Delivering the NHS Foundation Trust Pipeline: Single Operating Model

Part 2 – SHA Oversight of NHS Trusts

3 August 2012

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	**Provider Development**	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	Procedure - new
Gateway Reference	17885
Title	Single Operating Model - Part 2
Author	DH, Provider Development
Publication Date	**03 August 2012**
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Circulation List	PCT Cluster CEs, NHS Trust CEs, Care Trust CEs
Description	To support the delivery of the FT pipeline, the next year will be a crucial phase in maintaining the momentum established following the signing of Tripartite Formal Agreement 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.
Cross Ref	Single Operating Model - Part 1
Superseded Docs	N/A
Action Required	N/A
Timing	**Preparation for implementation due from date of issue**
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For Recipient's Use	

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1. Introduction

1. This document describes the second element of the Single Operating Model (SOM) which focuses on the oversight of NHS Trusts. Oversight includes clinical quality, finance, service performance, governance and the delivery of the Tripartite Formal Agreement (TFA).

2. The development of the SOM has been Strategic Health Authority (SHA) Cluster-led with DH and other stakeholder involvement as necessary. The first phase of the SOM focused on the development and assurance of Foundation Trust (FT) applications at SHAs. Further phases of the SOM will focus on the DH FT review process, transactions and consistency of judgement.

3. The SOM aims to drive a consistent approach across the country and to prepare for the establishment of the NHS Trust Development Authority (NTDA). It is also about driving delivery of the FT pipeline in 2012/13 which is a key year for building the momentum to support the objective for the majority of the remaining NHS Trusts to achieve FT status by 2014.

4. 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 support the transition to the NTDA.

5. The SOM is about improving each NHS Trust's journey to achievement of FT status alongside enhancing the DH and SHA assurance processes that enable this.

SOM Principles

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

Table: 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 Secretary of State 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.

7. There will be a formal review of the various parts of the SOM after 6 months of implementation. There will also be other opportunities to review the model to ensure it is delivering the benefits intended.

Clinical Quality

8. 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 overseeing the ongoing delivery of quality healthcare services and clinical outcomes in the remaining NHS Trusts. It is important therefore to be explicit that the continuing delivery of quality healthcare services and clinical outcomes need to remain the focus of SHA Clusters in this transitional period, alongside the actions directed to establishing a sustainable provider sector, with all NHS Trusts achieving FT status.

9. There is momentum within the current system to deliver an all FT sector. This will only be sustained with continued focus and delivery of quality clinical services for patients.

Oversight

10. SHA Clusters have accountability for the performance of NHS Trusts in 2012/13. Alongside this, individual providers will have relationships with commissioners through contracts in relation to delivery of performance commitments. Oversight does not duplicate these functions nor the level of detail that underpins them. That is, it does not replace the performance management functions of SHAs and DH. Given this there is no explicit involvement in this oversight approach for commissioning organisations.

11. Oversight focuses on developing self awareness and self management of issues by Trust Boards. NHS Trusts are required to become self governing autonomous organisations when they mount a FT application and the oversight approach develops the skills which will be tested in detail as part of the assessment for FT status and what will be required once authorised.

12. Oversight sits alongside and complements the development and assurance of Foundation Trust applications. Oversight is an on-going process rather than a set piece review as other elements are for NHS Trusts working towards becoming an FT e.g. Historical Due Diligence (HDD), Board Governance Assurance Framework (BGAF) etc.

13. Oversight will apply to all NHS Trusts including those going forward as stand-alone organisations and those with other strategies for the future such as those merging with other organisations.

14. Oversight will link directly to the FT development and assurance processes in that the monthly meetings with NHS Trusts will be used to oversee progress with action plans linked to the TFA, HDD reviews, BGAF and Quality Governance Framework.

15. The approach to oversight tries to encourage processes and behaviours that promote the development of a credible FT application including self awareness, self assessment, and the development, management and delivery of action plans by the Trust Board.

