Monitor

Making the health sector work for patients

Guide for applicants

Updated October 2015

www.gov.uk/monitor

About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

Contents

1. Introduction

Monitor's process for assessing applications for foundation trust status has three main tests to determine whether the applicant:

- is well led so it can deliver quality services to patients on a sustainable basis
- has governance arrangements that are effective in practice
- is legally constituted.

We must be confident that the trusts we authorise as foundation trusts pass these three tests. We must be able to give assurance to Parliament and a wide range of stakeholders that they do.

This *Guide for applicants* (updated October 2015) ('the guide') is written for NHS trusts applying to Monitor for authorisation as foundation trusts. It replaces the previous *Guide for applicants* dated October 2013. It explains what you need to know about applying and what our assessment process is. Our aim is to help you complete the process with as little disruption to your day-to-day patient services as possible.

1.1. What is in the guide?

Authorisation criteria (see Section 2):

- overall criteria you are required to meet on the three tests to be authorised
- what we look for to see whether you meet the criteria.

Content of the assessment (see Sections 3 to 5): how we assess you to see if you meet the required criteria to pass the three tests.

Application process (see Section 6):

- an indicative timeline
- what we expect of you
- what you can expect from us.

Results (see Section 7): the possible outcomes of the application and what they mean for you.

1.2. Changes to the guide

The guide has been revised for ease of use and all amendments since its first publication in 2013 have been incorporated.

The content now reflects assessment against the well-led framework and some other minor changes to the application process.

Well-led framework

In 2014 the Care Quality Commission (CQC), Monitor and the NHS Trust Development Authority (NHS TDA) set out plans for developing an aligned view of a well-led organisation. In April 2015 we published *Well-led framework*[1] which aligns Monitor and the NHS TDA's definition of a well-led organisation with the characteristics set out in the CQC's inspection approach.

All three organisations now use this common understanding of a well-led organisation across regulatory and assessment activities. The well-led framework incorporates and replaces the quality governance assurance framework (QGAF) and the board governance assurance framework (BGAF) for Monitor and NHS TDA. Effective from the date of this guide (October 2015), we now assess the leadership of applicant trusts against this framework.

The assessment against the well-led framework does not entail many changes to the application process. The overarching authorisation requirements for foundation trust status remain the same. Our work to see if trusts are legally constituted is also largely unchanged.

The two main changes are:

- Applicants need to provide an overall board statement confirming that the trust is well led according to the well-led framework. This replaces the quality governance statement and the organisational capacity self-certification.
- We assess applicants against the well-led framework in two workstreams, one on quality governance and one on corporate governance. This division allows us to focus on quality while minimising changes to the assessment process and, therefore, the burden on applicants (see Sections 2 and 3).

Administrative changes

Administrative changes in this updated guide include:

- updating the CQC requirements for authorisation to be in line with CQC's new inspection approach and recommendations set out in the government's response to the Public Inquiry into Mid Staffordshire
- updating risk rating requirements to be consistent with the risk assessment framework[2]

[1] Available from: www.gov.uk/government/publications/well-led-nhs-foundation-trusts-a-framework-for-structuring-governance-reviews
[2] Available from: http://www.gov.uk/government/publications/well-led-nhs-foundation-trusts-a-framework-for-structuring-governance-reviews

- applicants close to referral contemplating a transaction should engage with Monitor and NHS TDA at an early stage so that an appropriate timetable for assessment can be agreed to ensure the process does not unduly delay the changes required to improve services to patients.

Where to get further help

Other resources to help you in your application are provided in the appendices.

2. Authorisation criteria and what we assess

2.1. Authorisation criteria

To authorise an applicant for foundation trust status, Monitor must be satisfied the applicant:

- is well led so it can deliver quality services to patients on a sustainable basis
- has governance arrangements that are effective in practice
- is legally constituted.

Table 1 gives the criteria applicants must meet in each of these three areas.

Table 1: Authorisation criteria

Assessment test	Requirement for authorisation
Is the trust well led?	• provides board certification that the applicant meets the requirements of the well-led framework and that there are plans to ensure ongoing compliance with the conditions of the provider licence
	• meets the requirements of the well-led framework, which means demonstrating: ○ a quality governance score of <4 with an overriding rule that none of the four categories of the well-led framework is rated entirely amber/red[3] ○ an overall rating of no worse than amber/green against the corporate governance elements of the well-led framework (that is, good practice excluding quality governance)
	• provides a letter of representation before Monitor's authorisation decision which confirms that all relevant information has been provided to Monitor[4]
How effective are the governance arrangements in practice?	• must demonstrate that: ○ it has been awarded either a 'good' or an 'outstanding' rating from CQC at its most recent inspection ○ the letter of assurance from CQC received immediately preceding the authorisation decision confirms the applicant is providing care at an appropriate quality to proceed in its application CQC's judgement is made taking account of whether: ○ the applicant trust is registered with CQC and whether the registration is subject to additional conditions (other than location conditions) ○ the trust is the subject of any regulatory action and the current

[3] As defined in Section 3.
[4] The wording for the letter of representation is given in Appendix 6.

Assessment test	Requirement for authorisation
	status of this ○ CQC holds any information from its Intelligent Monitoring or any other surveillance systems which would trigger the need for a responsive focused inspection ○ CQC is taking any enforcement or other investigation activity at the trust or such activity is planned, including preliminary inquiries into outlier alerts • continue to meet the quality threshold set by the Department of Health (DH) or NHS TDA at the time of referral • has an access and outcomes metrics service performance score of <4 (as defined in the risk assessment framework)
	• demonstrates that the trust has a high likelihood of generating a sustainable net income surplus by year 3 of the projected period, unless there are exceptional circumstances, and maintaining a reasonable cash position
	• has a minimum financial sustainability risk rating (FSRR) of 3 at authorisation and on a quarterly basis in the first full year of projections, unless there are exceptional circumstances
	• provides a board statement which confirms sufficient working capital for the next 12 months, accompanied by an appropriate professional opinion on this statement • provides board certification that financial reporting procedures are satisfactory and this is based on an appropriate professional opinion
Is the applicant legally constituted?	• applicant's proposed constitution complies with Schedule 7 of the 2006 Act (as amended) and is otherwise appropriate • the required statutory consultation has been held with the bodies referred to in Section 35(5) of the 2006 Act • the content of the consultation and the applicant's response to the outcomes of the consultation process have been adequate • elections have been held for the council of governors in accordance with the proposed constitution and electoral rule
	• there is a board of directors and council of governors constituted in accordance with the constitution
	• proposals provide a representative and comprehensive governance strategy: ○ the council of governors reflects the composition of the membership and the affiliations and financial interests of the governors are known ○ affiliations and financial interests of the board are known ○ there are clear structures and comprehensive procedures for the effective working of NHS foundation trust boards • steps have been taken to secure representative membership
	• ensures the provision of commissioner requested services (CRS) in the business plan, and can and will comply with the provider licence

2.2. What we look at to assess whether an applicant meets the criteria

Table 2 gives an overview of what we consider in our assessment of whether an applicant meets the criteria for foundation trust status.

Table 2: What Monitor looks at

Assessment test	Requirement for authorisation
Is the trust well led? We look at your governance arrangements using 10 lines of inquiry/ questions across four domains	**Strategy and planning** 1. Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver? 2. Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services? **Capability and culture** 3. Does the board have the skills and capability to lead the organisation? 4. Does the board shape an open, transparent and quality-focused culture? 5. Does the board support continuous learning and development across the organisation? **Processes and structure** 6. Are there clear roles and accountabilities in relation to board governance (including quality governance)? 7. Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance? 8. Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance? **Measurement** 9. Is appropriate information on organisational and operational performance being analysed and challenged? 10. Is the board assured of the robustness of information?
How effective are the governance arrangements in practice? We look at evidence from current and near-term performance against outcomes metrics	• CQC quality of care threshold • TDA threshold • access and outcomes metrics • year 1 FSRR • sustainability over three years under a reasonable downside

Assessment test	Requirement for authorisation

Is the applicant legally constituted?
We check an applicant's constitution and governance arrangements
	• applicant's proposed constitution complies with Schedule 7 of the 2006 Act (as amended) and is otherwise appropriate
	• the required statutory consultation has been held with the bodies referred to in Section 35(5) of the 2006 Act
	• the content of the consultation and the applicant's response to the outcomes of the consultation process have been adequate
	• elections have been held for the council of governors in accordance with the proposed constitution and electoral rule
	• there is a board of directors and council of governors constituted in accordance with the constitution
	• proposals provide a representative and comprehensive governance strategy:
	  ○ the council of governors reflects the composition of the membership and the affiliations and financial interests of the governors are known
	  ○ the affiliations and financial interests of the board are known
	  ○ there are clear structures and comprehensive procedures for the effective working of NHS foundation trust boards
	• steps have been taken to secure representative membership
	• ensures the provision of CRS in the business plan, and can and will comply with the provider licence

3. Is the applicant well led?

3.1. Overview

We assess the appropriateness of the governance arrangements against the outcomes and good practice in the well-led framework. In addition we ask for direct evidence to support assurance across the framework.

The framework is organised under 10 questions which fall into four domains (see Figure 1):

1. **Strategy and planning** – how well is the board setting direction for the organisation?
2. **Capability and culture** – is the board taking steps to ensure it has the appropriate experience and ability, now and in the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?
3. **Process and structures** – do reporting lines and accountabilities support the effective oversight of the organisation?
4. **Measurement** – does the board receive appropriate, robust and timely information and does this support the leadership of the trust?

Each question has outcomes that the review 'tests'/investigates. As noted in Section 1, we have aligned these with CQC's approach to assessing well led.

We undertake our assessment on 'well led' in two workstreams:

- quality governance
- corporate governance.

This approach ensures the focus on quality is maintained and minimises the regulatory burden on applicants. You need to demonstrate you meet the good practice criteria, and if you do not, how your board is assured that this is not a concern.

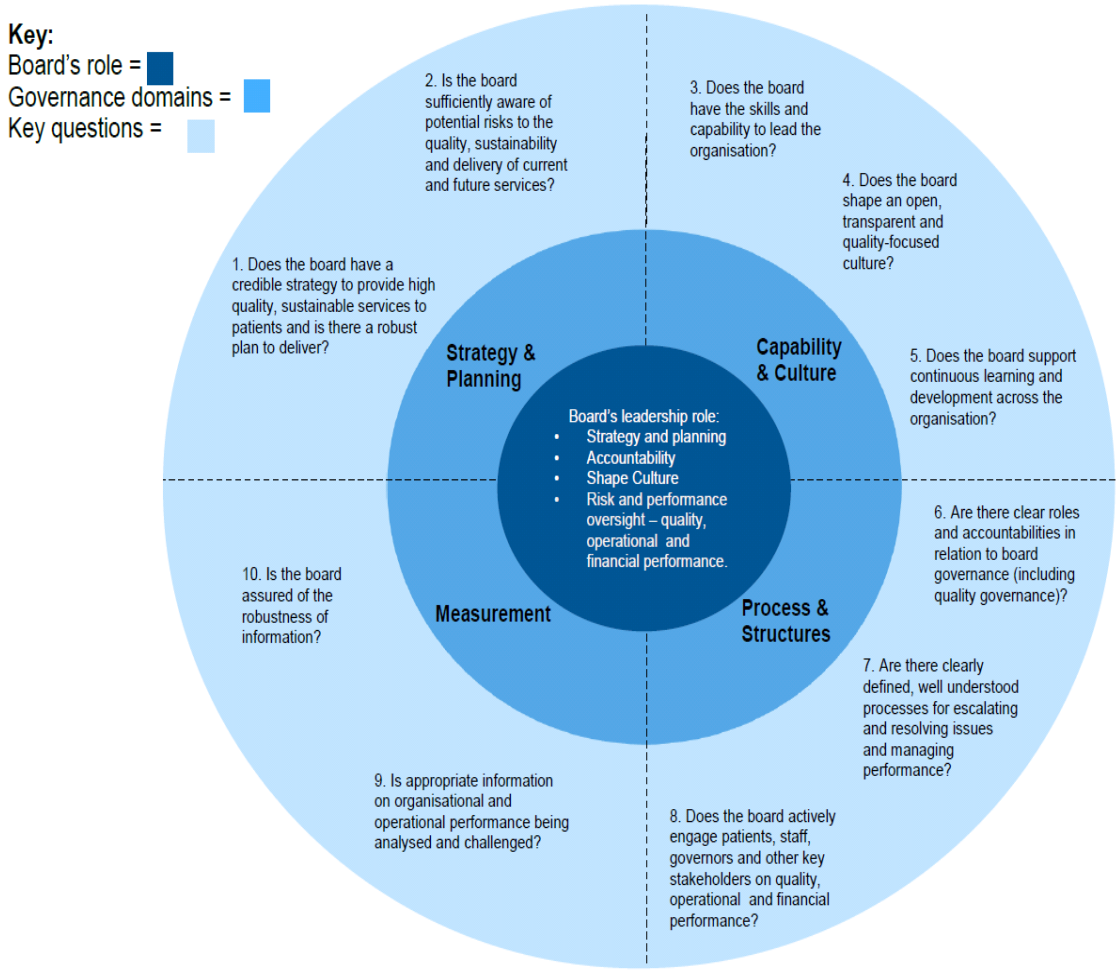
Submission requirements

To test whether you meet the requirements of the well-led framework we ask you to provide a set of overarching submissions as follows:

- a well-led board statement
- a letter from the chair confirming that the whole trust board has confidence in the arrangements in place for each area set out in the well-led board statement
- a quality governance board memorandum (in support of the quality governance statement in the well-led board statement) (see Appendix 2)

- a strategy development memorandum (in support of the strategy development statement in the well-led board statement) (see Appendix 3)
- the relevant trust board paper(s) defining its approach to the remaining areas in the well-led board statement
- the trust board minutes confirming the trust board has confidence in the arrangements for each area
- direct evidence supporting assurance against the framework (see Table 5).

Figure 1: Questions within the four domains of the framework



3.2. What we do

To assess the appropriateness of the governance arrangements we:

- hold a meeting to discuss the well-led board statement and the process the board went through to make the statement
- review the overarching submissions and additional direct evidence provided by you or requested during the assessment
- consider oral evidence gained through structured interviews with your board and staff (at divisional level)
- observe committee meetings
- consider evidence obtained from meetings with stakeholders.

You should be aware that we also look at publicly available information, including that obtained from conducting media searches.

3.3. How we conclude on 'well led'

The decision on whether or not an applicant is well led considers our assessment of both quality and corporate governance. The risk ratings are defined in Table 3.

To be authorised you need to demonstrate:

- a **quality governance** score of <4 with no domain of the well-led framework being entirely amber/red
- for **corporate governance**, an overall 'RAG' rating of no worse than amber/green.

Our approach to rating quality governance is based on our assessment of the evidence in support of the good practice allocated to the quality governance workstream. This approach is consistent with the previous guide (published in October 2013) to ensure there is a clear focus on quality and the previous bar for authorisation is maintained.

For corporate governance the assessment team considers the evidence in support of the good practice allocated to the corporate governance workstream and bases its overall RAG rating on the definitions given in Table 3. The team allocates a single overall RAG rating for the workstream, with a minimum requirement of amber/green for authorisation.

Table 3: Governance risk rating definitions

Corporate governance risk rating	Quality governance score	Definition	Evidence
Green	0.0	Meets or exceeds expectations	Many elements of good practice and no major omissions
Amber/green	0.5	Partially meets expectations but confidence in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, no major omissions and robust action plans[5] to address perceived shortfalls with proven track record of delivery
Amber/red	1.0	Partially meets expectations but some concerns for capacity to deliver within a reasonable timeframe	Some elements of good practice and no major omissions Action plans to address perceived shortfalls are in early stage of development with limited track record of delivery[6]
Red	4.0	Does not meet expectations	Major omission identified Significant volume of action plans required to address shortfall and concerns about management capacity to deliver

We do not expect trusts to meet all the areas of good practice. The list of what we look at (see Table 2) is not intended to be used for 'box ticking'. Instead it should guide you in considering whether your processes and overall organisational culture in these areas are fit for purpose. We expect boards to have assured themselves that where there are shortfalls these do not raise concerns.

Requirement for external review to support the conclusion on governance

Where we identify concerns about an applicant's governance, risk management or quality governance during the assessment that individually do not justify a decision not to give authorisation, we record them on a comprehensive organisational matrix.

[5] Expectations for action plans are detailed in Section 4.
[6] 'Proven track record of delivery' means the trust can provide evidence of how this has been achieved in the past.

The comprehensive organisational matrix is a balanced RAG-rated scorecard that brings together the areas of concern across the governance and quality governance domains. The range of RAG-rated factors includes, but is not limited to:

- quality governance score of red or amber/red
- staff, patient and stakeholder feedback
- other performance indicators, eg serious incidents, complaints, access and outcomes metrics performance
- assurance concerns
- CQC's regulatory position.

Monitor's senior team with appropriate input from individuals with senior NHS experience, NHS TDA and CQC decides, based on the evidence recorded, whether:

- no further work is required as the level of evidence is sufficient to conclude that the concerns can be tolerated and lie within the authorisation threshold
- no further work is required as the level of evidence is sufficient to conclude that the concerns together with the supporting action plans are sufficient to allow an authorisation with a side letter
- there is insufficient evidence to conclude that the level of concern is within the tolerance for authorisation and therefore more in-depth analysis is required to determine the operational implications.

Our decision to request further commissioned work is not according to strict criteria but on a case-by-case basis, dependent on the concerns raised and their cumulative impact. As already mentioned we involve individuals with senior NHS experience, NHS TDA and CQC; this is to ensure we identify all material concerns without placing too great a regulatory burden on applicant trusts.

We decide with CQC and NHS TDA the most appropriate way to conduct additional work and write to applicants setting out the reasons for the decision to request this. This work may include:

- Monitor's assessment team probing more deeply into operations and management at the divisional level
- review by CQC
- commissioning an external peer review team to probe more deeply into service performance
- commissioning an external review into governance arrangements.

Before external reviews are commissioned, we would expect the scope and outputs of the review to be mutually agreed between Monitor and the applicant trust. It is for the applicant's board to commission the work and to pay for this if a fee is charged.

An appropriate pause in the timeline for the application is allowed to reflect the time necessary to undertake the external review and to implement and embed its recommendations. When we recommence our assessment we review the trust's response to the recommendations.

3.4. Further guidance for applicants

The well-led framework details the standard for good practice we assess trusts against.

Table 4 summarises the questions and outcomes in the well-led framework and shows how these are linked to the two well-led workstreams. It also provides examples of the type of direct evidence trusts should submit (in addition to the overarching submissions described above) to allow us to assess them against the well-led framework.

Applicants already familiar with our approach to the assessment of quality governance should be aware that, while the standard of good practice we assess against remains largely unchanged, the alignment process with CQC and NHS TDA has resulted in some reordering/renumbering of the questions.

You should also look at the guidance in Section 5 before making any submissions.

Table 4: How the well-led framework outcomes are assessed

Strategy and planning		
Question 1	**Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?**	**Submissions/documents required**
Workstream Quality governance (QG) and corporate governance (CG) CG CG QG and CG QG	**Outcome being tested:** • there is a clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant • the vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others • the challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place • strategic objectives are supported by quantifiable and measurable outcomes which are cascaded through the organisation • staff in all areas know and understand the vision, values and strategic goals	**Overarching submissions:** • strategy memorandum • quality governance memorandum • integrated business plan (IBP) **Direct evidence examples:** • stakeholder/staff engagement strategy • performance reporting • quality improvement plan • quality account • performance reports relative to quality goals
Question 2	**Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?**	**Submissions/documents required**
Workstream QG	**Outcome being tested:** • there is an effective and comprehensive process in place to identify, understand, monitor and address current and future	**Direct evidence examples:** • direct evidence on risk management: ○ risk management strategy and policies

QG	risks • service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively. Financial pressures are managed so that they do not compromise the quality of care	approved by the trust board. This should include criteria for measuring and evaluating risks and procedures for establishing contingency plans ○ annual governance statement, including disclosures of significant internal control issues (eg serious untoward incidents in the last two years) ○ a schedule detailing the evidence the trust board has relied on in making the annual governance statement ○ management report demonstrating how the trust board has satisfied itself that it has adequate controls in place to manage risk. If the applicant has used any form of external review in its assessment process, Monitor will expect copies of the report • board assurance framework and any reviews performed on it • corporate risk register • direct evidence to support the assurance over assessing and monitoring quality impacts of cost improvement plans (CIPs) and service developments (see Appendix 7 for additional guidance)

Capability and culture		
Question 3	**Does the board have the skills and capability to lead the organisation?**	**Submissions/documents required**
Workstream QG and CG QG and CG QG	**Outcome being tested:** • the board has the experience, capacity and capability to ensure that the strategy can be delivered • the appropriate experience and skills to lead are maintained through effective selection, development and succession processes • the leadership is knowledgeable about quality issues and priorities, understands what the challenges are and takes action to address them	**Direct evidence examples:** • reviews of board effectiveness (internal or externally commissioned) • board skills self-assessments • board training attendance relevant to governance • organisational development strategy • succession plans
Question 4	**Does the board shape an open, transparent and quality-focused culture?**	**Submissions/documents required**
Workstream QG QG and CG QG and CG	**Outcome being tested:** • leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity • candour, openness, honesty and transparency, and challenges to poor practice are the norm. Behaviour and performance inconsistent with the values are identified and dealt with swiftly and effectively, regardless of seniority • the leadership actively shapes the culture through effective engagement with staff, people who use the services, their representative and stakeholders. Leaders model and encourage co-operative, supportive relationships among staff so that they feel respected, valued and supported	**Direct evidence examples:** • organisational development strategy • staff surveys/feedback (national and local) • cultural/staff engagement work • equality and diversity strategy • patient surveys • incident reporting statistics • patient and public involvement strategy • complaints reporting – by theme/directorate, commissioner follow-up • examples of service level management (SLM) reports (or similar)

QG and CG QG QG	• mechanisms are in place to support staff and promote their positive wellbeing • there is a culture of collective responsibility between teams and services • the leadership actively promotes staff empowerment to drive improvement and a culture where the benefit of raising concerns is valued	• lessons learned (evidence of information being captured and disseminated)
Question 5	**Does the board help support continuous learning and development across the organisation?**	**Submissions/documents required**
Workstream QG QG QG	**Outcome being tested:** • information and analysis are used proactively to identify opportunities to drive improvement in care • there is a strong focus on continuous learning and improvement at all levels of the organisation. Safe innovation is supported and staff have objectives focused on improvement and learning • staff are encouraged to use information and regularly take time out to review performance and make improvements	**Direct evidence examples:** • quality account • performance reports relative to quality goals • benchmarking information reviewed by the board • trust's strategy • quality improvement plan • organisational development strategy • examples of communication with staff on quality • performance reports relative to targets • all reports and peer reviews (including drafts) commissioned either internally or externally covering governance arrangements at the trust or the quality of service at the trust within the last two years and associated action plans

Processes and structures		
Question 6	**Are there clear roles and accountabilities in relation to board governance (including quality governance)?**	**Submissions/documents required**
Workstream CG QG and CG QG	**Outcome being tested:** • the board and other levels of governance within the organisation function effectively and interact with each other appropriately • structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective[7] • quality receives sufficient coverage in board and other relevant meetings below board level	**Direct evidence examples:** • governance structures, including the board and its subcommittees • terms of reference for board and subcommittees • board role descriptions/objectives • board minutes (public and private) for the past 24 months • full papers (public and private) for most recent board meeting • quality committee minutes for past 24 months • audit committee minutes for past 24 months • independent accountants report on financial reporting procedures • direct evidence of governance arrangements for partnerships, joint working arrangements and shared services (see Appendix 7 for additional guidance) • outcome of any external reviews on board governance and summary of changes undertaken

[7] Appendix 7 provides guidance on the principles governing local arrangements such as Section 75 and other agreements, and how they work in an NHS foundation trust environment

