Chair ensures decisions are agreed by all parties • Chair agrees actions and timescales with clearly assigned responsibility.		

• Chair holding NEDs and EDs to account		
<u>NED contribution</u> • All NEDS contribute their views • Do the NEDS provide sufficient challenge • Are all required skills/experience represented on the Board • Are NEDs involved in monitoring and scrutinising • Is there full debate on relevant topics. • Do the NEDs ensure that action plans are realistic and practical. • Is there appropriate balance between strategy and assurance, finance and quality • Do the NEDs hold the EDs to account		
<u>Executive contribution</u> • All EDS contribute their views • Do EDs contribute outside of their own area of expertise • Do the EDS provide sufficient challenge		

• Are all required skills/experience represented on the Board • Are EDs involved in monitoring and scrutinising • Is there full debate on relevant topics. • Do the EDs create action plans are realistic and practical. • Is there appropriate balance between strategy and assurance, finance and quality		
Is there a clear link between the risk register and Board Assurance Framework		
Is there balance between public and private sessions.		
How do the Board assure themselves that agreed actions are followed through as required Is there an action log. Is it taken seriously at the board meeting.		
Is there appropriate prioritisation of items in the board meeting. (in terms of time spent and scrutiny)		
Are there clear linkages in governance terms between the Board and the various committees.		
Does the Board review and act upon committee		

minutes and reports.		
Do the NEDs that chair board committees present information to the board.		

Observations- Board behaviour, composition, commitment, collective decision making, engagement.

Area	Areas of Good Practice	Areas for Further Development
The board is composed of individuals with relevant experience, gender, age and ethnicity in order to address all relevant issues		
The board meet regularly enough to address the needs the needs of the organisation		
The atmosphere is business like, but relaxed, members interact, and engage at ease with other. There is eye contact, and open body language. Respect for each other is demonstrated and the board behave as one group.		
Members effectively challenge by asking penetrating questions, actively listening and asserting position. Challenge is met by openness and willingness to discuss		

Observations – Coverage of key issues

Area	Areas of Good Practice	Areas for Further Development
Quality		

Strategy		
Risk		
Performance		
Finance		
Workforce		

ANNEX D – ISSUES TO BE COVERED AT INTERVIEWS WITH COMMISSIONERS

Main objective is to determine the alignment between Trust and commissioner strategies.

Table: Areas to be covered in interviews with commissioners, as a minimum

Areas to be covered at interviews:
Local environment and its impact on the commissioner(s) and Trust
Other issues faced by the commissioner(s) and their impact on the Trust
The financial performance of the commissioner(s) and its impact on the trust
Activity assumptions and strategic commissioning plans
Performance monitoring
Contracting
Payment by Results
Relationships and support for application
Quality
Efficiencies
Service Developments
Views of Trust Board

Annex E – Standard assurance report for readiness review/Board to Board meeting

SLIDE 1

Confidential

Provider

Board to Board meeting [date]
SHA FT Assurance Report
[Provider] NHS Trust

[Author]

[NHS lozenge]
[SHA name]

SLIDE 2

Overall summary page

Provider

Overall	
Legally constituted and representative	●
Good business strategy	●
Financially viable	●
Well Governed	●
Capable board to deliver	●
Good service performance	●
Quality	●
External relations	●
Governance Risk Rating	●
Service Performance	●
Quality Performance	●
Board Governance Assurance Framework	●
Historical Due Diligence	●

Financial Risk Rating	12/13	13/14	14/15	15/16	16/17
FRR Base	●	●	●	●	●
FRR Mitigated d/side	●	●	●	●	●

2

SLIDE 3

A: Legally constituted and representative

Provider

Detail	
A1: Constitution	
• Final governance rationale	xxx
• Legal sign off of constitution	xxx
A2: Consultation	
• Process	
• Feedback	xxx
A3: Membership strategy	
• Final membership strategy	xxx
• Recruiting; expressions of interest	
• Representation	xxx
A4: Governors	
• Arrangements for initial elections	xxx

SLIDE 4

B: Good business strategy

Provider

B1: Strategic analysis	
• SWOT / PESTLE analysis & documentation	xxx
• Market assessment & documentation	xxx
B2: Clinical strategy	xxx
B3: Board assurance framework	xxx
B4: Supporting strategies	
• HR strategy and workforce plan	xxx
• Estates strategy	xxx
• IMT strategy	xxx
B5: Integrated business plan	
• Commissioner support	xxx
• Other stakeholder support	xxx