Overview of oversight model

Co-ordinated formal monthly meeting between the SHA and each NHS Trust covering quality, finance, governance and the Foundation Trust application

- A co-ordinated formal monthly meeting with an agenda covering clinical quality, finance, service performance, governance and TFA progress.
- Ongoing review of TFA progress and oversight of FT readiness action plans including Historical Due Diligence, Board Governance Assurance Framework and Quality Governance Framework.

Use self-certification from Trust Boards to promote Board ownership of issues and to prepare Trusts for the Monitor approach

- Self-certification, as part of the oversight model, is about preparing and guiding NHS Trusts in relation to the regulatory model for when they become FTs.
- The oversight model will use self-certifications to form part of the information to guide and inform the formal monthly meetings between the SHA and each NHS Trust.
- The content and accuracy of the self-certifications will also form part of the monthly meetings, proportionate to risks identified with these.
- The use of self-certification does not replace the SHA Cluster Performance Management function and the governance arrangements adopted to hold NHS Trusts to account against performance requirements.

Use risk ratings that help Trust Boards understand the discipline of working as a self governing autonomous organisation and their importance in making a credible Foundation Trust application

- A key part of the approach to oversight is to use the Monitor Compliance Framework risk ratings.
- Consideration of each NHS Trusts position against the governance risk rating and financial risk rating will be the basis on which this is delivered. Key to this will be: understanding the requirements needed against these ratings to be authorised as an FT; being clear on the current position and; any actions to get to the necessary levels against these.
- Risk ratings being part of this approach to oversight does not replace any of the performance or financial reporting requirements (including FIMS) required to deliver the performance management functions.
- This approach to oversight will also include the submission of a quality and a contractual return to inform a wider discussion about ongoing issues in relation to contracts and quality.

Clear escalation

- Rules based approach to escalation linking local and national escalation processes. Escalation can include a more direct approach to performance management as one intervention tool.
- These local interventions are linked to the national escalation as determined by the TFA Monitoring and NHS Performance Framework ratings.

NHS Trust oversight – rationale for change

16. The following provides details on the reason the oversight approach is being implemented:

    - A single approach to delivering the FT pipeline based on best practice will promote consistency and support preparations for the NTDA.

    - SOM principle three (see page 4) is to promote further alignment with Monitor's criteria and methodology. The oversight approach includes using Monitor's Compliance Framework to determine readiness for FT status, which is a key element of the assessment criteria.

    - Principle five is to ensure the SOM integrates the performance management of the TFA milestones and actions. The oversight approach deliberately focuses on the Trust Board and good governance across the organisation. It mirrors Monitor's use of Board self-certification, governance and financial risk ratings. The provision of risk based, evidenced self-certification is best practice preparation for independent self-governing and regulated organisations, as required for achievement of FT status.

    - The use of a co-ordinated formal monthly meeting with a Trust covering clinical quality, finance, performance, governance and TFA progress will promote a better understanding and better engagement across the disciplines required to become FT-ready.

17. In addition to the above rationale, part 1 of the SOM, SHA development and assurance of FT applications, will fully realise its benefits alongside the implementation of this oversight approach. The two are complementary with both focussing on building and testing the capability of applicant FT Boards. The other parts of the SOM, including the DH FT assurance approach and the promotion of consistent judgement, will also be supported by this oversight approach to working with NHS Trusts across SHA Clusters.

Approach to oversight

18. This aspect of the SOM, referred onwards in this guidance as the Trust Oversight Approach (TOA), is based on the principle that NHS Trusts must govern themselves effectively.

19. Each NHS Trust Board has the primary responsibility for compliance with legal duties, the delivery of safe, effective, high quality care, the delivery of financial plans and the effective management of risk. The Board needs

to work effectively with their commissioners and deliver contracted standards and targets.

20. Effective governance is a common characteristic of successful organisations and is the key underpinning test of a successful FT application.