Question 7	**Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?**	**Submissions/documents required**
Workstream QG and CG QG and CG CG	**Outcome being tested:** • the organisation has the processes and information to manage current and future performance • performance issues are referred to the relevant committees and the board through clear structures and processes • clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns	**Direct evidence on performance management:** • performance management strategy and policy documents approved by the trust board • an example of the performance reports regularly submitted to the board • an example of exception reporting on performance to the board • reports (including action plans where available) from inspectorates including the CQC • all reports and peer reviews (including drafts) commissioned either internally or externally and covering governance arrangements at the trust or the quality of service at the trust within the last two years
Question 8	**Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?**	**Submissions/documents required**
Workstream QG QG	**Outcome being tested:** • a full and diverse range of people's views and concerns are encouraged, heard and acted on. Information on people's experiences is reported and reviewed alongside other performance data • the service proactively engages and involves all staff and	**Direct evidence examples:** • incident reporting arrangements • raising concerns (whistleblower) policy • analysis of complaints and incidents • patient surveys (national and local) • communication strategy

QG and CG QG and CG	assures that the voices of all staff are heard and acted on • staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted on • the service is transparent, collaborative and open with all relevant stakeholders about performance	• examples of performance information shared with the public and stakeholders • governors and members engagement strategy
Measurement		
Question 9	**Is appropriate information on organisational and operational performance being analysed and challenged?**	**Submissions/documents required**
Workstream QG and CG QG and CG	**Outcome being tested:** • integrated reporting supports effective decision-making • performance information is used to hold management and staff to account	**Direct evidence examples:** • recent performance reports at board, subcommittee, divisional and service level • reports showing performance against organisational priorities • financial reporting procedures report from independent accountants
Question 10	**Is the board assured of the robustness of information?**	**Submissions/documents required**
Workstream QG and CG	**Outcome being tested:** • the information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant	**Direct evidence examples:** • coding accuracy reports • internal audit reports on data accuracy • data quality strategy/policy

4. How effective are the governance arrangements in practice?

In parallel with our work on the well-led framework we assess recent and near-term performance information to check that the board's leadership arrangements are effective in practice.

The performance information we look at is:

- CQC's quality of care threshold
- NHS TDA's quality threshold
- performance against access and outcomes metrics as set out in Monitor's risk assessment framework for foundation trusts
- financial sustainability over a three-year period
- current performance against the financial sustainability risk rating (FSRR).

A summary of our requirements in each of these areas is provided Table 5 below.

4.1. CQC quality of care threshold

The way Monitor works with CQC to obtain its views is set out in Section 6.

Before being referred to Monitor for assessment, applicants must pass a CQC inspection (receiving either a 'good' or 'outstanding' rating) under the Chief Inspector of Hospitals' (CIOH) regime.

Before making our authorisation decision we will have received a letter from CQC confirming the most recent inspection outcome and the current status of the CQC's regulatory oversight of the applicant trust. This letter will provide a recommendation from the CQC as to whether the applicant trust is providing care at an appropriate level of quality to proceed in its foundation trust application.

NHS TDA quality threshold

We will not authorise a trust whose quality performance has deteriorated against the threshold set by NHS TDA at the time of referral. This is set at a CQC rating of at least 'good'. We expect to receive a letter from NHS TDA confirming it is unaware of any issues that would alter the recommendation to support the trust's application.

The way we work with NHS TDA (and NHS England in the case of trusts providing high security psychiatric services) to obtain its views is set out in Section 6.

4.2. Access and outcomes metrics

As part of the assessment process, Monitor looks at the applicant's performance against access and outcomes metrics set out in the risk assessment framework in force at the time of the assessment.

Monitor may authorise an applicant that is not meeting all the access and outcomes metrics, but this depends on the severity of the failure and the robustness of action plans to return it to compliance.

4.3. Financial sustainability

We review the applicant's business plan and long-term financial model (LTFM) to understand the assumptions underpinning them. From this we identify key risks in the applicant's plan and determine whether it has adequate arrangements in place to manage risks and achieve its goals.

We also seek to ensure that commissioner requested services (CRS) are being provided and verify compliance with relevant statutory requirements.

To gauge the financial sustainability of the business plan we first seek to establish if:

- the projected level of activity can be supported by the assumed cost base and whether any significant changes (eg in unit costs of activity) have been clearly explained
- assumptions regarding the asset base and capital expenditure are capable of supporting the projected level of service activity
- the capital expenditure assumptions can be funded by forecast operating cash flows, financing cash flows (eg borrowing) and capital structure
- the plans incorporate the disposal of property or assets required to support the delivery of CRS (see Appendix 9)
- revenue growth assumptions are aligned with commissioner expectations
- efficiency savings are supported by robust plans
- workforce plans support delivery of the strategy and manage any risks.

We then undertake sensitivity analysis to determine whether the long-term projections supporting the applicant's business plan meet the financial sustainability requirements for authorisation.

Further guidance on the elements of the financial sustainability assessment is provided in Section 4.4 with definitions set out in Appendix 9.

Table 5: How we assess how effective governance arrangements are in practice

CQC quality of care threshold		
	Does the trust meet the CQC bar?	**Submissions/documents required**
Authorisation criteria	To be authorised the applicant must demonstrate: • it has been awarded either a 'good' or 'outstanding' rating from the CQC at its most recent inspection • the letter of assurance from CQC received immediately preceding the authorisation decision confirms that the applicant is providing care at an appropriate level of quality to proceed in its foundation trust application. CQC's judgement is made taking account of whether: ○ the applicant trust is registered with CQC and whether the registration is subject to additional conditions (other than location conditions) ○ the trust is the subject of any regulatory action and the current status of this ○ CQC holds any information from its Intelligent Monitoring or any other surveillance systems which would trigger the need for a responsive focused inspection ○ CQC is taking any enforcement or other investigation activity at the trust or such activity is planned, including preliminary inquiries into outlier alerts If the required confirmation isn't received, the trust can't meet the authorisation criteria set out in Section 7	**Third party** • assurance letter from the CQC • CQC CIOH report

Access and outcomes metrics		
	Is performance against access and outcomes metrics acceptable?	**Submissions/documents required**
Authorisation criteria	Applicants must demonstrate they have an access and outcomes metrics service performance score of <4. However, if the service performance score is between 1 and 3, to be authorised applicants must demonstrate that actions to return to compliance are robust and based on realistic assumptions **Questions we ask** • Is the service performance score as defined in the risk assessment framework <4? • For any performance breaches is there a clear and robust action plan in place to return to compliance? **Work we do to assess action plans** To assess the robustness of the action plan we seek assurance that the applicant has: • fully diagnosed the underlying causes of the failure • set reasonable underlying assumptions to drive a return to compliance (that is activity forecasts and capacity and resource assumptions) • developed an action place to address the failure. This needs to be sufficiently detailed, including clear milestones, responsibilities and timeframes analysed by actions within the applicant's control and those that require action within the local health economy	**Trust direct evidence** • access and outcomes performance information • action plans • direct evidence supporting assurance

	Monitor also seeks to understand how the board has assured itself that return to compliance will be achieved	
Financial sustainability and year 1 FSRR		
	Is the applicant sustainable?	**Submissions/documents required**
Authorisation criteria	To meet the financial sustainability tests the applicant must demonstrate that it can: • with a high likelihood generate a sustainable net income surplus by year 3 of the business plan unless exceptional circumstances exist • with a high likelihood maintain a reasonable cash position • achieve a minimum FSRR of 3 in the first year of authorisation • receive a clean/unqualified opinion from the independent accountants on the adequacy of the applicant's working capital and financial reporting procedures	**Trust direct evidence** • board statement and memorandum on working capital and financial reporting procedures (see Appendices 4 and 5) • IBP (five year) • long-term financial model (LTFM) (updated for current year trading and other material changes from the NHS TDA phase) • workforce plan • capacity planning • estates strategy • CIPs for the current year, two forecast years and as much as is available (eg key themes) beyond that • current trading analysis • schedule of contractual commitments **Third party** • historical due diligence report • independent accountants' working capital

		review (including financial reporting procedure)
How Monitor concludes on financial sustainability	To conclude on whether the authorisation tests are met Monitor seeks assurance of the reasonableness of the underlying assumptions driving the LTFM by: • reviewing the LTFM and documentary evidence supporting assumptions • interviewing the finance team and divisional management teams • analysing historical and current year performance including budgeting accuracy • benchmarking assumptions against other similar trusts • considering third-party evidence including meetings with commissioners and the work of the independent accountants Using this information Monitor then performs a sensitivity analysis to assess financial sustainability under assessor and downside case by year 3 post the current year outturn. Judging sustainability beyond this period involves consideration of the: • scale of challenge in the local health economy • robustness of the applicant's strategy development • capacity and capability of the management team Sensitivity analysis is performed over a longer period if there is a major change in the business model beyond three years (eg where a new PFI building becomes operational beyond three years)	**Trust direct evidence** • LTFM (updated for current year trading and other material changes from the NHS TDA phase) • IBP (five year)

4.4. Further guidance on financial sustainability tests for applicants

This section provides additional detail on how we assess the financial sustainability of applicant trusts and further details of the requirements to support the independent accountants' opinion on working capital and financial reporting procedures.

Integrated business plan and long-term financial model review

Our assessment of financial sustainability includes review of the applicant's business plan and LTFM to understand the assumptions driving them. The content that should be included in the IBP will have been provided in the NHS TDA phase.

Sensitivity analysis

Review of the assumptions underlying the projections includes sensitivity analyses to evaluate the impact of the main risks faced by the applicant and to gauge its financial sustainability. Our aim is to determine the strength of the applicant's financial position when exposed to risk. Also, we seek to understand the extent to which the trust has identified ways these risks can be mitigated and whether plausible contingency plans exist.

We use two scenarios as the starting point in assessing trusts: an 'assessor case' and a 'downside case'.

Assessor case

The assessor case reflects our estimate of the pressures and risks to a provider's income and costs. While the published assessor case assumptions are applied to all applicants, it is recognised that each provider has its own specific circumstances and, to some extent, these can mitigate the risks (and therefore part of the efficiency requirements). Where mitigating actions are backed by careful and evidence-based planning, we consider off-setting our assumptions with their impact.

In addition to the published assumptions, we also adjust the sensitivity analysis to reflect any trust-specific risks that come to light in the course of the assessment process.

The results of the assessor case determine whether trusts meet the FSRR authorisation criteria listed in Section 2.1.

Downside case

The downside case, which adjusts the assessor case for a set of plausible downside risks, is applied for three years post outturn and is considered in conjunction with our work on strategy. It is used to assess financial sustainability over the full five-year period.

CIP analysis

When reviewing the applicant's CIPs we consider the:

- governance of the CIP process
- main initiatives planned for the current year and future periods
- scope for delivery of these schemes
- how the trust will mitigate any shortfall.

We also consider how the trust identifies and monitors the impact of CIPs on quality as part of our quality governance work against the well-led framework (see Section 3 and Appendix 7).

Independent opinion on working capital and financial reporting procedures

The trust board needs to provide us with a statement that it has sufficient working capital to meet its obligations for the first 12 months of operation as a foundation trust. This board statement is reviewed and reported on by independent accountants.

The board also needs to provide a board memorandum, which sets out the:

- projections, key assumptions and sensitivities that support the board's statement covering the first 12 months of operation
- projections for the second 12-month period (months 13 to 24) together with the risks associated with meeting them.

The independent accountants are required to provide:

- a professional opinion on the board's statement that the applicant has sufficient working capital to meet its obligations for the first 12 months of operation
- comment on the projections and risks described in the memorandum
- a report on the trust's financial reporting procedures;[8] this involves reviewing the trust's:
    - corporate governance arrangements
    - high level controls
    - risk management processes

[8] The initial work will be conducted as part of the historical due diligence work undertaken by the independent accountants during the NHS TDA-led trust development phase.

- management reporting framework
- financial controls and reporting procedures
- audit arrangements.