SLIDE 5

C: Financially viable

Provider

Detail	
C1: Underlying performance: • Historic • Current • Planns	xxx
C2: Macro assumptions analysis	
• Implied efficiency requirement (base case and downside)	xxx
• Activity levels	xxx
C3: Efficiency plans	
• Targets	xxx
• Detailed plans including minimum 2 years of CIP plans	xxx
C4: Scenario analyses	
• Base case modelled	xxx
• Downside and mitigations	xxx
C5: WC facility & capital funding	Xxx
C6: Compliance with financial triggers	

SLIDE 6

Financially viable: cost improvement programme

Provider

In year CIP as a % of cost base (above)	x.x%	x.x%	x.x%	x.x%	x.x%	x.x%	x.x%
Additional efficiency of service redesign for quality		x.x%	x.x%	x.x%	x.x%	x.x%	x.x%
Cumulative CIP as a % of cost base (plan period)			**x.x%**	**x.x%**	**x.x%**	**x.x%**	**x.x%**
Efficiency implied by base case assumptions			x.x%	x.x%	x.x%	x.x%	x.x%
Cumulative implied efficiency requirement			**x.x%**	**x.x%**	**x.x%**	**x.x%**	**x.x%**
Efficiency requirement Monitor downside		4.5%	5.1%	4.8%	4.6%	4.5%	Ext 4.5%
Cumulative Monitor downside efficiency			**5.1%**	**10.1%**	**15.2%**	**20.4%**	**Ext 25.8%**

1. Xxx
2. Xxx
3. Xxx
4. xxx

SLIDE 7

Financially viable

Scenario analysis

Base case | Downside | Mitigated downside | Working capital facility | Provider

Normalised earnings	Cash at bank	FRR
Normalised earnings graphed	Cash at bank graphed	FRR graphed
Base case	Base case	Base case
Downside	Downside	Downside
Mitigated downside	Mitigated downside	Mitigated downside

Scenario analysis submitted within IBP (graphed above)
- XXX

Additional conceivable downside pressures: £(XX.x)m
- XXX

Additional mitigations provided by the trust: £(XX.x)m (trust has requested we stress that these are highly confidential)
- xxx

Potential shortfall in mitigating conceivable downside £(XX.x)m

SLIDE 8

D: Well governed

Provider

Detail	
D1: Governance documentation (FT) including risk management process	xxx
D2: Strategy setting & planning	xxx
D3: Self certifications	xxx
D4: Review of Trust financial reporting	xxx
D5: Independent accounting review	xxx
D6: Service line management	Xxx
D7: Governance risk rating	Xxx
D8: Board Governance Assurance Framework	Xxx
D9: Board ownership of strategy and financial plan	Xxx

SLIDE 9

Well governed:
Revised board committee structure

Provider

Organisation chart showing proposed committee structure for the foundation trust

9

SLIDE 10

E: Capable board to deliver

Provider

Detail	
E1: Board development	xxx
E2: Board performance	
• Board observations	xxx
• Readiness board to board	xxx
• Quality & risk committee observation	xxx
• Finance/Audit committee observation	xxx
• Challenge board to board	xxx
E3: Board members	
• Required qualifications including financially quality Audit Committee Chair and NED with clinical background	xxx
• Independent majority	xxx
• Board interviews	xxx
• General	Xxx
E4: Board Governance Assurance Framework	

SLIDE 11

Well governed: capable board to deliver:
Non-executive chair and directors

Provider

Name: Position and committee memberships, Experience xxx Qualification xxx Other xxx	photo

Name: Position and committee memberships, Experience xxx Qualification xxx Other xxx	photo
Name: Position and committee memberships, Experience xxx Qualification xxx Other xxx	photo
Name: Position and committee memberships, Experience xxx Qualification xxx Other xxx	photo
Name: Position and committee memberships, Experience xxx Qualification xxx Other xxx	photo

SLIDE 12

Well governed: capable board to deliver:

Provider

Executive directors

Name: Position and committee memberships,
Experience xxx
Qualification xxx
Other xxx

Name: Position and committee memberships,
Experience xxx
Qualification xxx
Other xxx

Name: Position and committee memberships,
Experience xxx
Qualification xxx
Other xxx

Name: Position and committee memberships,
Experience xxx
Qualification xxx
Other xxx

Name: Position and committee memberships,
Experience xxx
Qualification xxx
Other xxx

SLIDE 13

F: Good service performance

Provider

Overview	xxx
F1: Compliance with Monitor Compliance Framework requirements including: Service performance risk ratings for past year Detail of performance vs specific targets	xxx
F2: Risks with future compliance against service performance requirements	xxx

