Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
29th July 2010

TITLE	**Foundation Trust Application**
SUMMARY	Summarises progress with the Application. The Trust has now been formally passed to Monitor by the Secretary of State. An initial visit by Monitor has now taken place and will inform the batching decision.
BOARD ASSURANCE (Risk) / IMPLICATIONS	Achieving FT status is an overarching objective supported by the White Paper confirming that all NHS organisations need to become FTs by 2013.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Consultation with the local community and key stakeholders took place in 2009
EQUALITY AND DIVERSITY ISSUES	The intention is for the membership to be as representative as possible of the diversity of the local community.
LEGAL ISSUES	None known
The Trust Board is asked to:	Note the progress report
Submitted by:	Raj Bhamber Director of Workforce and Organisational development
Date:	21 July 2010
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Trust

FOUNDATION TRUST PROJECT DIRECTOR'S REPORT

Introduction

This report provides an update on the current status of the Trust's application to become an NHS Foundation Trust, progress with the self certification process, the new quality governance proves, communications and an early analysis of the risks to compliance when authorised.

Current Status on the Application to become an NHS Foundation Trust

Monitor, the Independent Regulator of NHS Foundation Trusts, confirmed receipt of support from the Secretary of State on 7 July 2010 and invited the Trust to commence the application for authorisation as an NHS Foundation Trust by forwarding the information contained in the Foundation Trust Project board report on 7 July (i.e. a covering letter from the Chief Executive, a copy of the letter confirming support from the Secretary of State, proposed constitution of the NHS Foundation Trust, Integrated Business Plan, as submitted to the Department of Health) by midday on 12 July 2010. The Trust response was submitted on 9 July 2010, ahead of schedule, which will have enabled an early desktop review of the IBP against a checklist.

On 13 July 2010 Monitor informed the Trust of an initial visit on 15 July 2010 content as follows:

Monitor Assessment Team:	David Thomas Hill, Senior Assessment Director Sarah Dorje, Assessment Manager (to be confirmed) Kate Belton, Assessment Analyst
1.00 to 2.30 pm	Valerie Howell, Deputy Chief Executive and John Headley, Director of Finance and Information Strategic Overview, Key Risks and Issues
2.45 to 3.45 pm	John Headley, Director of Finance and Information Financial Model and Commissioning
4.00 to 5.00 pm	David Fluck and Paul Crawshaw, Associate Medical Directors and Caroline Becher, Chief Nurse Clinical Quality and Governance

The meeting is likely to inform a batching decision (assignment to an assessment group) and an indicative timetable for a proposed authorisation date.

Board members are asked to note the overview of the Monitor Phase (Phase 3), as outlined in Guide for Applicants, published by the Department of Health and Monitor, which comprises the following:

- An overview and objectives of the assessment process
- Legal constitution
- Robust governance arrangements
- Financial viability
- Schedule of services
- Service line reporting
- Key internal and external stakeholders
- The board to board presentation

Early indications are that the Monitor assessment phase will last for 3 to 4 months, and provisional Board-to-Board dates are 28 September, 30 September, 2 November, 4 November, 30 November and 2 December.

Therefore, the authorisation date is likely to be 1 December 2010 or 1 January 2011. The duration of this phase will be subject to the Trust's readiness for the assessment, particularly in relation to the new framework for quality governance, for which Monitor allows an additional month, and the robustness of downside mitigation plans.

Progress: Board Self Certification (proposed process and timetable)

A detailed schedule of requirements for Board self certification (relating to a range of matters, including the constitution, clinical and corporate governance, performance management processes and systems, Board and management capacity and schedule of services) has been developed.

This schedule of requirements is currently undergoing rigorous review, scrutiny and challenge, having been collated by the Corporate Co-ordinating Group , reviewed by the Executive Directors collectively on 20 July 2010 and will be further reviewed by individual Directors and the FT project team.

The full Trust Board will consider and assess the final evidence base to underpin self certification prior to the August Board meeting, and subsequently recommend the statements to the Chairman for approval.

A high level summary of the assessment with submission forms Appendix A

Progress: Staff Briefings, Internal and External Communications

The schedule of staff briefings, led by Executive Directors and the Foundation Trust Project Manager, have been delivered according to plan, with more than 20 meetings held across the hospitals between 5 and 23 July 2010.