Summary of approach to Trust Oversight Approach

Self regulation	The TOA is based on the principle that NHS Trust Boards are responsible for ensuring that the Trust has effective governance systems, processes for gaining and providing accurate assurance, for ensuring that the Trust meets their statutory obligations and triggers to identify and escalate high risk issues.
Self awareness	NHS Trust Boards are expected to demonstrate strong self awareness through the delivery of accurate self certification and self assessment.
Proportionality	The TOA will operate a risk based approach to management with the intensity of monitoring and intervention adjusted in line with the identified level of risk.
Transparency	The TOA provides a transparent method of risk assessment that is understood by all parties. NHS Trusts are expected to adopt a "no surprises" philosophy, to provide accurate information and robust self-certification. Disclosure of risks and concerns should be swift and candid as should be the identification of issues and actions to address these.
Openness	NHS Trusts and the SHA should disclose and discuss risks and issues promptly and candidly.
Minimal information requirements	Information requests will be kept to a minimum and will normally be based on the information that we would expect an NHS Trust Board to use to effectively run their organisation.

2. Processes for delivering the Trust Oversight Approach

21. The processes by which the TOA will be delivered is described via the following sub-headings:

    - Monthly oversight meetings
    - Self-certifications
    - Escalation
    - Use of standard templates
    - Annual operating plan

Monthly oversight meetings

22. The standard approach to the TOA is to meet with members of the NHS Trust Executive team on a monthly basis.

23. Each SHA Cluster will field a consistent team month to month. These meetings will be the key regular formal interaction between the SHA and the Trust. The SHA will field staff to discuss clinical quality, finance, service performance, governance and TFA progress with a Trust via one formal interaction rather than multiple single topic meetings.

24. The NHS Trust will decide who it fields at these meetings. The expectation is that the SHA will meet with members of the Trust Executive and that the team fielded by the Trust will be able to discuss the issues set out on the agenda for the meeting on behalf of the Trust and agree to take actions. If there are problems in terms of the ability to discuss and answer issues raised at the meeting or a lack of senior engagement then the SHA may specify attendees from the NHS Trust.

25. An action log will be produced by the SHA following each meeting with a named lead and timeframe for delivery of the agreed actions.

26. A typical Trust oversight meeting agenda would cover as a minimum:

    Section 1 – Introduction:

    - Actions from the previous meeting

    Section2 – Oversight:

    - Clinical quality
    - Service performance
    - Testing of self-certifications

- Governance risk rating
- Financial risk rating, CIP delivery and FIMS
- Contractual return
- Quality return

- Review of Accountability Agreement if required

Section 3 – Progress with FT application:

- Progress with FT application in particular TFA progress
- Progress with FT action plans including:
  - BGAF
  - HDD
  - Quality Governance Framework
- Progress with Monitor assessment/deferral issues, for relevant organisations

27. To support consistency in delivering these meetings, a standard oversight meeting pack for the SHA team would include as a minimum:

- TFA document
- SHA performance dashboard and DH Performance Framework summary
- FIMS return
- Quality information briefing
- Self-certification submission
- FT actions plans (e.g. HDD, BGAF)

28. The intelligence gathered from the oversight meetings will be used by the SHA to inform the TFA Red-Amber-Green (RAG) rating return to the DH and form part of the discussions that determine the final ratings.

Self-certifications

29. The SOM requires NHS Trusts to regularly self-certify governance and financial risk ratings on a monthly basis. They are also required to submit a template of quality and contractual information and provide an accurate self assessment against a series of Board statements drawn from the Monitor Compliance Framework.

30. The standard timing for the submission of self-certification declarations from NHS Trusts will be on or before the last working day of each month. As a result of escalation an NHS Trust may be required to receive self certification or other information on a more frequent basis.

31. All declarations and self-certification should have been robustly discussed and approved by the Trust Board with the discussion minuted. The self-certification submissions should be signed off on behalf of the Trust Board by the Chair and Chief Executive (or nominated deputies).

32. Self certifications should be submitted on time and in full. Late, incomplete or inaccurate self-certification will automatically be over-ridden to a red governance risk rating.