SLIDE 14

G: Quality

Provider

Detail	
G1: Quality governance framework	xxx
• Assessment & action plan following independent third party review	xxx
G2: Monitor Quality Performance	xxx
G3: SHA Medical/Nursing Director review	xxx
• Summary of assessment against quality indicator dashboard	xxx
G4: Satisfaction surveys	xxx
• Staff survey & action plan	xxx
• Patient survey & action plan	xxx
G5: CQC action	xxx
G6: Quality impact of CIPs	xxx
G7: Other	xxx
• NPSA report & action plan	xxx
• SI reporting & action plan	xxx
• NHSLA	xxx
• Other	xxx

SLIDE 15

Quality

Provider

SHA view of trust's performance on Monitor quality governance questions

Quality Governance questions	Trusts self assessment	Independent Third party review
1. Strategy		
A. Does quality drive the trust's strategy? xxx B. Is the board sufficiently aware of potential risks to quality? xxx		
2. Capability and Culture		
A. Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? xxx B. Capability and Culture - Does the board promote a quality-focused culture throughout the trust? xxx.		
3. Processes and Structure		
A. Are there clear roles and accountabilities in relation to quality governance? xxx B. Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? xxx C. Does the Board actively engage patients, staff and other key stakeholders on quality? xxx		
4. Measurement		
A. Is appropriate quality information being analysed and challenged? xxx B. Is the board assured of the robustness of the quality information? xxx C. Is quality information used effectively? xxx		

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SLIDE 16

H: External Relationships

Provider

Detail	
H1: Commissioner feedback	xxx
• Local environment and its impact on the commissioner(s) and Trust	xxx
• Other issues faced by the commissioner(s) and their impact on the Trust	xxx
• The financial performance of the commissioner(s) and its impact on the trust	xxx
• Activity assumptions and strategic commissioning plans	xxx
• Performance monitoring	xxx
• Contracting	xxx
• Payment by Results	xxx
• Relationships and support for application	xxx
• Quality	xxx
• Efficiencies	xxx
• Service Developments	xxx
• Views of Trust Board	xxx
H2: Triangulation	xxx
H3: Contractual status	xxx
H4: Reconfigurations	xxx
H5: Commitment to plans	xxx
• Letter of commissioner support	xxx
H6: Other stakeholders	xxx

SLIDE 17

Annex additional information

	Provider
A: Legally constituted and representative	
B: Good business strategy	
C: Financially viable	
D: Well Governed	
E: Capable board to deliver	
F: Good service performance	
G: Quality	
H: External relations	
Key Risks	

SLIDE 18

Financially viable: forecast outturn [current year]

Provider

Table of FRR for YTD and FOT

Table of leading indicators of financial risk YTD in Qs

Commentary on the above

Summary I&E, with cash flow extract below

YTD versus actual

FOT versus FY plan

Bar chart of monthly surplus

Versus planned trajectory

Bar chart of monthly

CIP delivery

Versus planned trajectory

Year to date position

- xxx

Financial forecast

- xxx

Risks and Opportunities

- xxx

CIP

- xxx

SLIDE 19

Financially viable: capital expenditure and funding

									Provider
Depreciation	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
Capital spend	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
Net funding requirement	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx

Capital expenditure

Bar chart of annual capital expenditure analysed as input to the LTFM

Capital funding

Bar chart of annual capital funding flows (PDC and loans) as input to the LTFM

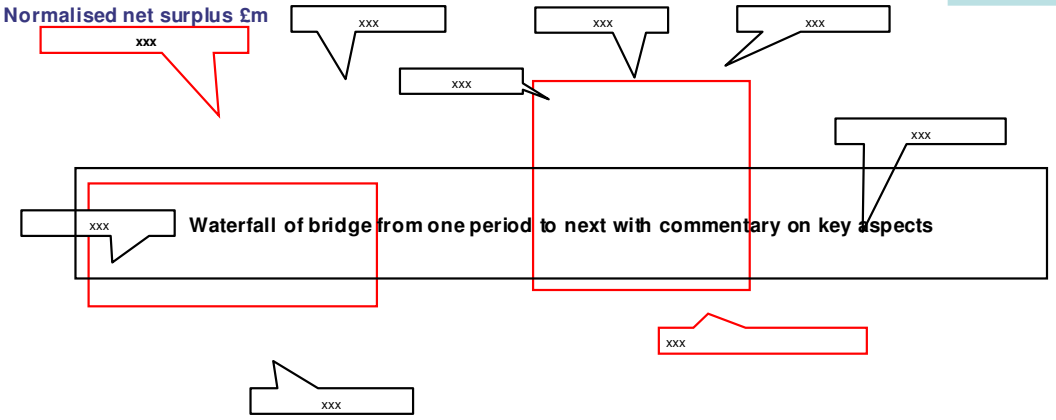
19

SLIDE 20

Bridge analysis: 2010/11 to 2011/12

Normalised net surplus £m

Provider



Margin xx %

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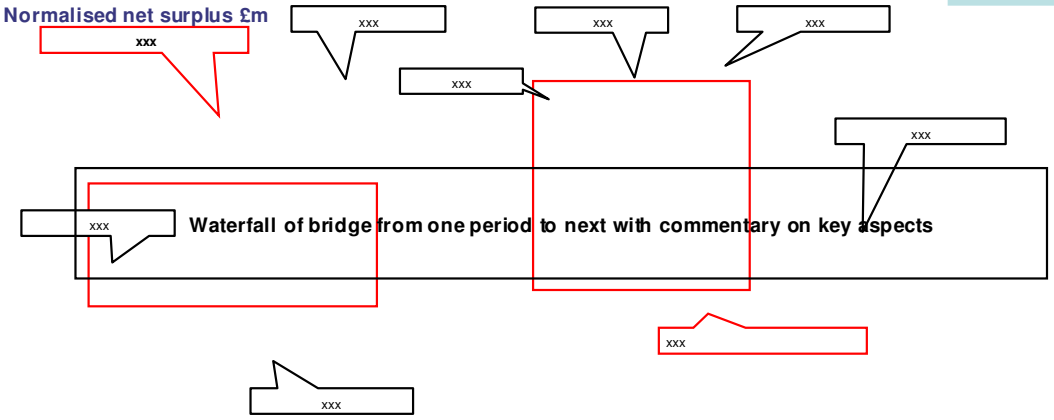
xxx

SLIDE 21

Bridge analysis: 2011/12 to 2012/13

Provider

Normalised net surplus £m



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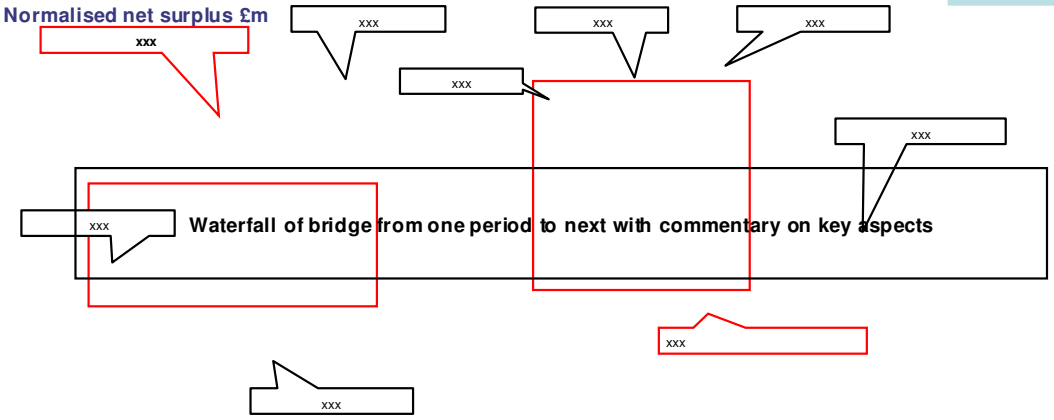
21