A ‘clean’/unqualified opinion is required from the independent accountants on the adequacy of working capital and financial reporting procedures for an applicant to be authorised. However, a clean opinion is not sufficient in itself to ensure NHS foundation trust status is approved.

Section 6 includes details of how the trust is expected to engage with the independent accountants.

Working capital facility

We accept that for the trust board and the independent accountants to provide the requisite opinion, some applicants may require working capital facilities.

Where necessary, applicants should establish whether they can secure the necessary facilities from Independent Trust Financing Facility. It is recommended that applicants talk to potential providers of working capital facilities and their independent accountants early in the process. It should be stated that the facilities are conditional on achieving NHS foundation trust status. If this possibility looks unlikely, applicants should inform both Monitor and NHS TDA. Without sufficient working capital an applicant will not be authorised.

Applicants should note that we only include wholly committed lines of credit that are available for draw down in the calculation of the liquidity metric in the FSRR.

5. Is the applicant legally constituted?

An applicant is considered legally constituted if it can demonstrate that the standards in Table 6 have been met.

To determine whether an applicant has met these standards, we:

- review documentary evidence
- gather oral evidence from the applicant through structured interviews.

As part of the assessment process we check an applicant's constitution to determine whether it meets the necessary requirements. We also consider aspects of the governance arrangements that fall outside of the well-led framework.

Appendix 10 defines the relevant terms and our expectations for the submissions.

Table 6: What we assess to conclude on whether a trust would be legally constituted

Legally constituted		
	Is the applicant legally constituted?	**Submissions/documents required**

Authorisation criteria	• the applicant's proposed constitution complies with Schedule 7 of the 2006 Act (as amended) and is otherwise appropriate
	• the required statutory consultation has been held with the bodies referred to in Section 35(5) of the 2006 Act
	• the content of the consultation and the applicant's response to the outcomes of the consultation process have been adequate
	• elections have been held for the council of governors in accordance with proposed constitution and electoral rule
	• there is a board of directors and council of governors constituted in accordance with the constitution
	• proposals provide a representative and comprehensive governance strategy:
	  ○ the council of governors reflects the composition of the membership and the affiliations and financial interests of the governors are known
	  ○ the affiliations and financial interests of the board are known
	  ○ there are clear structures and comprehensive procedures for the effective working of NHS foundation trust boards
	• steps have been taken to secure representative membership
	• ensures the provision of CRS in the business plan, and can and will comply with the provider licence
		Direct evidence:
		• constitution, including election rules
		• summary of statutory consultation (including issues raised and the applicant's response)
		• details of the electoral process and report on initial election responses
		• electoral rules and regulations
		• subsequent update on elections
		• membership strategy
		• update on progress made in implementation of membership strategy, governance arrangements and rationale
		• register of governors' interests
		• register of directors' interests
		• well-led self-certification
		
		We may request additional documentary evidence during the assessment process

6. The application process

This section explains an applicant's main responsibilities and how we work with you during the application process.

6.1. Assessment timeline

The timeline is confirmed when the assessment slot and team are allocated. More detail on what an applicant can expect can be found in Section 6.3.

6.2. Applicants responsibilities

Initiates the application

NHS TDA is responsible for assessing readiness and supporting NHS trust applications for foundation trust status. Details of the process for gaining NHS TDA support can be found in its accountability framework.[9] Requirements include a CQC CIOH report with an overall rating of 'outstanding' or 'good' (see Section 2).

NHS TDA writes to Monitor when an applicant has its support to begin the assessment process. Once the letter is received, Monitor writes to the applicant with instructions on how to initiate the application. To activate an application you need to send us:

- an application letter from the NHS trust chief executive
- a copy of the:
    - letter confirming the applicant has the support of NHS TDA
    - proposed constitution of the NHS foundation trust
    - IBP as submitted to NHS TDA.

We aim to commence the assessment within one month of referral from NHS TDA, but the interval may be longer if the number of referrals, reactivations of previous assessments and transaction work exceeds our provider appraisal capacity.

[9] Available from: www.ntda.nhs.uk/blog/2015/04/02/delivering-for-patients-the-201516-accountability-framework-for-nhs-trust-boards/

Potential applicants close to being referred to Monitor that are contemplating a transaction or have recently completed a transaction or change in care model should let us and NHS TDA know early in the planning. We can then draw up a manageable timetable for you that makes sure the assessment process doesn't get in the way of any change that is in patients' interests.

If you are considering undertaking a transaction you should look at our transaction guidance: *Supporting NHS providers: Guidance on transactions for NHS foundation trusts*.[10] This guidance applies to all transactions undertaken by foundation trusts.

Provides documentary evidence

You are responsible for submitting the evidence described in Sections 3 to 5, and any other information we request during the process.

Submissions, excluding those initiating the application, are made via a web-based portal. Details of how to access this are provided once an assessment slot and Monitor team have been confirmed.

You must ensure that:

- you meet our and the independent accountants' submission deadlines
- the information submitted is recent and accurate.

Where the evidence is excessive in volume or its relevance to our authorisation criteria is unclear, we may ask you to explain its relevance before we undertake our review.

Co-operates with Monitor

It is your responsibility to co-operate fully with all parties during our assessment. Staff (including board members) and non-executive directors must make themselves available to attend and participate in meetings with Monitor or the independent accountants. This includes participation in the board-to-board meeting (see Section 6.3).

The application and assessment process is very demanding on the time of trust senior management. It is advised that you plan and prepare accordingly to ensure you have sufficient resources to cope with the extra demands placed on you.

You must inform Monitor and the independent accountants of any changes that occur during the assessment process which significantly change your:

[10] Available from: www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers

- business plan assumptions
- financial viability
- governance arrangements
- constitution.

Examples include (but are not limited to) changes in key personnel, never events, deterioration in the financial position or a loss of contracts.

You are expected to provide a letter of representation before our authorisation decision which confirms you have provided all relevant information (see Appendix 6).

Engages with the independent accountants

You are expected to co-operate with the independent accountants during the reviews of working capital and financial reporting procedures. This includes, but is not limited to, the provision of the LTFM and any other information they need to complete their work, and access to staff (including board members).

The independent accountants are responsible for providing the opinions detailed in Section 4. To give further context to these they:

- provide a professional opinion to the trust board and Monitor on whether the trust board has made its board statement after due and careful inquiry
- prepare a report documenting the findings of the working capital review; this report should cover the period of the professional opinion as well as the projections for the second year of operation
- report on the applicant's financial reporting procedures
- provide copies of their opinion and report to the trust board and Monitor.

Although the assessment process has been funded by NHS TDA, both NHS TDA and Monitor aim to keep costs within planned levels. It is therefore essential that cost overruns, particularly from any additional expenditure associated with the involvement of independent accountants, are avoided. If any cost overruns are deemed to have been caused unnecessarily by an applicant, the trust concerned may be required to settle these costs.

6.3. What Monitor does

Prioritises applications based on capacity

We normally assign applicants to available assessment slots in the following order:

1. assessment of mergers or risk rating significant transactions of existing foundation trusts[11]
2. deferred applicants reactivating their application
3. postponed applicants reactivating their application
4. new applicants.

If the number of applicants exceeds the available assessment slots there may be a need to batch applicants (see Appendix 12). However, we aim to minimise delays to the start of an assessment. The maximum delay is unlikely to be longer than six months.

If there is an available slot the assessment starts immediately with a batching checklist completed as part of the assessment kick-off meeting. If significant issues arise, we may delay the assessment to allow the trust sufficient time to address those issues.

Plans the process timetable and notifies the applicant

Once an application has been initiated, we notify the applicant of the assessment timetable. It should be assumed that the overall assessment will take a minimum of five months.

We are in regular contact with applicants throughout the assessment process. Where issues are identified that require resolution before an applicant can meet our criteria, the timetable for assessment is amended to allow applicants to address these before the assessment review recommences. For example, where:

- the independent accountants raise issues which preclude them from giving a clean opinion
- we require an external review be to undertaken.

A board-to-board meeting takes place approximately three months after the assessment starts if, based on an analysis of the outstanding issues, we believe we will be able to make a decision on the application within one to two months of the board-to-board meeting.

[11] Monitor's Provider Appraisal team is responsible for reviewing these types of transactions in addition to its work assessing foundation trust applications.

Assigns a team

We assign an assessment team to each applicant, led by a senior manager. This team is the primary contact during the process and should be the first point of contact for queries.

The team includes a member of Monitor's legal team who determines whether the constitution meets the necessary requirements and provides input into the governance aspects of the assessment. A quality governance associate provides expert challenge on the conclusions reached on the quality governance areas of the well-led assessment.

Reviews submissions

During the assessment process the team reviews the applicant's submissions (see Sections 3 to 5) and may request further information to support our conclusions.

Interviews trust personnel

During the assessment process key personnel from the trust are interviewed. The assessment team contacts the applicant at the beginning of the assessment process to indicate who it wishes to interview. It is usual to expect the following to be interviewed:

- board
- board subcommittees
- finance team
- quality leads
- clinical directorates
- focus groups with consultants and senior clinicians.

We also observe the main committees such as the board and quality governance committee.

Convenes the board-to-board meeting

Each applicant is given the opportunity to present its business plan to Monitor at a board-to-board meeting. This important meeting provides another perspective on the information gathered, helping to inform the conclusion we reach.

One to two weeks before this meeting, issues that have the potential to lead, in their own right or together with other issues, to an authorisation concern are discussed by the assessment team with the applicant's chief executive. We then send the

applicant a letter setting out the most significant issues, which will be on the board-to-board meeting agenda.

The board-to-board meeting gives the applicant's board the opportunity to respond to the issues raised. We also use this forum to ask questions about the applicant's medium-term strategy.

Presentation

At the start of the meeting applicants are asked to make a brief presentation that summarises the following:

- the trust's external opportunities and challenges, and its internal strengths and weaknesses, eg:
    - the trust's local health economy and how the trust views the local health economy
    - key patient and population drivers of the local health economy
    - other providers in the local health economy (including new entrants), how the trust engages with them and their key actions and foci
    - the trust's assessment of its own position with regard to financial and clinical sustainability
- the trust's strategy to address the opportunities and challenges in light of its strengths and weaknesses
- the extent to which the IBP delivers this strategy.

The presentation is followed by questions from Monitor's panel; these link to the letter sent to an applicant before the meeting.

Attendees

The applicant's executive and non-executive board members are expected to attend, including non-voting executives who normally attend the trust board meeting and any associate non-executive directors. We allow one observer from the trust to attend, eg the board secretary or project manager. The assessment team also attends but does not participate.

Monitor's panel comprises the Executive Director of Provider Appraisal and an Assistant Director from Provider Appraisal who lead the questioning; they are normally supported by Monitor's Chief Executive and at least one non-executive director.

Engages with key stakeholders

We conduct interviews with other external bodies and parties, including but not limited to:

- external auditors
- internal auditors
- lead commissioners and stakeholders
- CQC
- TDA
- NHS England (when assessing providers of high security services).

In addition, we write to an applicant's MPs and local Healthwatch to inform them of the assessment process and to ask if there are any concerns that they wish to raise with our assessment team.[12] The assessment team gathers feedback on applicants by attending a quality surveillance group.[13]

As part of our well-led review, we seek to understand the trust board's arrangements to actively engage with patients. We consider whether feedback is actively solicited on an ongoing basis, and proactively sought during the design of new pathways and processes. Our review includes assessment of how regularly and how intelligently patient feedback, including complaints, is interrogated by the applicant. We also look for approaches the board is using to 'bring patients into the board room', eg face-to-face discussions, video diaries, ward rounds and patient shadowing.

Takes account of CQC's judgement

We take account of CQC's regulatory judgement as part of the authorisation criteria (see Section 2). The assessment team discusses the applicant with CQC during the assessment process, reviews CIOH reports and considers the content of CQC's Intelligent Monitoring reports (as available). We receive a letter of assurance from CQC approximately 10 days before our authorisation decision. This sets out CQC's judgement on the applicant.

If any issues are raised in this letter that could affect the authorisation decision, we may decide to postpone this decision until the specific matters are satisfactorily resolved.