33. Where an issue of non-compliance is identified the Trust should submit the relevant Board approved action plan to rectify the issue. In line with the principle of avoiding duplication this would normally be the same level of detail that has been presented to the Board to provide them with assurance that an issue can be rectified. An action plan would normally include a clear timeline, accountable leads and resource requirements. The action plan should allow the Trust Board and the SHA to monitor progress and delivery.

34. It is for NHS Trust Boards to agree robust action plans. The SHA will normally focus monitoring on delivery against the broad assurance provided by the Board. In exceptional circumstances, where a responsive action plan is deemed to be weak or inappropriate, the SHA may require different or alternative actions and this would be seen as an indicator of poor governance.

35. In this document we use the term self assessment to cover a Trust Board forming their own view on an issue and self-certification to mean the formal confirmation of the position of the Trust to an external body. For example, a Trust will need to undertake a self assessment of themselves and their organisation to complete the Quality Governance Framework or BGAF review. The review, discussion and debate is the process of self assessment. An example of self-certification is the provision of a set of risk ratings or assurance statements to the SHA or to Monitor.

Escalation

36. NHS Trust Boards have the main responsibility for assessing and mitigating risk alongside resolving issues when these occur.

37. Where appropriate the SHA will provide support to NHS Trusts to resolve issues before, or instead of, escalation or intervention.

38. In determining whether to escalate a Trust or intervene the SHA will make a judgement based on the scale of the issues, the risk ratings, any relevant Board assurance or early notification of issues, whether there are credible plans to resolve the issues identified and the track record of the Trust in terms of delivering plans to resolve issues and sustain an improved position.

39. Issues that lead to escalation or intervention will be judged on a case by case basis but the following list provides some potential examples:

- Red risk ratings
- Quality or safety concerns
- Lack of progress in developing a credible FT application in particular failure to achieve TFA milestones
- CQC concerns
- Financial instability
- Failure to meet key national and/or contractual standards
- Breach of legislation
- Issues of system alignment
- Concerns linked to governance and/or the capability of Board members

40. Escalation actions taken will need to respond to the particular issues but could include:

- Intervention on one or more aspect of performance
- Direction on one or more issue of concern
- Mandated external support

41. The means by which such actions could be instigated may include

- SHA Executive Director led escalation meeting
- SHA Chair and CEO led escalation meeting
- Escalation letter from the SHA Director of Provider Development, SHA Chief Executive or SHA Chair
- SHA – NHS Trust Board to Board meeting

42. In more extreme circumstances the SHA may deem it necessary to intervene to resolve one or more issues. Intervention will need to respond to the particular issues but could include:

- Formal warning or formal instruction
- The requirement to undertake a third party review
- Placing an SHA appointee at the Trust to act as an advisor
- Pursuing an alternative solution to the Trust making their own standalone FT application

43. The national escalation process as driven by the TFA RAG ratings will continue as currently established and evolve in line with any wider

developments to the process as part of the transition. Further guidance on this can be found at the following link:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133373

Use of standard templates

44. Each SHA Cluster will issue standard templates that NHS Trusts will be required to complete each month. These templates are presented at annexes A – H in this document.

Annual operating plan

45. NHS Trusts need an annual operating plan as part of the TOA.

46. The annual operating plan should link to the first year of a longer term Business Plan. The annual operating plan will be focussed on planned developments and risks for the year ahead. The annual operating plan should bring together clear joined up detail and narrative on risks, activity, finance, workforce, quality and strategy. The annual operating plan should be aligned with the plans of commissioners and with regional and national priorities.

Contents of the annual operating plan

- Commentary on the previous year and the delivery of plans
- Strategy and service developments
- Alignment to commissioner plans
- Key risks
- Improving quality and safety
- Delivering contractual and national targets and standards
- Activity assumptions
- Financial plans
- Workforce plans
- Sustainability
- Delivering a successful FT application
- Declarations and self certifications

47. The annual operating plan must be approved by the NHS Trust Board.

3. Evidence and information requirements for the Trust Oversight Approach

48. The previous section of this guidance describes the process by which the TOA will be delivered. The next section describes the evidence and information that will be the basis of the key interactions that form this model.

