Whittington Health NHS

**Trust Board**

**ITEM: 12**

**DATE:** 27 June 2012

**TITLE: Foundation Trust Application progress report including:**
(i) Board Governance Assurance Framework (BGAF)
(ii) Monitor Quality Governance Framework (MQGF)
(iii) Tripartite Formal Agreement
(iv) Accountability Agreement

| **SPONSOR: Joe Liddane** | **REPORT FROM:** Fiona Smith and David Seabrook |
|---|---|

**PURPOSE OF REPORT:**

- To receive the independent assessment reports on:

(i) the (BGAF) as provided by Ernst & Young including the Trust's action plan,
(ii) the MQGF provided by RSMTenon,
following presentations by the leads at the seminar session;

- To review progress in relation to the Accountability Agreement and the Tripartite Formal Agreement

**EXECUTIVE SUMMARY:**

**BGAF**
This review is completed and there are actions around performance information, board visibility, monitoring of plans and director appraisal.

**MQGF**
This review is completed and further details as to the implications of this and the actions required will be provided following the receipt of the formal report.

**Accountability Agreement and Tripartite Formal Agreement**
A progress update accompanies this report

**PROPOSED ACTION:** That the assessments by Ernst & Young (BGAF) and RSM Tenon (QGF) be received and the position on the Tripartite Formal Agreement and Accountability Agreement be noted.

**APPENDICES:**

1. Independent Review of the Board Governance Memorandum – Ernst & Young
2. The assessment of the MQGF is to follow
3. Accountability Agreement
4. Tripartite Formal Agreement

**DECLARATION**
In completing this report, I confirm that the implications associated with the proposed action shown above have been considered – any exceptions are reported in the Supporting Information:

Implications for the NHS Constitution, CQC registration
Financial, regulatory and legal implications of proposed action
Risk management, Annual Plan/IBP
Moving Ahead – how does this report support any of the Trust's 5 Strategic Goals

## Supporting Information

This paper gives an update to the Board on progress with the development of the Trust's Foundation Trust (FT) application and sets out the next steps in the process and the key risks and mitigating actions. It focuses on delivery against key milestones in the Trust's project plan and those outstanding in the Tripartite Formal Agreement (TFA).

## Background – Board Governance Assurance Framework (BGAF) and Monitor Quality Governance Framework (MQGF)

1. The Department of Health (DH) have introduced a Single Operating Model model (SOM) to support and assure NHS trusts through their foundation trust (FT) applications. The rationale behind the introduction of the SOM is to:
   - Draw on best practice to develop a consistent approach to the development and assurance of aspirant FTs;
   - Enhance the processes underpinning the delivery of the FT pipeline;
   - Support the transition from SHA accountability for delivery of the FT pipeline to the NHS Trust Development Authority (NTDA) in April 2013.

2. The SOM introduces one common set of tools, processes and guidance for FT development and application. The assurance process within the SOM are aligned with Monitor's authorisation approach around the three assessment criteria of Legally Constituted, Well Governed and Financially Viable

3. The Monitor Quality Governance Framework (MQGF) was originally designed by Monitor in 2010 as part of their assessment of aspirant foundation trusts. The Department of Health's SOM introduced an independent review of a self-assessment against the ten criteria and this is integrated with the SHA's own assurance review of quality. The Single Operating Model also includes the Board Governance Assurance Framework (BGAF) as a new self-assessment, again accompanied by an independent review.

4. For the BGAF, the Board reviewed the draft self-assessment (the Board Governance Memorandum) at the March board meeting and seminar. The assessment activity took place in May 2012, as detailed in the appendix to the report by Ernst & Young.

5. There is no pre-set threshold for the BGAF, but there is an expectation any red flags (as detailed in the methodology) will be mitigated; the results of the BGAF

assessment are reflected in the SHA's board to board summary of an aspirant trust.

6. Monitor set a threshold for authorisation/licensing purposes of 3.5 through the scoring mechanism the QGF, arising from the RAG ratings assessed in the independent review.

**Board Governance Assurance Framework**

7. Ernst & Young presented their findings at the "confirm and challenge" meeting with the Chair and Chief Executive on 6 June. The board seminar received a presentation from the Ernst & Young lead on 27 June.

8. Of the 15 RAG (Red-Amber-Green) assessment areas in the Board Governance Assurance Framework, Ernst & Young considered that the evidence the Trust presented supported its self-assessment in eleven areas. However on this basis, they amended four areas from green to amber-green in the areas of board development & appraisal, performance reporting and environmental focus.

9. The narrative report is attached at appendix 1 and it recognises the actions being taken, such as in relation to embedding the board seminar programme and improvements to the financial/performance information provided to the board.