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[12] If concerns are raised, the assessment team will organise a meeting or call to discuss these.
[13] Quality surveillance groups provide a proactive forum for collaboration, systematically bringing together the different parts of the health economy to share information.

Seeks confirmation from NHS TDA

We request a letter from NHS TDA approximately 10 working days before the authorisation decision. This letter confirms the date NHS TDA made the decision to support the application and whether it is aware of any matters arising since that date that may have materially affected its decision.

If any issues are raised in this letter that could affect the authorisation decision, we may decide to postpone this decision until the specific matters are satisfactorily resolved.

Seeks confirmation from NHS England (providers of high security psychiatric services only)

Appendix 11 explains how we engage with NHS England when assessing applicants providing high security psychiatric services.

Reviews third-party reports

Independent accountants

We review the reports of the historical due diligence and financial reporting procedures work conducted by independent accountants during the NHS TDA development phase to:

- assess the historical position of the trust
- help assess the robustness of the business plan.

The assessment team is in regular contact with the independent accountants and reviews their work as part of the assessment process to reach a conclusion on whether the trust is well led (see Section 3) and financially sustainable (see Section 4).

Other third-party reports

We review any reports on the applicant written as part of the NHS TDA phase along with any other reports from other external third parties, eg well-led reviews or quality governance assessments.

Communicates the final decision

Towards the end of the assessment process the assessment team finalises the papers to present at the internal decision meeting that formally considers the application. A decision may be made to authorise, defer or reject an application. Section 7 explains what the different outcomes mean for an applicant.

Most decisions are taken by Monitor's Provider Appraisal Executive, an executive committee of the board. However, a decision may be referred to Monitor's board if the decision is considered high risk or policy forming.

Applicants are usually informed of the decision following Monitor's board meeting.

Complies with the Freedom of Information Act

Monitor is under a duty to comply with the provisions of the Freedom of Information Act. A freedom of information request may be made to us in respect of information supplied to us by an applicant. In such cases we notify the applicant of the request and seek the applicant's views before disclosing any information.

For the application process to work effectively there must be a free exchange of information and views between Monitor and an applicant. This is in the interests of patients and the public as well as both Monitor and the applicant. We respect the confidentiality of information supplied or acquired in the course of the application process in so far as this is not inconsistent with our legal obligations under the Act.

7. Possible outcomes of the application and what they mean for the applicant

7.1. Application outcomes

The possible outcomes of an application are:

- authorisation
- rejection
- deferral
- postponement
- withdrawal.

This informal notification is subject to strict embargo until the formal letter informing applicants of Monitor's decision is received. Applicants must not communicate the outcome to any other parties including:

- employees
- stakeholder groups and organisations
- the press.

Monitor contacts an applicant's communication team in the week before the outcome is decided to explain the communication process in more detail and to agree a communication plan once the application outcome has been notified.

7.2. Authorisation

If we decide to authorise the applicant, we:

- notify the applicant formally by letter
- issue the applicant with an authorisation confirming that it has attained foundation trust status. This letter is accompanied by a single schedule, which is the trust's constitution as approved by Monitor (see Section 5)
- issue the applicant with a provider licence under the terms of the Health and Social Care Act 2012.

Side letters

Sometimes an applicant satisfies all the statutory requirements to be authorised but the application process uncovers some matters that it needs to address quickly. In these cases, we authorise the applicant and send a side letter detailing the matters

that it must address, within a specified timeframe where appropriate. Side letters are published on Monitor's website.

Provider licence

The provider licence is the main tool with which we regulate providers of NHS services. The licence contains obligations for providers of NHS services that allow Monitor to fulfil its duties in relation to:

- setting prices for NHS-funded care in partnership with the NHS Commissioning Board
- enabling integrated care
- preventing anti-competitive behaviour which is against the interests of patients
- supporting commissioners in maintaining service continuity.

It also enables us to oversee how foundation trusts are governed.

In some cases, authorised applicants may be issued with a provider licence containing special conditions under the provisions of the Health and Social Care Act 2012.

Further guidance on the provider licence can be found here.[14]

Relationship management

As soon as an applicant is authorised as an NHS foundation trust, it is allocated a Monitor relationship team and given the team's contact details.

This team is the first point of contact for the NHS foundation trust for all correspondence and queries about the licensing, monitoring and enforcement procedures. The team should be able to give advice or information in response to most initial queries received from foundation trusts. If it cannot, it forwards the query to someone in Monitor who can, and lets the foundation trust know who that is.

Regulatory regime

Once a trust has been authorised it is subject to monitoring against Monitor's risk assessment framework.

[14] Available from: www.gov.uk/government/publications/the-nhs-provider-licence

Newly authorised NHS foundation trusts are required to submit a quarterly return to Monitor. The return records:

- actual financial performance against the authorised plan
- achievement against other non-financial performance targets and measures as set out in the risk assessment framework.

7.3. Rejection

If we decide to reject an application, we notify the applicant formally by letter and send a copy to NHS TDA. The letter sets out the areas where the application fell short of our assessment criteria.

The assessment team usually visits the applicant to give a formal debrief of the reasons for rejection.

If an unsuccessful applicant wishes to reapply at a future date, it has to go through the whole application process from the beginning, starting with:

- gaining NHS TDA support for the new application
- making a new application to Monitor.

The applicant needs to meet the criteria set out in this guide and again hold elections for governors. We do not insist that the applicant recruits entirely new members for these elections but we need assurance that:

- the applicant has continued to engage its membership since the previous application
- those members recruited for the original application wish to be members for the next one and remain eligible
- the membership of the applicant's public constituency is still representative of those eligible for membership in respect of its new application (see Appendix 10).

7.4. Withdrawal

An application is treated as withdrawn if the applicant:

- requests to withdraw from the application process or
- does not reactivate its application within the period set out in either the deferral letter (see Section 7.5) or letter confirming a postponement (see Section 7.5).

In exceptional circumstances Monitor may extend the period of a deferral or postponement. The applicant must write to Monitor within the time period setting out the reasons. We consider the reasons given and write to the applicant to either agree an extension or set out the reasons why the issues are not considered exceptional and therefore the application is treated as withdrawn.

Withdrawing an application completely nullifies it. That means there is no longer an application for us to consider; a withdrawn application cannot be reactivated and continued at a future date.

If a trust that has withdrawn its application wishes to reapply for authorisation as an NHS foundation trust at a future date, it needs to start the whole application process again. The process is the same as set out for a rejection (see Section 7.3)

7.5. Deferral

Where we consider that neither authorisation nor rejection is appropriate, we may decide to defer an application. We only do this if the outstanding issues preventing a successful application:

- can be satisfactorily resolved by the applicant within a reasonable time or
- are outside the direct control of the applicant or
- there is a combination of the two issues.

We set the length of a deferral and give the end date of the deferral period in our decision letter to applicants. It usually does not exceed 12 months, but depends on the nature of the issues preventing authorisation and generally is shorter if the applicant can resolve the issues satisfactorily on its own. An applicant may ask to reactivate its application when it is satisfied that the deferral issues have been addressed, but this request must be within the specified deferral period.

If the applicant believes it will not be able to reactivate its application on or before the specified end date of its deferral, it should discuss this with us as soon as possible. We may treat an application as withdrawn if it is not reactivated in time and the delay has not been discussed with us (see Section 7.4).

Reactivating a deferred application

When deferred applicants believe they are in a position to request a reconsideration of their application, they should write to us. They do not need to regain NHS TDA support but do need to demonstrate to us that the issues triggering the deferral have been satisfactorily resolved.

On receiving a reactivation request, we let the applicant know what information it needs to submit, which will depend on the issues identified in the decision letter, and when. Resubmitted information is subject to the same rigorous assessment as

information submitted for the initial application. The assessment team also conducts interviews and seeks any further evidence needed to complete the assessment.

The information we ask for is likely to include:

- an updated business plan; where an applicant's strategy has changed significantly it may be necessary for the revised business plan to be subjected to public consultation (see below)
- an updated financial model, readdressing the working capital and long-term financial assumptions that underpin the business plan
- an updated board statement on 'well led' and consideration of risks to compliance with the provider licence
- an update on any changes to governance arrangements since the deferral date
- an updated constitution or confirmation that there have been no changes to the proposed constitution
- personal profiles of any new board members
- an updated governance strategy or confirmation that there have been no changes to the trust's governance strategy since the deferral date
- the results of any re-consultation exercises.

Following a deferral or postponement, a trust will need to provide evidence of how it has continued to engage with the public, members and governors to seek their views on any changes to its plans. In some circumstances we may expect a trust to re-consult on its business plans, eg if its:

- strategy has changed significantly
- proposed membership or governance structures have been materially amended since the original consultation.

If the trust does need to re-consult, this should take place during the deferral/ postponement period. Trusts should determine the appropriate length and scope of the consultation and report the results to us, once the assessment process starts again.

During the deferral period, trusts should continue to engage with their membership and governors. Trusts can hold elections for seats that:

- become vacant over time
- are needed for any new constituencies/classes created

- are considered necessary because the membership has grown significantly and the shadow governors are no longer considered representative of the class/area.

In addition, the trust is required to provide an updated board memorandum and board statement confirming the adequacy of financial reporting procedures and working capital arrangements. The independent accountants need to:

- update their working capital report
- sign a clean working capital opinion to underpin the board statement.

Under DH guidelines issued on 27 September 2010, applicants are required to fund any update work by the independent accountants. A trust cannot be authorised unless a clean working capital and a financial reporting opinion have been provided to Monitor.

It is usually the case that a second board-to-board meeting is held as part of the reassessment process. If the period of deferral is short, eg less than three months, and there have been no material changes to the business plan, there may be no requirement for a second board-to-board meeting.

7.6. Postponement

Where issues arise during the assessment process that need to be resolved before an authorisation decision is possible, applicants can write to us to request a postponement. They must state the:

- reasons for the postponement
- length of postponement required
- actions the trust will take to address the issues identified.

We decide whether or not to accept a request for postponement on a case-by-case basis. We expect to receive requests for postponements no later than one week after the board-to-board meeting and only consider requests received after this date in exceptional circumstances.

We may require a postponement if we do not receive the required third-party assurances (that is, the letters from NHS TDA and CQC, and the clean opinions from the independent accountants; see Section 4) in time.

Our batching process (see Appendix 12) aims to identify early issues that could delay the assessment process, so we only expect to receive requests for postponements because of unexpected issues arising once the detailed assessment work starts. We are unlikely to grant postponements for longer than 12 months unless there are exceptional circumstances.

If we decide to grant a postponement, we write to the applicant setting out:

- the length of the postponement
- the date by which the applicant needs to write to us to confirm the postponement issues have been addressed and that it is ready to recommence its application.

If we have not received confirmation that the trust wants to reactivate its application by this date, the application may be treated as withdrawn (see Section 7.4) unless there are exceptional circumstances.

Reactivating a postponed application

The requirements and steps for reactivating a postponed application are the same as those for reactivating a deferred application (see Section 7.5).

Appendix 1: Well-led board statement

The trust chair should make the statement below on behalf of the trust after due and careful consideration by the trust board. The wording of the statement should not be changed without discussion with the assessment team.

[TRUST'S LETTERHEAD]

Private and confidential

Monitor
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[DATE]

In connection with the application of [NAME OF THE TRUST] for NHS foundation trust status, the board of directors confirms that:

Quality governance

a. The board is satisfied that to the best of its knowledge and using its own processes (supported by Care Quality Commission information and other metrics it choses to adopt) the trust has, and will keep in place, effective leadership arrangements for the purposes of monitoring the ongoing sustainability of delivering high quality care and continually improving the quality of healthcare provided to patients including:

   i. ensuring required standards are achieved (internal and external)

   ii. investigating and taking timely action on substandard performance

   iii. planning and managing continuous improvement

   iv. identifying, sharing and ensuring delivery of best practice

   v. identifying and managing risks to quality of care.

This encompasses an assurance that due consideration has been given to the quality implications of future plans (including service redesigns, service developments and cost improvement plans) and that processes are in place to

monitor their ongoing impact on quality and take subsequent action as necessary to ensure quality is maintained.