49. It is divided into the following sections:

- TFA progress
- NHS Trust Governance Declarations
- Governance risk rating
- Financial risk rating
- Contractual return
- Quality return
- Board statements

TFA progress

50. Each NHS Trust has signed a TFA with the DH and SHA which sets out risks, milestones and a deadline for their FT application to be presented to the DH. In addition the lead commissioner for each NHS Trust is signed into each TFA to agree support of the process and timescales set out in the agreement.

51. As part of the self certification return to the SHA the NHS Trust Board should outline progress with the milestones and actions contained in the tri partite formal agreement.

52. Milestones that should have been delivered, or are now due, should be rated as:

- green – fully achieved on time
- amber – fully achieved but late
- red – not fully achieved by the due date

53. Future milestones should be rated as:

- green – on track
- amber green – there is some risk of non delivery by the agreed timescale
- amber red – there is a high risk of non delivery by the agreed timescale
- red – the milestone will not be delivered on time

54. The return of milestone ratings will provide insight into progress but also the ability of a Trust Board to accurately self assess. Progress against the TFA and other key steps in the FT application process will be discussed at the regular Trust oversight meetings.

NHS Trust Governance Declarations

55. As part of the monthly self-certification, each NHS Trust is required to complete and signed the declaration as laid out at annex C.

Governance and financial risk ratings

56. The governance and financial risk ratings that will be used to support the TOA are based on Monitor's latest Compliance Framework. This includes the indicators of forward financial risk as laid out in the framework. This is all available at the following link:

http://www.monitor-nhsft.gov.uk/sites/default/files/Compliance%20Framework%2030%20March%202012%20FINALv1.3.pdf

57. NHS Trust Boards need to be familiar with Monitor's Compliance Framework as part of preparing to become an FT.

58. Standard templates will be shared with NHS Trusts which will stipulate what information is required to be shared each month.

Quality return

59. Clinical quality is a core element of oversight. The monthly self-certification return from NHS Trusts will include headline quality information signed off by the Trust Board. The single cross-Directorate monthly review meeting with a Trust will include a representative from the clinical quality team. Quality is a standard agenda item for the monthly oversight meetings.

60. The TOA requires NHS Trusts to make a quality return providing contemporary quality related information. The return is not risk rated but the indicators will be used as the basis for the clinical quality discussion at the Trust oversight meetings between the NHS Trust and the SHA. Other contextual information on quality will also be used and discussed.

61. The SHA will escalate NHS Trusts that have significant and/or persistent quality or safety concerns, are perceived as having higher risks in terms of quality and safety and/or poor governance processes linked to issues of quality. This could include an escalation meeting led by the SHA Medical Director and Chief Nurse with their Trust counterparts.

62. The oversight meetings will be used to work with NHS Trusts to understand their position against the Quality Dashboards used by the Medical Directors forum to review FT applications. The on-going oversight meetings will be used to review improvement against the metrics.

Contractual return

63. In addition to risk ratings, SHA Clusters will also use a contractual return to support the TOA. The contractual return and broader commissioner relations and alignment will be discussed at the regular Trust Oversight meetings between the NHS Trust and the SHA.

64. A template will be provided for the contractual return. Each NHS Trust will need to provide confirmation that:

- All key contracts are signed
- Both the NHS Trust and commissioner are fulfilling the terms of the contract.
- There are no disputes or performance notices in place.
- There are no disputes over the terms of the contract which might, or will, necessitate SHA intervention or arbitration.

65. The statements relate to contracts that make up 25% or more of the Trusts income. NHS Trusts will need to provide further detail if these statements cannot be confirmed.

Board statements

66. As part of the TOA, NHS Trusts are required to self assess themselves against a series of Board statements. These statements are drawn from the Monitor Compliance Framework. The statements will provide an ongoing indicator of the position of the Trust in a range of critical areas and the ability of the Trust to accurately self assess.