10. The principal further actions now required are considered to be:
    - A process for the board regularly to monitor the delivery of the Trust's strategy
    - Strengthen arrangements for individual objective-setting and review for all directors
    - Consultation, internal and external on the Integrated Business Plan
    - A programme of activity to improve board visibility

    The action plan to address these items is attached as below:

**BGAF: Action Plans for Amber-Green ratings**

| **Assessment Area** | **Action** | **When** | **Who** | **Financial implications** |
|---|---|---|---|---|
| 2.1. Effective board level evaluation | Commission externally led board development exercise | Delivery in September 2013 | Joe Liddane and Yi Mien Koh | £25,000 |
| 2.2 Whole Board Development | Continue to deliver the board seminar programme | Ongoing | David Seabrooke | |
| 2.4 Board member appraisal | Ensure individual objective setting and annual appraisal for directors | Ongoing | Joe Liddane and Yi Mien Koh | |
| 3.1 Performance reporting | Greater integration of financial and performance outturn information | September 2012 | Richard Martin and Maria Da Silva | |
| 3.4 Quality of board | Preceding month's outturns | July 2012 | Maria Da | |

| | | | | |
|---|---|---|---|---|
| papers/timeliness of information | to be made available to each meeting | | Silva | |
| 3.3 Environmental and strategic focus | Quarterly progress updates with the delivery of the Trust's strategy | First update September 2012 | Yi Mien Koh | |
| 4.1 External stakeholders | Undertake consultation on IBP with staff and stakeholders | Summer 2012 | Richard Martin | |
| 4.2 Internal stakeholders | | | | |
| 4.3 Board visibility | Implement visits programme for all directors | Summer 2012 | Joe Liddane and Yi Mien Koh | |

## Monitor Quality Governance Framework

11. The Trust Board self-certified against the Monitor Quality Governance Framework at the 23 May meeting having had the opportunity to discuss the assessment and evidence related to this at a previous Board Seminar. The Board assessed its governance score as 2.5.
12. The self certification has been reviewed by the independent auditors RSM Tenon who have undertaken a table top review of all of the supporting evidence, including additional information requested by them, and 1:1 interviews with staff members of their choosing.
13. RMS Tenon will present their draft report in relation to the Monitor Quality Governance Framework to board members at the seminar session on 27 June. The draft report will be circulated separately as appendix 2 and additional copies will be tabled on the day of the meeting.
14. Following receipt of the formal report an action plan will be developed to address improvements required and delivery against this will be lead by the Medical Director and monitored through the Quality Committee.

### Tripartite Formal Agreement

15. The May and June Tripartite Formal Agreement (TFA) submissions are attached at appendix 3 & 4 respectively for ratification. Both submissions were reviewed internally and approved by NCL prior to submission to NHS London. The Board is reminded that the development of these returns falls outside of the Boards reporting timetable and as such cannot be received in advance for approval. The Board have given the CEO delegated responsibility for approval.
16. Overall RAG rating remains Amber/Red. All in month ratings are green rated.

## Accountability agreement

17. The Accountability Agreement (AA) is one of the required elements of the SOM and is attached at appendix 5.

18. The AA is a key supporting document to the Tripartite Formal Agreement (TFA). The Board approved the Accountability Agreement it was duly signed by the three signatories. It describes the key deliverables that are pre-requisites to our successful FT application and the expectations of all parties

towards their achievement. The AA demonstrates that Whittington NHS Trust has a plan with a definitive timeline to submit a Foundation Trust application to DH. In signing the AA the Trust acknowledges that the SHA will intervene if there is a sustained failure to deliver either the required levels of operational and financial performance or deliver the agreed trajectory to a successful FT application.

19. The Trust is currently in its due diligence phase and progress against each of the items has been updated and can be see from page 11 onwards in Appendix 5.

20. The Board should note that keys risks to the FT application have now changed from those in the AA following agreement of the Trust's SLA contract and are those approved at the recent audit committee and included in the BAF. Chapter 7 of the IBP also reflects the key financial risks.

21. HDD1 is underway and Deloittes are due to present their report to the Trust by the end of June. HDD1 is focussing on financial management and governance within the organisation. These reviews have and will generate action plans for improvement and have executive leads allocated to drive implementation. Updates will be presented at future Board meetings.

22. The Trust now has regular joint meetings with NCL and NHS London to formally engage on our path to become a Foundation Trust. The next significant point will be at the end of July when NHS London undertake a Readiness review meeting (Gateway 2)

**IBP/LTFM**

23. The Trust has reached agreement with NCL over its 2012/13 contract and this has now been reflected in the LTFM. Version 3 of the IBP and LTFM is being presented to Trust Board at the seminar on 27 June.