Corporate governance

a. The board is satisfied that it has undertaken a strategy development exercise which is consistent with relevant guidance such as Monitor's strategy development toolkit, within the last three years (or more recently where there have been significant changes in the internal or external environment) to ensure that it can provide quality, sustainable services to patients. Specifically, the board is satisfied that:

   - this process has considered the trust's vision and mission and the challenges it faces in achieving them, including other providers and potential providers, the local health economy finances, population healthcare demand and the trust's own strengths and weaknesses
   - the trust has articulated a strategy that addresses these challenges and has in place processes to monitor each of the internal and external factors on an ongoing basis to ensure the strategy remains relevant
   - this strategy is the basis of the integrated business plan (IBP) submitted to Monitor.

b. 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.

c. The selection process and training and development programmes in place ensure that the non-executive directors have appropriate experience and skills.

d. The management team[15] has the capability and experience necessary to deliver the IBP.

e. The board is satisfied that the trust has an effective and robust diversity and equality strategy.

f. The management structure in place is adequate to deliver the IBP, including but not restricted to:

i. effective board and committee structures

[15] Management team means executive directors and their direct reports.

ii. clear responsibilities for the board, for committees to the board and for staff reporting to the board and those committees

iii. clear reporting lines and accountabilities throughout its organisation.

g. The necessary planning, performance management and risk management processes are in place to deliver the IBP, including but not restricted to:

iv. obtaining and disseminating accurate, comprehensive, timely and up-to-date information for board and committee decision-making

v. the timely and effective scrutiny and oversight by the board of the trust's operations

vi. effective financial decision-making, management and control

vii. taking appropriate account of quality of care considerations.

h. Issues and concerns raised by external assessment groups have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner.

i. An annual governance statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the statement.

j. The board is satisfied that effective systems and/or processes are in place to ensure compliance with healthcare standards binding on the trust, including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions.

Other certifications

a. The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing access and outcomes metrics (after the application of thresholds) as set out in Appendix A of the risk assessment framework; and all known access and outcomes metrics going forwards.

b. The board has in place a register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all board positions are filled, or plans are in place to ensure any board vacancies are filled.

c. The board has considered all likely future risks to compliance with the NHS provider licence and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach of conditions occurring and the plans for mitigation of these risks to ensure continued compliance.

For an NHS trust engaging in a major joint venture, or academic health science centre (AHSC), Monitor may ask the trust to provide evidence that the board is satisfied that the trust has fulfilled, or continues to fulfil, the criteria in Appendix G of the risk assessment framework.

Signed for and on behalf of the board:

Title:

Date:

Trust:

Appendix 2: Quality governance board memorandum

This is a document which summarises the applicant's approach to quality governance. It should be prepared in support of the relevant elements of the board statement on quality governance arrangements. The suggested memorandum structure below makes reference to the relevant questions posed by the well-led framework by reference to the good practice as set out in the annex of that document.

Applicants are not expected to display every element of good practice. As a general rule, applicants should either describe how they comply with good practice or explain how and why they take a different approach. Applicants are not expected to duplicate information from other submissions within the memorandum and are instead encouraged to cross-reference specific sections of other documents.

The preparation of the strategy memorandum and the information therein are the responsibility of the board of directors. A suggested memorandum structure is provided:

Executive summary and conclusion

Strategy and planning

1. Does the board have a credible strategy to ensure a viable clinical and financial future?

- description of board's quality strategy, and links to its main corporate strategy, vision and values
- detail of quality priorities and goals to delivery and how they have been developed and cascaded across the trust
- detail of how the board monitors progress against the goals and addresses performance that is not on course

2. Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

- description of board's approach to understanding, monitoring and addressing current and future significant risks to the trust and the delivery of its key objectives
- description of the board's approach to assessing service developments and other initiatives for their impact on quality
- description of how the board is assured that the efficiency projects and other service/operational developments do not compromise the trust's ability to meet required quality standards

- description of how these initiatives are monitored for ongoing impact on quality (eg service redesigns, service developments)

Capability and culture

3. Does the board have the skills and capability to lead the organisation?

- overview of leadership arrangements, the board's selection and development process and how this supports the delivery of effective quality governance
- description of the board's approach to challenging and addressing poor performance in relation to the delivery of high quality care

4. Does the board shape an open, transparent and quality-focused culture?

- explanation of the leadership and mechanisms used to drive high quality compassionate care
- description of the board's approach to creating an open, honest and transparent culture; how it addresses staff behaviours which conflict with this culture and the underlying values that support it
- description of board's approach to ensuring robust diversity and equality strategy
- description of how the trust learns from both internal and external sources of information which may give insight into its safety culture

5. Does the board support continuous learning and development across the organisation?

- process adopted by the board to select relevant quality information, details of what is reviewed, targets set and performance against targets
- details of staff involvement and engagement activities undertaken by the trust to build a workforce focused on quality improvement
- details of the board's approach to promoting and reviewing staff innovation to improve operational performance and quality of care
- examples of how review of quality information has led to improvements in quality

Process and structures

6. Are there clear roles and accountabilities in relation to board governance (including quality governance)?

- description of roles and committee structures and how responsibilities are disseminated through the organisation
- description of how the board is assured that the above are effective

7. Are there clearly defined, well-understood processes for referring and resolving issues and managing performance?

- description of the trust's performance management system for responding to and managing adverse quality performance, including details of arrangements for referring issues
- approach to clinical audit and how it drives continuous improvement
- internal audit approach to quality governance arrangements

8. Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?

- description of how the board engages with patients/service users, staff and stakeholders
- description of how the organisation acts on feedback received from patients/servicer users, carers and other stakeholders
- description of how staff are encouraged to raise concerns and how these are managed and acted on

Measurement

9. Is appropriate information on organisational and operational performance being analysed and challenged?

- details of the trust's performance management approach and how quality performance information reviewed by the board is backed by more detailed information and the use of soft intelligence
- where relevant, details of the trust's data-sharing agreements

10. Is the board assured of the robustness of the information?

- details of the board's approach to assuring data quality

- how internal audit is used to review the robustness of data and a description of how findings are followed up and resolved
- details of the creation and prioritisation of the audit programme
- examples of how quality information has led to improvements in quality

Factual accuracy

Appendix 3: Strategy memorandum

This document summarises the applicant's approach to strategy development and delivery. It should be prepared in support of the relevant elements of the board statement on governance arrangements. The suggested memorandum structure below makes reference to the relevant questions posed by the well-led framework by reference to the good practice as set out in the annex of that document.

Applicants are not expected to display every element of good practice. As a general rule, applicants should either describe how they comply with good practice or explain how and why they take a different approach. Applicants are not expected to duplicate information from other submissions within the memorandum and are instead encouraged to cross-reference specific sections of other documents, including their integrated business plan. In particular, we do not expect trusts to reproduce their strategy in the memorandum, but rather signpost to the document(s) where it is set out.

The preparation of the strategy memorandum and the information therein are the responsibility of the board of directors. A suggested memorandum structure is:

Executive summary and conclusion

- summary of the trust's external opportunities and challenges and its internal strengths and weaknesses
- summary of how the trust's strategy responds to the opportunities and challenges in light of the strengths and weaknesses
- description of how the board is assured that the capability exists at board and senior management level to deliver the strategy, and that there is a credible plan in place to do that

1. Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?

- description of the process followed by the trust to develop the strategy (including any subsequent refreshes) and of any self-assessment by the trust of its approach
- statement of the trust's vision[16] and strategy, and an explanation of how the strategy supports delivery of the vision
- description of the trust's values and the behaviours it has identified to support the strategy

[16] Vision is the aspirational future state which the trust wants to achieve.

- explanation of how the above relate to the Five Year Forward View
- description of the key external factors impacting on the trust's strategy, including but not limited to: population and demographic changes, commissioning intentions, policy developments, competitive threats and opportunities
- description of the key internal factors impacting on the trust's strategy, including but not limited to: the organisation's capabilities and weaknesses, costs and scale of services and operational issues, such as people, estates and facilities
- description of how the trust's key stakeholders, including staff and patients, have been engaged in the development of the trust's strategy
- description of the principal ways in which the trust horizon scans to ensure that it identifies internal and external changes, and how the board considers the potential impact on the strategy of those changes
- explanation of how, in light of identified internal and external challenges, the board has considered the sustainability (financial, clinical and operational) of services
- summary of the key options considered to address any identified risks to sustainability and an explanation of the rationale for the approach adopted in each case
- description of the mechanisms in place which the trust is using to engage with local health economy partners to address critical issues impacting on long-term sustainability
- summary of the key processes in place to monitor and manage delivery of the plan, including how strategic objectives are cascaded through the organisation

2. Does the board have the experience, capacity and capability to ensure that the strategy can be developed and delivered?

- statement of the sources of assurance obtained by the board over the capability, experience and capacity within senior management and the wider workforce to deliver the strategy
- explanation of how any concerns about capability, experience and capacity have been addressed
- description of the key relevant board-level experience in relation to strategy development and implementation

Appendix 4: Proforma board statement on working capital and financial reporting procedures

The trust chair should make the statement below on behalf of the trust after due and careful consideration by the trust board. The wording of the statement should not be changed without discussion with the assessment team.

[TRUST'S LETTERHEAD]

Private and confidential

Monitor
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[DATE]

Working capital

In connection with the application of [NAME OF THE TRUST] for NHS foundation trust status, the board of directors has reviewed the NHS trust's future working capital requirements from [DATE OF WORKING CAPITAL PERIOD]. The results of this review are set out in the attached board memorandum dated [DATE], which has been prepared after due and careful inquiry.

In the opinion of the board of directors [taking into account the trust's new working capital facilities], the working capital available to the trust is sufficient for at least the 12 months from [DATE].

Financial reporting procedures

The board of directors confirms that it has established procedures which provide a reasonable basis for it to reach a proper judgement as to the financial position and prospects of the trust.

The basis of the board of directors' confirmation is set out in the attached board memorandum dated [DATE].[17] The board of directors confirms that it will continue to maintain procedures at or exceeding this level of quality subsequent to [DATE].

[17] Provided in Appendix 5.

Signed for and on behalf of the board:

Title:

Date:

Trust:

Appendix 5: Board memorandum on working capital and financial reporting procedures

This appendix gives a suggested table of contents for the board memorandum. The preparation of the board memorandum and the forecasts therein are the responsibility of the directors.

1. Introduction and background

2. Executive summary:

- summary of headroom
- key assumptions
- sensitivities
- financial reporting procedures
- conclusion

3. Basis of preparation

4. Key assumptions:

- income
- other income
- commercial and other non-patient income
- expenditure (pay and non-pay)
- other factors

5. Income and expenditure accounts:

- summary of historical and projected income and expenditure
- analysis by income and expenditure category

6. Balance sheets:

- summary of historical and projected balance sheet
- analysis by balance sheet category

7. Cash flows:

- summary of headroom

- analysis of cash movements
- facilities and covenants

8. Sensitivities

9. Financial reporting procedures:

- management reporting
- board involvement
- finance department
- financial reporting processes
- financial awareness
- internal and external audit
- forecasting and monitoring process
- previous forecasting history

10. Conclusion:

- board statement on working capital and financial reporting procedures[18]

11. Factual accuracy:

- board confirmation of factual accuracy; suggested wording:

  "We have read the report on the trust's projected working capital requirements and financial reporting procedures report prepared by [INDEPENDENT ACCOUNTANTS] dated [DATE] and confirm the following:

  - we are not aware of any factual inaccuracies within the draft report
  - opinions and representations, which have been attributed to persons referred to in the report, are properly attributed to those persons."

Signed for and on behalf of the board:

Title:

Date:

Trust:

[18] Wording as per Appendix 4.

Appendix 6: Letter of representation

The trust chair should make the statement below on behalf of the trust after due and careful consideration by the trust board. The wording of the statement should not be changed without first discussing it with the assessment team.

[TRUST'S LETTERHEAD]

Private and confidential

Monitor
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[DATE – in the month prior to decision]

Re: Application for NHS foundation trust status – management representations

This letter of representation is provided in connection with your assessment of [NAME OF THE TRUST]'s ('the trust') application for foundation trust status, for the purpose of determining whether the trust meets the authorisation criteria set out in Section 2 of the *Guide for applicants* (updated October 2015).