SLIDE 22

Bridge analysis: 2012/13 to 2013/14

Provider

Normalised net surplus £m



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xxx

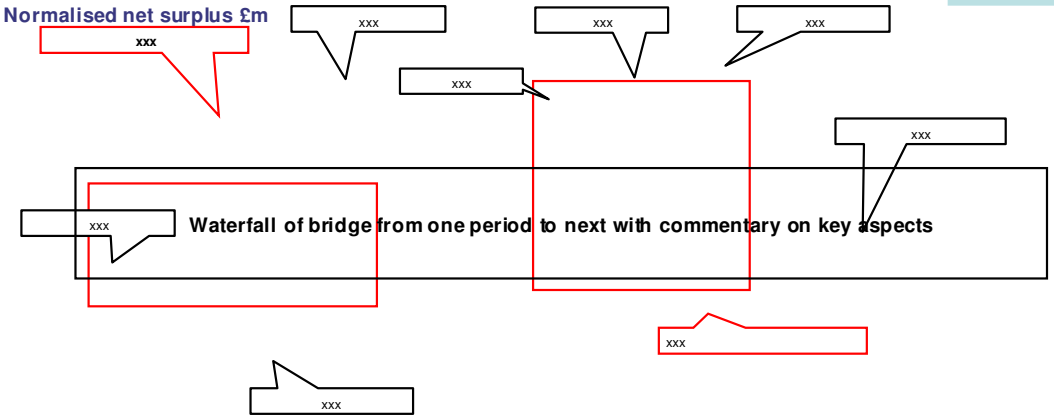
22

SLIDE 23

Bridge analysis: 2013/14 to 2014/15

Provider

Normalised net surplus £m



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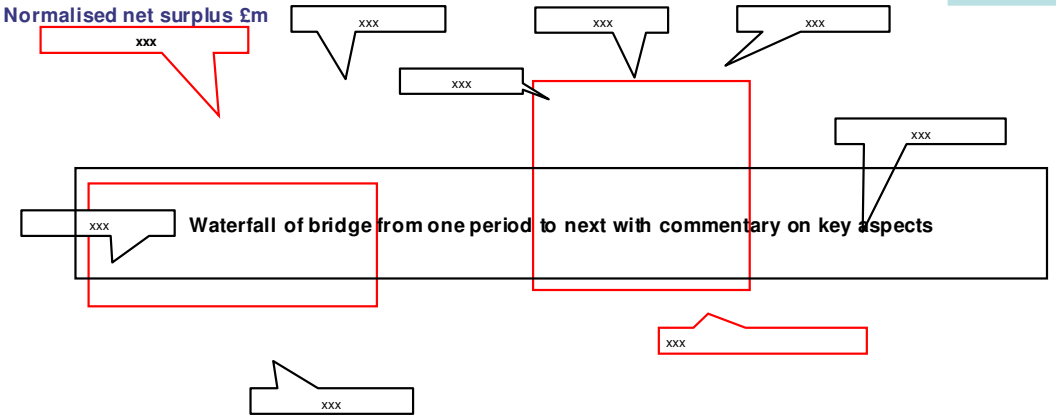
23