24. The Trust is working with NCL to agree planning assumptions and both NCL and NHS London will receive the IBP and LTFM by the end of this month once they have been approved by the Trust Board.

25. The FT application will now start to focus work on the development of proposals regarding the roles and responsibilities of the Council of Governors to ensure compliance with the Health and Social Care Act. The constitution will also need to be refreshed and the Governance Rationale and other supporting documents drafted for presentation to the Trust Board.

# Board Governance Assurance Framework (BGAF)

## The Whittington Hospital NHS Trust

Independent review of the Board Governance Memorandum

## 19 June 2012

Ernst and Young LLP

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**Private and confidential**

19 June 2012

The Directors of The Whittington Hospital NHS Trust
NHS London

Dear Sirs

**Independent review of the Board Governance Memorandum**

In accordance with our engagement letter dated 9 May 2012 (the 'engagement agreement'), we have undertaken a review of the Trust's supporting evidence, conducted interviews with key internal and external stakeholders, interviewed each Board member and conducted a Board observation session. We have discussed our findings with the Chair and Chief Executive of the Trust.

**Purpose of our report and restrictions on its use**

Unless required by law, you will not provide this report, or the attached letters, or a copy thereof, to any third party without our prior written consent which we may or may not at our discretion grant, withhold or grant subject to conditions. In no event, regardless of whether consent has been provided, will we assume any liability or responsibility to any third party to which this report, or the attached letters, are disclosed or otherwise made available. If any other party chooses to rely on the contents of this report, it does so entirely at its own risk.

**Scope of our work**

Our work in connection with this assignment is of a different nature to that of an audit. Our report to you is based on enquiries of and discussions with management and a review of documents made available to us. We have not sought to verify the accuracy of the data or the information and explanations provided by management.

**Basis of our work**

The information contained in this report has been based on evidence provided by the Board to support its current capacity and capability self assessment.

It is also based upon other information and explanations given to us by the directors and employees of the Trust.

**Structure of the report**

The Executive Summary sets out the key observations and recommendations arising from our review. The remainder of the report contains more detail of each indicator of effective Board governance. We stress that, whilst we have identified in the Executive Summary key issues in the prescribed DH report format, there may nevertheless be other issues raised in the remainder of the report, which are of importance to you.

Yours faithfully

Steve Kirby

Partner

Ernst & Young LLP

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# Executive summary

## Key Observations

- The Trust in its current form is relatively new. It was established in April 2011 after the merger of the previous Whittington Hospital with the community health services of NHS Islington and NHS Haringey to become an NHS integrated care organisation (ICO). Haringey children's services were subsequently integrated with the organisation in May 2011. The Board is made up of Executive Directors (EDs) and Non-Executive Directors (NEDs) of the predecessor organisations.
- The terms of appointment of a number of NEDs commenced on the date the new ICO was formed, hence there are a number of termination dates around the same time in 2015.
- The Chief Executive was appointed on 1 April 2011 and is seen to be a good leader and focused on driving the agenda of the Trust. The Board is well balanced, the members have a good mix of experience in the private, public and voluntary services.
- The Chair is considered a good leader and manages the Board discussions well. He had previously been the Chair of the pre-existing Whittington Hospital since 2007.
- The NEDs provide strong challenge during Board discussions and there is a positive engagement between the EDs and NEDs.
- The Board members are considered visible within the organisation and plans exist for EDs and NEDs to conduct patient safety walkabouts as part of engagement with internal stakeholders. Externally, however, there is no formal schedule for Board members to attend key external events.
- There was no review of the Board conducted in 2011 because the focus was on the reorganisation of the Trust and setting out the Whittington Health Strategy. However, an evaluation by Internal Audit was completed in April 2012, which provided "Significant Assurance" opinion.
- On a monthly basis the Board receives the Performance Dashboard which reports on performance and quality measures relevant to the integrated range of services. Financial and quality data are not yet integrated and information presented relates to two months prior to the date of the Board meeting. The Trust is looking to improve performance reporting and has appointed an interim Head of Performance who starts in June 2012. In addition, the Trust has secured additional funding of £5m to improve its electronic patient records systems.
- The Board has a record of holding regular Board seminars but does not have a formal Board development programme in place. This was drafted in May 2012.
- We are aware that the Trust has recently agreed with NHS London, to a three month extension to the timetable outlined in their Tripartite Formal Agreement.