The sessions have further energised staff who welcome the following opportunities which flow from Foundation Trust status:

- The opportunity to re-invest surpluses locally
- The recognition for being high-performing and accreditation as a Foundation Trust
- The flexibilities and freedoms for local reward schemes

The Head of Corporate Affairs has arranged a further programme of briefing sessions for members interested in standing for election to the Council.

The New Quality Governance and Assessment Process

The new quality governance requirements as set out in the addendum to the Guide for Applicants are effective for all authorisation decisions made after 1 August 2010 and therefore apply to the Ashford and St Peter's Hospitals NHS Trust application. This includes requirements for a Board Memorandum and self certification on Quality Governance, which Monitor's assessment process will then test. Under the transitional arrangements described in the consultation response, applicants will be allowed additional time within the timetable (expected to be one month) to prepare the draft Board memorandum and collate evidence on Quality Governance. Monitor's assessment team will provide more details of the requirements once the assessment commences. At this stage, it is felt unlikely that the Trust will require the additional time which is being availed to this process.

A high level summary, best practice and requirements form Appendix B.

Risk Analysis and Mitigation

The risks associated with this project principally fall into two areas as follows:

- Failure to achieve Foundation Trust Status (cross reference BAF Risk No 3.1 (attached at Appendix 1) and CRR 769. Please note that it is proposed that CRR 894 is removed, as it is subsumed into BAF 3.1. This proposal will be considered for approval by IGAC on 11 August prior to the full Trust Board on 26 August.

- All risks to compliance once authorised (as outlined in Appendix B12 of the Guide to Applicants Applying for Foundation Trust Status November 2008) will be considered at the Foundation Trust Project Board on 11th August drafted in Appendix 2 and an update will follow.

The Foundation Trust Board will review the risks and mitigation from hereon in.

Raj Bhamber
20 July 2010

Paper 7.1
Appendix A

Assessment Questions with submission: IBP & Governance (Reference pages 110 to 112)

	Question	Requirement	Submissions	
1	Does the **Integrated Business Plan** provide a level of activity and mix of services consistent with patient or service user needs and the requirements of the 2006 Act?	• Includes the required services • Make acceptable assumptions about property & asset disposals • Private patient income assumptions are consistent wit the cap • Strategy supported by key commissioners • Local & national service fit	• Schedule of mandatory services (including education & training) • IBP • IBP • Details of private patient income assumptions • IBP • IBP	VH
2	Is the **Integrated Business Plan** internally consistent?	• Resources (people, costs & facilities) consistent with projected service activity & funding • Capital assumptions consistent with projected service activity • Clear & consistent implementation plan (recruitment& borrowing)	• IBP • Working Capital Review • Financial projections • Working capital Review • IBP	JH
3	Is **Integrated Business Plan financially viable and sustainable?**	• Clear about proposed major changes • Realistic assumptions (impact of PBR, patient choice and AfC) • Realistic set of risk scenarios & clear contingency plans	• IBP • IBP • LTFM • IBP • Financial Projections & working capital review	JH
4	Do the proposals provide a representative & comprehensive **governance strategy**	• Representative membership • Board of Governors reflect composition of membership affiliations & financial interests of governors known • Affiliations & financial interests of Board known • Clear structures & comprehensive procedures for effective working of NHS FT Board	• Membership Strategy • Updates on implementation of membership strategy • Constitution including election rules • Governance arrangements & rationale • Electoral rules & regulations • Account of current electoral process • Subsequent update on elections • Register of governors interests • Register of directors interests • Constitution • Governance arrangements & rationale	JG
5	Do the proposals meet the **statutory requirements** laid out in	• Proposed constitution in accordance with	• Constitution	JG

	the **2006 Act**	Schedule 7 to the 2006 Act • Proposed constitution otherwise appropriate • Statutory Consultation held • Elections conducted in accordance with election rules annexed to constitution	• Constitution • Summary of consultation held, issues & responses • Electoral process & results	
6	Does the Trust Board believe that the Trust has the **organisational capacity** necessary to deliver the IBP	• Trust Board confident that the management team has capability & experience to deliver the strategy • Selection Process in place to ensure that NEDs have appropriate experience & skills • Necessary management structures in place to deliver the strategy	• Self certification on management capability & experience • Self certification on process • Self certification on management structures • Self certification on planning • Direct evidence on performance management • Direct evidence on risk management • CQC reports • Service Development Strategy • Direct evidence of governance arrangements for joint ventures & partnerships	RB
7	How is the applicant **performing against existing targets and national core standards**	• Board assurance of action plans in place to meet existing targets & national core standards	• Self certification on targets & standards • Self assessment on healthcare targets & standards • Historical track record of target achievement & trajectory & action plans to address	VH