The trust's board of directors ('the board') tabled and agreed this letter at its meeting on [DATE]. I have been authorised to write to you on its behalf. The board confirms that the representations it makes in this letter are in accordance with the definitions set out in the appendix to this letter.

Representations

The board confirms, to the best of its knowledge and belief at the date of this letter, having made all such inquiries as it considered necessary for the purpose of informing itself that:

Long-term financial model (LTFM) and integrated business plan (IBP)

1. Measurement methods and significant assumptions used by the board in preparing the LTFM provided to Monitor have been disclosed and are reasonable.

2. The LTFM and IBP incorporate all known changes to service provision at the trust and the board has disclosed all known material risks to changes to service provision.

3. The assumptions underlying the LTFM are consistent with the board's knowledge of the business and the trust's operating environment.

4. All material events and material changes subsequent to the submission of the LTFM and IBP have been disclosed to Monitor.

5. The board has disclosed all material risks and uncertainties impacting the trust's business plan, including key strategic, operational (including IT) and financial risks.

Relevant information

6. The board has:

   - disclosed to Monitor all information of which it is aware having made reasonable inquiries that are both relevant and material to the assessment of the trust such as records, documents and other matters. For the avoidance of doubt, this includes all reports and peer review information (or latest draft where reports have not been finalised) commissioned either internally or externally and covering governance arrangements or the quality of services at the trust within the last two years

   - provided Monitor with the additional information requested in Sections 3 to 5 of the *Guide for applicants* (updated October 2015).

Internal control

7. The board acknowledges its responsibility for such internal control as it determines necessary for the conduct of the trust's business and the preparation of information, including that provided to Monitor, which is free from material misstatement, whether due to fraud or error. In particular, the board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

8. The board has disclosed to Monitor the results of any assessment of the risk that the information it has reported to Monitor may be materially misstated as a result of fraud.

9. There have been no instances of material or suspected fraud that the board is aware of, other than those already reported to Monitor as part of the assessment process, that involve:

   - management and, where appropriate, those charged with governance

- employees who have significant roles in internal control
- other employees where the fraud could have a material effect on the information provided to Monitor.

Legal compliance

10. The board has disclosed to Monitor all known material instances of non-compliance or suspected non-compliance with laws and regulations which affect the matters considered as part of the assessment.
11. The board has disclosed to Monitor all known material instances of actual or possible litigation and claims which affect the matters considered as part of the assessment.

Other matters

The board has actively considered all information provided to Monitor and has not identified any other matters it deems material to the assessment.

Signed for and on behalf of the board:

Title:

Date:

Trust:

Definitions (for the appendix to the letter of representation)

Material matters

Material omissions or misstatements of items are material if they could, individually or collectively, influence Monitor's view on whether the trust meets the authorisation criteria set out in Section 2 in the *Guide for applicants* (updated October 2015). Materiality depends on the judgement on the size and nature of the omission or misstatement in the surrounding circumstances. The size or nature of the item, or a combination of both, could be the determining factor.

Fraud

Fraudulent reporting involves intentional misstatements including omissions of amounts or disclosures in the information intended to deceive the user of the information.

Error

An error is an unintentional misstatement in the information provided.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies and oversights or misinterpretations of facts.

Appendix 7: Quality impact of CIPs

Tables A1 and A2 and Figure A1 provide trusts with some guidance on potential approaches to considering the quality impact of CIPs (question 2 of the well-led framework).

Table A1: Illustrative action plan for applicants

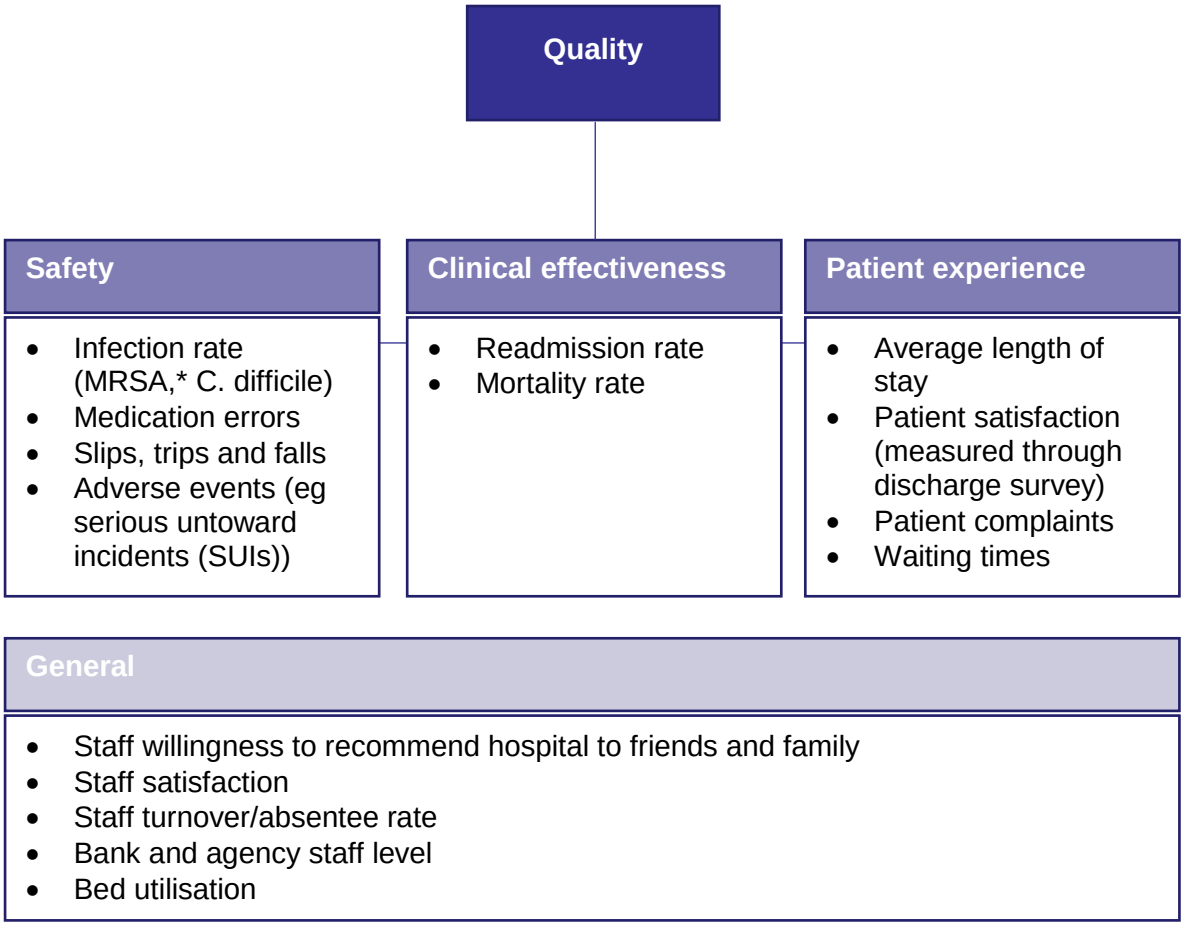
Identify potential CIPs	Assess potential impact on quality and cost	Approve plans	Assess actual impact on quality
• The majority of CIPs should be based on changes to current processes, rather than 'top-slicing' current budgets • Where possible, CIPs should be expected to have a neutral or positive impact on quality as well as reducing costs • At a minimum, CIPs should not put registration at risk by lowering quality below essential common standards	• CIPs should be categorised by potential impact on quality • CIPs with a significant potential impact on quality should be subject to an assessment of their impact on quality covering safety, clinical outcomes and patient experience, which could include: ○ analysis of current processes ○ key performance indicator (KPI) benchmarking ○ historical evidence • All CIPs should be subject to a detailed assessment of their financial impact, in line with current practice	• Clinicians understand and accept CIPs and approved plans have appropriate clinical ownership (eg relevant clinical director) • Board assurance is required that CIPs have been assessed for quality (potentially via direct approval for highest potential impact CIPs) • There must be an appropriate mechanism for capturing the concerns of frontline staff	• All CIPs should be subject to an ongoing assessment of their impact on quality, post roll-out: ○ identify key measures of quality covering safety, clinical outcomes and patient experience ○ monitor each measure before and after implement-ation ○ take action as necessary to mitigate any negative impact on quality

Table A2: Additional guidance on recommended analytical approaches

Approach	Description	Comments
Current processes	• Review of current processes to identify where waste exists and how it can be eliminated to reduce costs without compromising quality • Reducing variation is also very powerful	• Could include lean analysis, time–motion studies, staff interviews • Generally considered to be the most insightful piece of analysis
KPI benchmarking	• Benchmarking analysis of relevant operational 'inputs' to quality relative to peers and guidance (eg Royal College)	• Nurse-to-bed and doctor-to-bed ratios, average length of stay,* bed occupancy and bed density are examples of operational efficiency metrics which can be markers of quality • Useful as a prompt for discussions (eg Is it really feasible to reduce nurse head count when our nurse-to-bed ratio is already in the bottom decile relative to our peers?) • However, the limitations of this approach must be recognised: no direct link between operational inputs and quality outputs; hard to establish a peer group; generally poor quality data • Currently, benchmarking data are generally more available and useful for acute trusts than for mental health trusts
Historical evidence	• Analysis linking operational changes (eg nurse-to-bed ratio reductions) to quality outputs	• Analysis could be based on internal evidence (eg historical trends or differences between wards) or external evidence (eg published reports on experience in other trusts/countries) • However, it is important to recognise limitations of links between operational inputs and quality outputs

*Relevant as an indicator of quality when paired with readmission rates.

Figure A1: Suggested indicators to assess actual impact of CIPs on quality



*MRSA: methicillin-resistant Staphylococcus aureus.

Appendix 8: Partnership arrangements

Section 75 and other forms of agreement (question 6 of the well-led framework)

For each of its significant partnerships (including Section 75 contracts), the trust should be able to provide a clear description of the inputs into the joint venture, the expected outputs and any risks arising from the contract. A list of the things trusts should take into account when identifying any risks is given in Table A3.

Trusts should ensure they have appropriate contractual and risk arrangements with commissioners to minimise the financial risks of any secondary commissioning agreements.[19]

Table A3: Contract and agreement issues

Issue	Things to consider
Form of agreement	• Does the trust have agreements with its local authorities? • Are these agreements enabling frameworks or detailed forms of contract? • Is the trust content to carry over these forms of agreement to when it is an NHS foundation trust? • If not, what changes might be needed?

Benefits	• Is it clear from these agreements what the trust is hoping to achieve and how it will perform its duties within the partnership, eg delivery of the service, operating duties plus measurable milestones in terms of:
	  ○ service change?
	  ○ service improvement?
	  ○ user experience?
	  ○ financial efficiencies?
	  ○ financial growth?
	  ○ influence over future service direction locally?
	• Have any of these benefits been achieved to date?
	• How will these benefits be secured and safeguarded as an NHS foundation trust?
	• What new opportunities for benefits might be available as an NHS foundation trust?
	• What changes might be needed to secure these benefits?

[19] Trusts may be subject to exposure to risks with secondary commissioning, including out-of-area treatments in mental health. These can be costly and pose a material risk to the trust's financial plans, depending on where the risk lies in the agreements.

Issue	Things to consider
Finance and risk	• Where the trust is operating within a 'pooled' arrangement under s75 of the NHS Act 2006, is it satisfied that it has complied with the requirement for NHS commissioner consent to pool the resources which are the subject of the agreement(s)? • Are the agreements satisfactory in terms of demonstrating financial viability against the agreed objectives, targets and measurable milestones? • How do existing arrangements between the trust and its local authorities deal with reporting arrangements for information on finance and activity performance? • How do the existing arrangements address process for managing financial risk and its distribution in terms of: o contracts and collaboration with third-party providers? o overspends? o underspends? o budgetary pressures? o virement? o annual inflation? o cost improvements? o new investment proposals? • How could agreements between trusts and local authorities be made sensitive to service volumes and service quality? • Are the arrangements for indemnity and liability adequate? • Is the trust content to carry over this pattern of financial and service risks to when it is an NHS foundation trust? • If not, what changes might be needed?
Staffing	• Has the trust seconded staff in or out as part of an agreement? • Has the trust transferred staff under TUPE[20] in or out as part of an agreement? • Are the agreements about management of 'integrated staff' who can undertake each other's duties; or are the agreements about 'integrated management' of staff on behalf of a partner, without full integration of staff duties? • Is the trust clear on the differences between these types of agreements and the impact they may have on stability and viability of trust business? • Is the trust content to carry over this pattern of staffing to when it is an NHS foundation trust? • If not, what changes might be needed?