SLIDE 24

Bridge analysis: 2014/15 to 2015/16

Provider

Normalised net surplus £m



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xxx

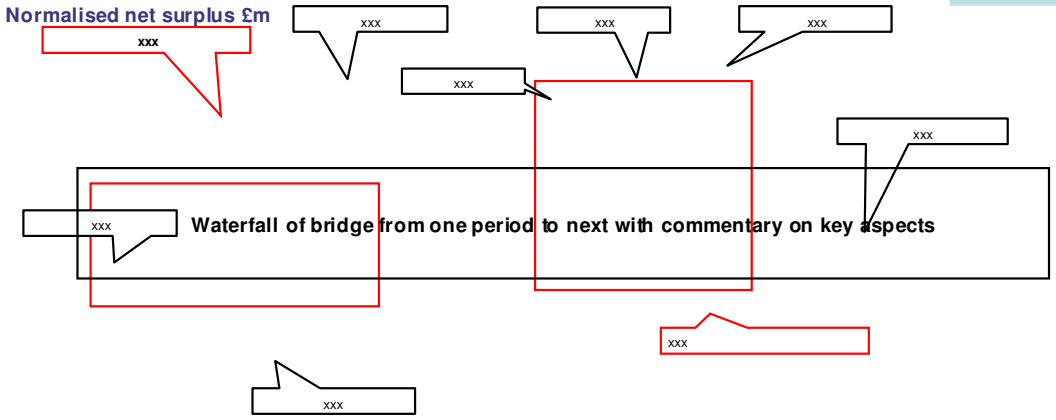
24

SLIDE 25

Medium term bridge analysis: 2010/11 to 2015/16

Provider

Normalised net surplus £m



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Margin xx %

xxx

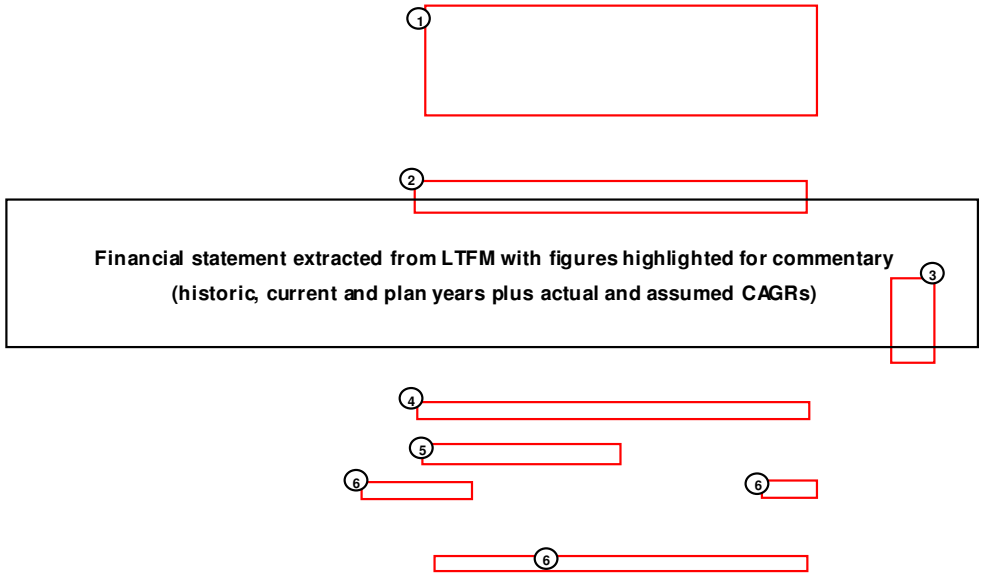
1. xxxx

25

SLIDE 26

Income statement

Provider



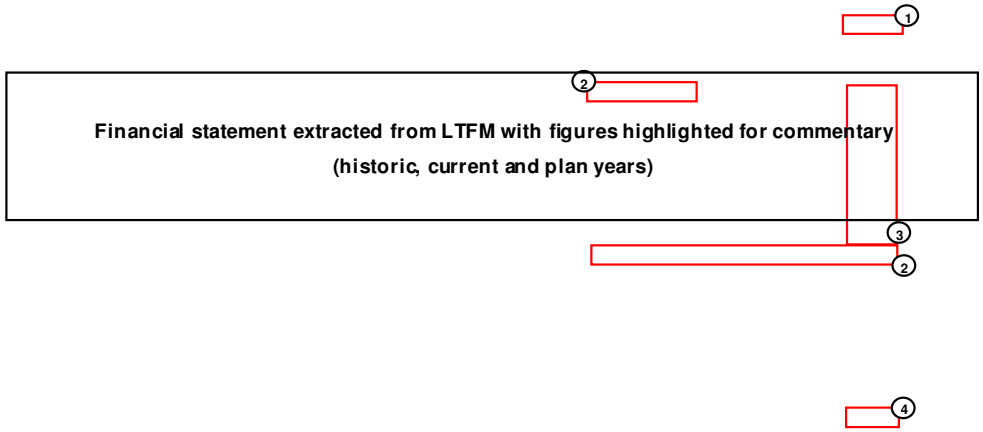
1.xxx

26

SLIDE 27

Balance sheet

Provider



1.xxx

27

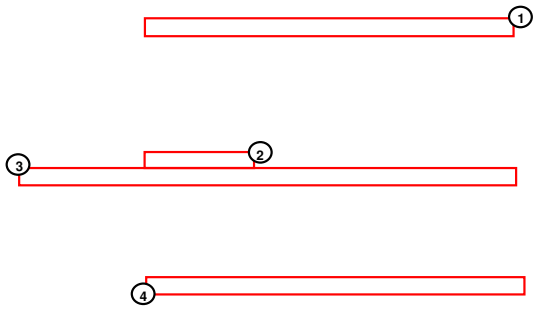
SLIDE 28

Cash flow

Provider

Financial statement extracted from LTFM with figures highlighted for commentary

(historic, current and plan years plus actual and assumed CAGRs)