Appendix B

Quality Governance Framework of ten key questions

	Question	Best Practice	Submissions
1	**1A Strategy – does quality drive the trust's strategy**	SMART Goals linked to national & local priorities; Communication of goals; mechansims for tracking performance & improvement	Board Statement, memorandum**,** strategy
2	**1B Strategy – is the board sufficiently aware of quality**	Board understanding/rating of current & future risks to quality & steps to address; evaluate CIPs/business cases; quality indicators to be tracked for early warnings; initiatives eg "lean" , benchmarking, trends	Ditto & direct evidence on evaluation of impact on quality, evaluation of CIP
3	**2A – Capability and Culture – does the board have the necessary leadership, skills and knowledge to ensure delivery of a quality agenda**	Rigorous board challenge, NED engagement & review; Board mix of skills and capabilities; able to identify well & poor performing services & actions to address; metrics for improving quality; external assurance where required	Ditto & board self assessment, training programmes
4	**2B Capability and Culture – does the board promote a quality-focused culture throughout the trust**	Active leadership; encourages staff empowerment & feedback from staff & patients & other Trusts & reporting of harm & error for learning purposes. Lean initiatives	Ditto & direct evidence in relation to quality culture (incident reporting, complaints reporting, staff surveys)
5	**3A Processes and Structure – are there clear roles and accountabilities in relation to quality**	Clear Structure chart with roles & responsibilities from Board to Ward to Board	Ditto & direct evidence in relation to roles and accountabilities (org structure charts, JDs, board minutes & agendas)
6	**3B Processes and Structure – are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance**	Robust clinical audit and internal audit functions; action plans from audits & re-audits to assess improvements & and sustainment	Ditto & direct evidence of processes for escalating & resolving issues (issue escalation process documentation, whistleblowing policy, clinical audit plan, patient and staff feedback reports)
7	**3C Processes and Structure – does the board actively engage patients, staff and key stakeholders on quality**	Patients in the boardroom, feedback from commissioners, GPs stakeholders, clarity on role/involvement of governors	Ditto & direct evidence of patient, staff & stakeholder engagement on quality (patient &staff feedback reports, stakeholder feedback)
8	**4A Measurement – is appropriate quality information being analysed and challenged**	Pyramid of granular information by sub committees, divisional leads & service lines covering safety, clinical effectiveness & experience – qualitative & quantitative	Ditto & direct evidence of measurement (board performance and directorate performance reports)
9	**4B Measurement – is the board assured of the robustness of the quality information**	Use of audits to ensure accuracy of information & Initiatives to improve coding	Ditto &direct evidence of measurement (coding accuracy reports, internal audit reports on data accuracy)
10	**4C Measurement – is quality information used effectively**	Clear, accurate, relevant and timely provision of information with internal trends & external benchmarks	Ditto & evidence of measurement (examples of quality improvements)

	Question	ASPH Evidence	Gap/Action required	Self assessment (rating)
1	1A Strategy – does quality drive the trust's strategy			
2	1B Strategy – is the board sufficiently aware of quality			
3	2A – Capability and Culture – does the board have the necessary leadership, skills and knowledge to ensure delivery of a quality agenda			
4	2B Capability and Culture – does the board promote a quality-focused culture throughout the trust			
5	3A Processes and Structure – are there clear roles and accountabilities in relation to quality			
6	3B Processes and Structure – are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance			
7	3C Processes and Structure – does the board actively engage patients, staff and key stakeholders on quality			
8	4A Measurement – is appropriate quality information being analysed and challenged			
9	4B Measurement – is the board assured of the robustness of the quality information			
10	4C Measurement – is quality information used effectively			

Note 1: Assessment methodology/triangulation: structured interviews at & below board to assess arrangements for managing clinical risks & ensuring ongoing improvements in standards of care, review of effectiveness of governance meetings, board and sub committees, interviews with external stakeholders.

Note 2: Considerations: CQC annual health check (periodic review) scores, high mortality rates, significant financial turnaround in last 2 years coupled with significant headcount reduction, board instability (high turnover of board posts), continued underperformance on targets (eg A&E).