67. NHS Trusts will be required to self assess themselves on a monthly basis against these statements and provide evidence of how they have gained assurance during the FT Trust assessment process. Ongoing self assessment against the statements will be key preparation for the assessment process.

68. NHS Trust Boards should ensure that they have sufficient evidence before providing positive assurance to the Board statements. In areas in which the Trust Board cannot give evidence they need to explain the actions and timescale they have agreed to be able to provide positive assurance.

4. Implementation and review

69. The four SHA Clusters currently adopt different models for working with their NHS Trusts to prepare for FT status. Given this there will be different implementation plans for each.

70. Taking into account these differences, a plan will be agreed between each SHA Cluster and DH to determine how and when they will implement the TOA. Each of these agreements will be required to facilitate, at the latest, the first round of formal monthly meetings to deliver the TOA by September 2012. These meetings should be preceded by the completion of the first set of self-certifications for the TOA

71. This part of the SOM will be reviewed after six months of implementation, alongside the other elements, taking into account other relevant frameworks and developments in this phase of transition for the functions delivering the FT pipeline.

Annex A – Single Operating Model Part 2 – Cover Sheet

SELF-CERTIFICATION RETURNS
Organisation Name:
<INSERT TRUST NAME HERE>
Monitoring Period:
June 2012
NHS Trust Over-sight self certification template

Returns to XXX by the last working day of each month

Annex B – Single Operating Model Part 2 – TFA Progress

TFA Progress

Jun-12

<INSERT TRUST NAME HERE>

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Comments where milestones are not delivered or where a risk to delivery has been identified
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				

Annex C – Single Operating Model Part 2 – NHS Trust Governance Declarations

2012/13 In-Year Reporting

Name of Organisation:		Period:	

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	
Financial Risk Rating (Assign number as per SOM guidance)	
Contractual Position (RAG as per SOM guidance)	

*** Please type in R, A or G**

Governance Declarations

NHS Trusts must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is satisfied that plans in place **are sufficient** to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below.

The board is suggesting that at the current time there is **insufficient assurance available** to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.

Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		

Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Annex D – Single Operating Model Part 2 – Governance risk rating

GOVERNANCE RISK RATINGS | **<INSERT TRUST NAME HERE>**

See 'Notes' for further detail of each of the below indicators

Insert YES (target met in month), NO (not met in month) or appropriate)
See separate rule for A&E

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Sep 11	Historic Data: Qtr to Dec-11	Historic Data: Qtr to Mar-12	Current Data: Apr-12	Current Data: May-12	Current Data: Jun-12
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0						
			Referral information	50%							
			Treatment activity information	50%							
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%							
			Patients dying at home / care home	50%							
	1c	Data completeness: identifiers MHMDS		97%	0.5						
	1c	Data completeness: outcomes for patients on CPA		50%	0.5						
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0						
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0						
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0						
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5						
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0						
			Anti cancer drug treatments	98%							
			Radiotherapy	94%							
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0						
			From NHS Cancer Screening Service referral	90%							
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5						
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5						
			for symptomatic breast patients (cancer not initially suspected)	93%							
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0						
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0						
			Having formal review within 12 months	95%							
	3g	Minimising mental health delayed transfers of care		=7.5%	1.0						
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0						
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5						
	3j	Category A call –emergency response within 8 minutes		75%	1.0						
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0						
Safety	4a	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0						
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0						
		CQC Registration									
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0						
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0						
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0						
				TOTAL		0.0	0.0	0.0	0.0	0.0	0.0

RAG RATING :

GREEN	**= Score of 1 or under**
AMBER/GREEN	**= Score between 1 and 1.9**
AMBER / RED	**= Score between 2 and 3.9**
RED	**= Score of 4 or above**

	Overriding Rules - Nature and Duration of Override at SHA's Discretion								
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective							
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.							
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter							
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.							
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter							
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter							
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter							
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.							
		Number of Overrides Triggered	***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	