[20] Transfer of Undertakings (Protection of Employment) Regulations.

Issue	Things to consider
Governance	• Are there arrangements for governance, monitoring and review of any local agreements? • If so, have they proved effective? Is the trust content to carry over this pattern of governance to when it is an NHS foundation trust? • If not, what changes might be needed?
Disputes	• Do the trust's agreements contain procedures for dispute resolution? • If so, have these been tested? Did they prove effective? • If not, what changes might be required in preparation for NHS foundation trust status?
Changes	• In summary, is the trust content with the current structure of its agreements with its local authorities? • What changes would be required to bring about a better structure? • What local work would be required to bring about those changes to ensure a fit with the NHS foundation trust framework?

Appendix 9: Financial sustainability

Table A4 defines terms used in the context of financial sustainability.

Table A4: Financial sustainability definitions

Term	Definition
Net income surplus	Positive net income after dividend payments on public dividend capital. Monitor will deduct one-off income and add back one-off expenses from the reported position to understand the underlying performance
By year 3 of the business plan	The timeframe that gives the trust time to adapt to a number of changes occurring within the healthcare system
Sustainable	Can be maintained beyond three years against a reasonable set of downside risks. In assessing sustainability beyond three years (post outturn) we will consider the: • scale of challenge in the local health economy • robustness of the applicant's strategy development • capacity and capability of the management team
With a high likelihood	A net income surplus (and cash) is achievable in both a realistic assessor case as well as a plausible downside case The assumptions included in the plausible downside case may depend on economic circumstances. The allowance made for any contingency plans ('mitigation plans') is based on Monitor's view of the plausibility of those plans and linked to the assessment of management capability, experience, structures and processes against the well-led framework
A reasonable cash position	The cash position is sufficient at the end of the third year of projections under both a realistic assessor case and a plausible downside case
An appropriate FSRR	The risk rating at authorisation and on a quarterly basis in the first full year as an NHS foundation trust must be a minimum of 3 unless there are exceptional circumstances. The basis for the calculation of this rating is set out in the risk assessment framework

Schedule of contractual commitments

Applicants must complete a standard schedule (provided by the assessment team) indicating which commissioners have signed contracts or are going to sign contracts; any significant activity expected to be undertaken outside of legally binding contracts should also be identified.

The workbook should also identify commissioner support received through s75 agreements (with support separately identified for each party) and income received from commissioners to fund any secondary commissioning undertaken by the trust.

Relevant assets

- Relevant assets are any item of property, including buildings, interests in land, equipment (including rights, licences and consents relating to its use), without which the trust's ability to meet its obligations to provide CRS would reasonably be regarded as materially prejudiced.
- We do not require relevant assets to be identified in the workbook at this time. NHS foundation trusts will, however, be required as a condition of their provider licence to maintain an asset register, which indicates which assets are considered relevant.

Appendix 10: Legally constituted

The constitution

To comply with the NHS Act 2006, an applicant's constitution must be compliant with the express requirements of Schedule 7 to that Act and must be otherwise appropriate.

In order to be considered 'otherwise appropriate' the constitution must not be inconsistent with any of the express requirements of Schedule 7. Applicants do have some flexibility as to what they include in their constitutions, but may be required to provide an explanation of the rationale for any non-mandatory inclusions.

Monitor expects that applicants will specify:

- a minimum age for governor appointment (being at least 16 at the closing date for nominations)
- a minimum age for members.

Other matters that an applicant should consider include:

- whether it requires a dispute resolution clause to resolve disputes between the board of directors and the council of governors
- whether the constitution is to provide for a nominations committee and for the appointment of non-executive directors, and clarification that this committee must only perform a role in relation to selection and not appointment. The nomination committee may be comprised of governors, directors or advisers as the trust considers fit, provided that the selection process provides the council of governors with a reasonable choice
- ensuring that at least half the board of directors, excluding the chairman, are non-executive directors. Where the constitution provides for parity between executive and non-executive directors, the chairman should have a casting vote.

The proposed constitution should incorporate, by reference or as an annex, the model election rules.[21] Any departure from these should be shown as a tracked change.

[21] Available from: www.nhsproviders.org/resource-library/model-election-rules-word-version/?preview=true

Membership

We require an update on the implementation of the membership strategy after the membership list for the current elections has closed. This update should include:

- an analysis of the public and patient constituencies
- an action plan to grow a representative membership.

A template for this update is provided in Table A5.

The trust needs to demonstrate that it has taken steps to secure a representative membership; that is, taken as a whole, the membership of the public constituency (and the patients' or service users' constituency, if there is one) is representative of those eligible for membership.

We need to understand the steps the trust has taken to avoid:

- over-representation of special interest groups
- under-representation of ethnic minority groups or people with disabilities or other special needs.

It should be noted that development of a representative membership should be with reference to current membership, with a particular focus on under-represented groups.

Elections

The Electoral Reform Services (ERS) and Mencap have worked together, specifically for mental health trusts, to help people with learning difficulties take part in election processes.

Mencap recommends that mental health trusts have a longer lead-in time to prepare for the election process and simplified election literature. This former allows for:

- education of the membership in the election process
- wide canvassing for candidates
- provision of support to those members wishing to stand for election.

The trust may also find that it has to provide support to enable some members to exercise their vote.

Table A5: Membership analysis

Public constituency (or patient constituency)	Number of members	Eligible membership	Over- or under-representation
Gender: Male Female			
Age (years): 0 to 16 17 to 21 22+			
Ethnicity: White Mixed Asian or Asian British Black or Black British Other			
Socioeconomic sub-grouping* ABC1 C2 D E			

*Socioeconomic data should be completed using profiling techniques (eg postcodes) or other recognised methods. To the extent socioeconomic data are not already collected from members, it is not anticipated that applicants will make a direct approach to members to collect this information.

Council of governors

We consider whether the council of governors reflects the composition of the membership and whether the affiliations and financial interests of the governors are known.

The applicant is required to:

- confirm its arrangements, including a timeline, for the first round of elections
- confirm how potential risks to representation are addressed within the current process.

We require the declared election results before making a decision on authorisation. This allows us to assess whether the make up of the council of governors offers a balanced representation.

We need to ensure there are clear structures and comprehensive procedures for the effective working of the board.

We need to understand how the intended governance structures would work in practice. In particular:

- the reporting lines to ensure, for example, that overall performance is managed
- the arrangements for managing/responding to adverse performance
- how the council of governors would exercise its functions, and how governors would be supported to maximise their contribution to the trust
- how interactions between the board of directors and council of governors would work.

Affiliations of governors and directors

We expect the trust to maintain a register of interests and declare publicly:

- any financial interest that the governors and directors may have in health or social care-related organisations that provide services to the NHS or
- any affiliation to health or social care-related campaigning special interest groups.

Commissioner requested services

Applicants are expected to ensure the provision of commissioner requested services (CRS) in the business plan. CRS are those services that local commissioners believe must continue to be delivered to local patients should the provider fail, ie be unable to carry on as a going concern. Commissioners should designate any service they commission a CRS if they want to make sure it will continue in such circumstances.

All services provided by newly authorised foundation trusts will automatically be designated CRS for the first 12 months following foundation trust authorisation. After this, services must be proactively designated CRS by commissioners if they are to remain CRS.

Appendix 11: Information for trusts providing high security psychiatric services

We require additional information and assurance when assessing trusts providing high security psychiatric services:

- an overview of how high risk decisions, including decisions on home leave, are managed and monitored
- as part of our well-led assessment, confidence that the trust board is assured of appropriate governance of decisions that have a security implication for admitted patients
- an assurance letter from NHS England before an authorisation decision is made.

Authorisation requirements

NHS England writes to us before the date of the authorisation decision for each provider of high security psychiatric services:

- regarding compliance with the directions issued by the Secretary of State for Health and based on the annual audit of the Safety and Security Directions
- to confirm that NHS England is not aware of any material issues that should be brought to Monitor's attention.

Post authorisation

If a trust providing these services is authorised, NHS England will:

- provide an annual letter of assurance to Monitor that the foundation trust is complying with directions issued by the Secretary of State and based on the annual audit of the Safety and Security Directions, and confirming whether or not NHS England is aware of any material issues that should be brought to Monitor's attention
- inform Monitor as soon as it receives notification of any incidents that fall within the high security hospital services serious incident report policy and serious incident definition set (1 August 2013).

Appendix 12: Batching

If the number of applicants is more than the available assessment slots, applicants may need to be batched.

Batching aims to identify any issues that may cause deferral, postponement or rejection based on the main drivers of these outcomes in the past. This informs the timetable for an applicant's assessment.

Batching looks at the:

- integrated business plan and historical due diligence reports
- key assumptions in the LTFM
- reviews of well led conducted during the NHS TDA phase. [22]

Telephone interviews (or a site visit) are carried out with the chief executive and finance director of each applicant, and telephone interviews with third parties as required (eg commissioners, CQC and others).

This process leads to a letter to the applicant confirming the timetable for assessment, together with details of the issues identified.

Where the number of applicants referred to us does not exceed the available slots, the assessment starts immediately with a batching checklist completed as part of the assessment kick-off meeting. In cases where significant issues arise we may postpone the assessment to allow the trust sufficient time to address those issues.

[22] Trusts may have undergone BGAF and QGAF reviews during the transition to the well-led assessment within the TDA phase. The reports should be sent to Monitor.

Appendix 13: Descriptions of documents referred to in this guidance

	Context
Well-led framework[23]	The trust will be assessed against the outcomes and good practice within the version of the framework, which is in effect when the assessment begins
Provider licence[24]**/2006 Act**[25]	The assessment guidelines should be read in conjunction with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the provider licence
Risk assessment framework[26]	The framework describes how Monitor oversees NHS foundation trusts' compliance with the governance and financial sustainability requirements of their provider licence
Transaction guidance[27]	Applicants who are considering undertaking transactions should be aware of Monitor's transaction guidance, *Supporting NHS providers: guidance on transactions for NHS foundation trusts.* This guidance applies once a trust is authorised as a foundation trust
Pricing guidance[28]	Following the 2012 Act, one of Monitor's new duties is to work with NHS England to design and operate the payment system for all NHS services, by setting the rules for determining the level of any payment. Applicants should therefore consider the latest pricing guidance provided by Monitor and ensure that any updates, changes or modifications of such guidance are reflected in their financial and operational assumptions
Strategic planning toolkit[29]	This toolkit is designed to support you with your strategy development process. It will give suggestions for each stage of the work: both on what to do and on how to do it. It is intended to help NHS providers develop a strong strategy for their trust, but it isn't prescriptive
Service line reporting (SLR)[30]	Applicants are encouraged to continue their development of SLR to enhance the financial reporting of the organisation. Further information on SLR is available on Monitor's website

[23] Available from: www.gov.uk/government/publications/well-led-nhs-foundation-trusts-a-framework-for-structuring-governance-reviews
[24] Available from: www.gov.uk/government/publications/the-nhs-provider-licence
[25] National Health Service Acts 2006 and 2012. Available from: www.legislation.gov.uk/
[26] Available from: www.gov.uk/government/publications/risk-assessment-framework-raf
[27] Available from: www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers
[28] Available from: www.gov.uk/government/collections/the-nhs-payment-system-regulating-prices-for-nhs-funded-healthcare
[29] Available from: www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers
[30] Available from: www.gov.uk/government/collections/service-line-management-an-approach-to-hospital-managment#guidance-on-service-line-management

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