1.xxx

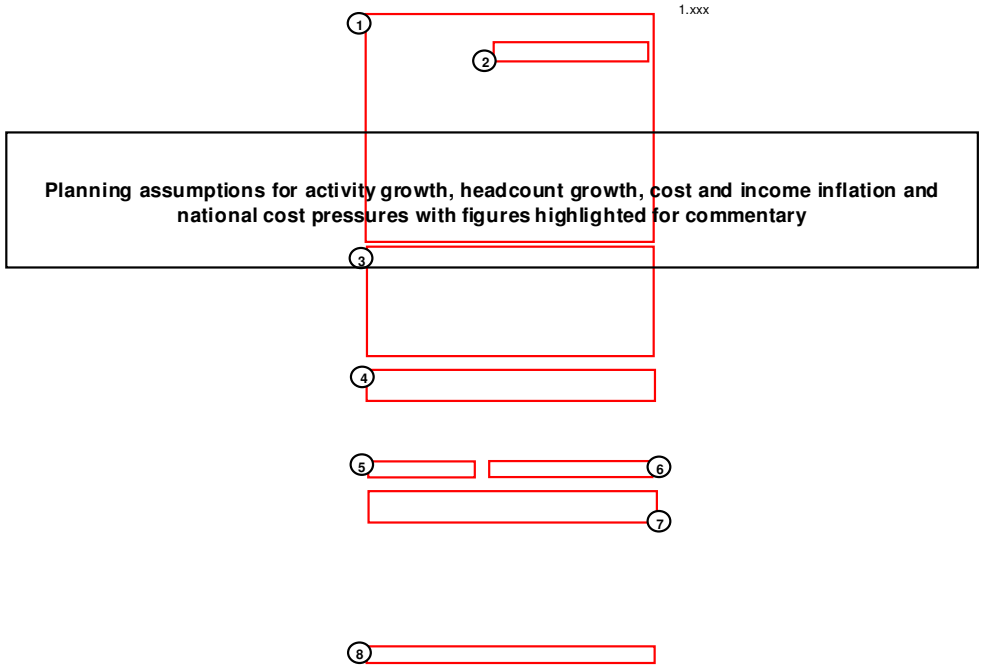
28

SLIDE 29

Key financial assumptions

Provider

1.xxx



29

SLIDE 30

Annex additional information

	Provider
A: Legally constituted and representative – Including membership information with Monitor Compliance Framework requirements reflected.	
B: Good business strategy	
C: Financially viable – Including most recent oversight submission compliance with financial triggers	
D: Well Governed – Including most recent oversight self-certification submission	
E: Capable board to deliver	
F: Good service performance	
G: Quality	
H: External relations	
Key Risks	
Latest Board statements to be provided	

SLIDE 31

X: Risks to achieving current trajectory

Provider

Risk	L	I	Controls and assurance	Gaps	R
Trust does not achieve NHSFT status to current trajectory	4	4	Xxx	xxx	16
Good business strategy xxx. xxx	3	4	xxx	xxx	9
	3	4	xxx	xxx	12
Financial viability xxx xxx	4	4	xxx	xxx	12
	4	4	xxx	xxx	9
Well Governed xxx.	4	3	xxx	xxx	9
Capable board xxx	3	3	xxx	xxx	9
Service performance xxx	4	4	xxx	xxx	9
External relationships xxx xxx	3	3	xxx	xxx	9
	4	3	xxx	xxx	12

L = likelihood I = impact R = residual risk score. Residual risk: increased ▲; reduced ▼.

Provider development assessment of risks to achieving the trajectory for foundation trust

SLIDE 32

Board assurance framework risks >11 (residual)

Provider

Risk	L	I	Areas for Improvement & Action Required	L	I
xxx	4	5	xxx	3	4
xxx	3	4	xxx	3	4
xxx	4	4	xxx	3	4
xxx	4	4	xxx	3	4
xxx	4	4	xxx	3	4
xxx	4	5	xxx	3	4
xxx	4	4	xxx	3	4
xxx	3	5	xxx	3	4
xxx	4	4	xxx	4	3
xxx	4	4	xxx	3	4
xxx	5	4	xxx	4	4
xxx	4	4	xxx	3	4
xxx	4	4	xxx	3	4
xxx	5	4	xxx	4	4
xxx	5	3	xxx	4	3
xxx	4	4	xxx	4	3
xxx	4	5	xxx	3	4
xxx	4	4	xxx	3	4

SLIDE 33

Strategic risks (IBP)

Provider

Risk	G	Impact	Controls / Assurance	N
xxx	25	xxx	xxx	16
xxx	20	xxx	xxx	16
xxx	16	xxx	xxx	12
xxx	16	xxx	xxx	12

ANNEX F – TEMPLATE FOR READINESS REVIEW/BOARD TO BOARD QUESTIONS

The following tables provides a template for questions at readiness review/Board-to-Board meetings:

Trust name:	
SHA name:	
Date of meeting:	
SHA representatives:	

Legally constituted and representative

SHA	Trust	Concern	Question	Appropriate Response

Notes

Good business strategy

SHA	Trust	Concern	Question	Appropriate Response

Notes

Financially viable

SHA	Trust	Concern	Question	Appropriate Response

Notes:

Well Governed

SHA	Trust	Concern	Question	Appropriate Response

Notes

Capable board to deliver

SHA	Trust	Concern	Question	Appropriate Response

Notes:

Good service performance

SHA	Trust	Concern	Question	Appropriate Response

Notes

Quality

SHA	Trust	Concern	Question	Appropriate Response

Notes:

External Relations

SHA	Trust	Concern	Question	Appropriate Response

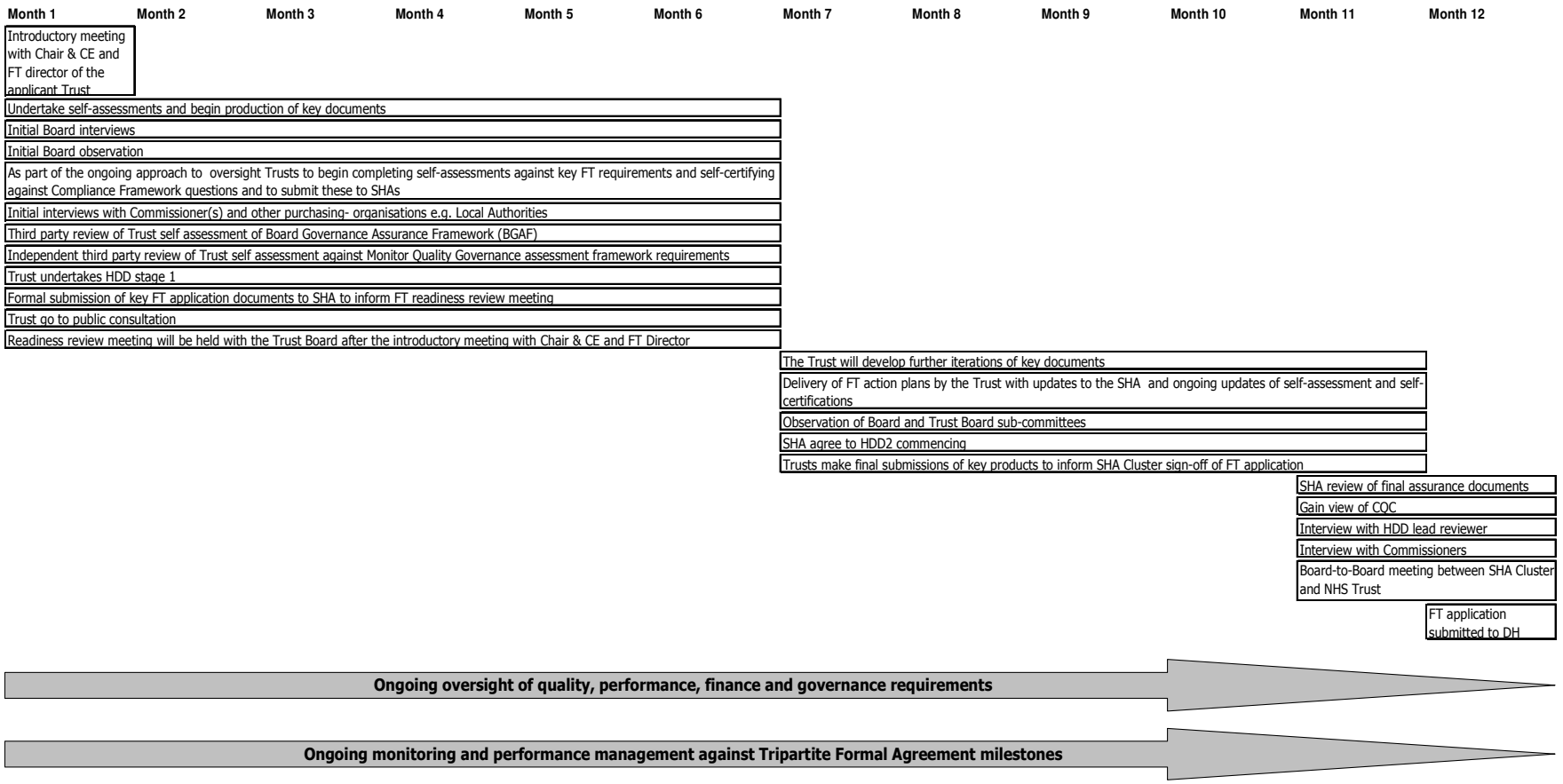
Notes

Delivery of TFA

SHA	Trust	Concern	Question	Appropriate Response

Notes

Annex F: Indicative timeline for implementation of single operating model



Annex H – Links to key documents

Board Governance Assurance Framework documents:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131547

Delivering sustainable cost improvement programmes – Joint publication by Monitor and Audit Commission:

http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/browse-category/developing-foundation-trusts/deli

Monitor Compliance Framework

http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-frame-0

Guide for Applicants

http://www.monitor-nhsft.gov.uk/home/becoming-nhs-foundation-trust/guidance-applicants