Annex E – Single Operating Model Part 2 – Financial risk rating

FINANCIAL RISK RATING | **<INSERT TRUST NAME HERE>**

								Insert the Score (1-5) Achieved for each Criteria Per Month				
			Risk Ratings					Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Comments where target not achieved
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1					
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50					
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5					
	I&E surplus margin %	20%	3	2	1	-2	<-2					
Liquidity	Liquid ratio days	25%	60	25	15	10	<10					
Weighted Average		100%						0.0	0.0	0.0	0.0	
Overriding rules												
Overall rating								0	0	0	0	

Overriding Rules :

Max Rating	Rule							
3	Plan not submitted on time	No						
3	Plan not submitted complete and correct	No						
2	PDC dividend not paid in full	No						
2	One Financial Criterion at "1"							
3	One Financial Criterion at "2"							
1	Two Financial Criteria at "1"							
2	Two Financial Criteria at "2"							

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

Annex F – Single Operating Model Part 2 – Financial risk triggers

FINANCIAL RISK TRIGGERS

<INSERT TRUST NAME HERE>

Insert "Yes" / "No" Assessment for the Month

	Criteria	Historic Data			Current Data				Comments where risks are triggered
		Qtr to Sep-11	Qtr to Dec-11	Qtr to Mar-12	Apr-12	May-12	Jun-12	Qtr to Jun-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters								
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months								
3	Working capital facility (WCF) agreement includes default clause								
4	Debtors > 90 days past due account for more than 5% of total debtor balances								
5	Creditors > 90 days past due account for more than 5% of total creditor balances								
6	Two or more changes in Finance Director in a twelve month period								
7	Interim Finance Director in place over more than one quarter end								
8	Quarter end cash balance <10 days of operating expenses								
9	Capital expenditure < 75% of plan for the year to date								

Annex G – Single Operating Model Part 2 – Contractual data

CONTRACTUAL DATA

<INSERT TRUST NAME HERE>

Insert "Yes" / "No" Assessment for the Month

Criteria	Historic Data			Current Data				Comments where reds are triggered
	Qtr to Sep-11	Qtr to Dec-11	Qtr to Mar-12	Apr-12	May-12	Jun-12	Qtr to Jun-12	
Are the prior year contracts* closed?								
Are all current year contracts* agreed and signed?								
Are both the NHS Trust and commissioner fulfilling the terms of the contract?								
Are there any disputes over the terms of the contract?								
Might the dispute require SHA intervention or arbitration?								
Are the parties already in arbitration?								
Have any performance notices been issued?								
Have any penalties been applied?								

*All contracts which represent more than 25% of the Trust's operating revenue.

Annex H – Single Operating Model Part 2 – Quality

QUALITY

			<INSERT TRUST NAME HERE>												
			Insert Performance in Month												
	Criteria	Unit	Jul-11	Ag -11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Comments on Performance in Month
1	SHMI - latest data	Ratio													
2	Venous Thromboembolism (VTE) Screening	%													
3a	Elective MRSA Screening	%													
3b	Non Elective MRSA Screening	%													
4	Single Sex Accommodation Breaches	Number													
5	Open Serious Incidents Requiring Investigation (SIRI)	Number													
6	"Never Events" in month	Number													
7	CQC Conditions or Warning Notices	Number													
8	Open Central Alert System (CAS) Alerts	Number													
9	RED rated areas on your maternity dashboard?	Number													
10	Falls resulting in severe injury or death	Number													
11	Grade 3 or 4 pressure ulcers	Number													
12	100% compliance with WHO surgical checklist	Y/N													
13	Formal complaints received	Number													
14	Agency as a % of Employee Benefit Expenditure	%													
15	Sickness absence rate	%													
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%													

Annex I – Single Operating Model Part 2 – Board statements

Board Statements

<INSERT TRUST NAME HERE>

June 2012

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the Trust Oversight Approach aspect of the Single Operating Model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	

	For FINANCE, that:	Response
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	

	For GOVERNANCE, that:	Response
6	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.	
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.	
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.	
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO			
Chair			