## Key Recommendations

The Trust has already taken action to address areas where it is not fully compliant with key elements within the Board Governance Assurance Framework. Our key recommendations, including the Trust's agreed timescale for implementation where applicable, are as follows:

- The Board members have a large agenda and the capacity of the Executives appears stretched. Executives should engage their deputies more which would also strengthen the contingency / succession plans for the Executives. While the agenda is larger, the Trust must ensure that successes are celebrated whenever possible
- The Trust should engage clinicians more in the development of the IBP as the current draft of the IBP has not drawn on sufficient engagement with clinicians and the clinical community.
- Since the Trust has challenging CIP targets, the QIPP Board should meet more frequently than once a month. We suggest bi-weekly.
- The enhancement of the Board outturn reports should ensure that members can easily triangulate key performance, quality and finance information. This could be achieved through a one-page dashboard with key information, and further enhanced by an increased emphasis on assessing performance both against a trend trajectory and planned outturn, as well as against external benchmarks where they exist.
- The Trust should develop a more structured approach to increase the profile and visibility of the Board members in key external events.

# RAG rating comparison summary

| Indicator | Section | Board RAG | Independent RAG | Same/Different |
|---|---|---|---|---|
| 1. Board composition and commitment | 1.1 Board positions and size | Green | Green | No Change |
| | 1.2 Balance and calibre of Board members | Green | Green | No Change |
| | 1.3 Board member commitment | Green | Green | No Change |
| 2. Board evaluation, learning and development | 2.1 Effective Board-level evaluation | Amber/ Green | Amber/ Green | No Change |
| | 2.2 Whole Board Development Programme | Green | Amber/ Green | ↓ |
| | 2.3 Board induction, succession and contingency | Green | Green | No Change |
| | 2.4 Board member appraisal and personal development | Green | Amber/ Green | ↓ |
| 3. Board insight and foresight | 3.1 Board performance reporting | Green | Amber/ Green | ↓ |
| | 3.2 Efficiency and productivity | Green | Green | No Change |
| | 3.3 Environmental and strategic focus | Green | Amber/ Green | ↓ |
| | 3.4 Quality of Board papers and timeliness of information | Amber/ Green | Amber/ Green | No Change |
| 4. Board engagement and involvement | 4.1 External stakeholders | Amber/ Green | Amber/ Green | No Change |
| | 4.2 Internal stakeholders | Amber/ Green | Amber/ Green | No Change |
| | 4.3 Board profile and visibility | Amber/ Green | Amber/ Green | No Change |
| | 4.4 Future engagement with FT Governors | Green | Green | No Change |

# Overview of approach and scoring criteria

## Description of Approach Taken

Our work was focused on providing independent assurance over the assertions made within the Trust's Board Governance Memorandum (BGM) and our work was divided into four key areas described below. Our scoring is aligned to DH guidance on the next slide.

**Review the BGM and the evidence**

This was predominantly a desk top exercise to determine whether the Trust's self assessment ratings for each of the five indicators were supported by clear and well documented evidence. The aim during this review was to establish evidence gaps, identify inconsistencies between the self assessment and evidence and develop additional lines of enquiry to test during our stakeholder and focus group meetings and Board member interviews.

**Assessing external stakeholder and focus group views**

To obtain a balanced view of the Board we gathered the views of external and internal stakeholders through individual meeting/calls and focus group sessions ***(see Appendix 1 for details).*** These sessions were shaped by the key themes arising from the review of the BGM and evidence. We considered the impact that the Board is having on the organisation and assessed the extent to which staff understood the impact that the Board is having on the organisation and assess the extent to which staff understand the Trust's vision and strategy.

The Trust was responsible for selecting a random sample of employees for the two focus group sessions and we worked with the Trust to arrange the sessions. We met with one patient group and carers to understand how the Trust gathers feedback from patients and staff. Each focus group session was for a duration of about 1.5 hours. The Trust provided the names and contact details of external stakeholders and we conducted focused telephone interviews to get their views on the capability of the Board and their suitability to govern an NHS FT.

**Board member interviews and Board observation session**

We conducted interviews with every Board member to assess Board members understanding of the IBP, LTFM, major risks, and test specific aspects of the self assessment. In addition, we discussed with the Senior Independent Director Sue Rubenstein the effectiveness of the Chair.

We observed a Board meeting during our review to understand how the Executive and Non-Executive Directors work together and interact.
In addition, the Board was observed to assess its effectiveness for example, how it holds the executive to account, whether Board challenge is appropriately balanced with support and the level of strategic discussion. One of our Directors attended the 23 May 2012 Board meeting as an observer.

**Board to Board session**

One of our Directors attended the 23 May 2012 Board Development session which also included non voting Executives, and conducted a 'Board to Board' session at the end of the meeting. In the course of this we explored the Board's awareness and understanding of areas such as strategy, BGM case studies, and key risks and mitigations.

# Overview of approach and scoring criteria (cont'd)

**The scoring criteria for each section is as follows:**

**Green** if the following applies:

- All good practices are in place unless the Board is able to satisfactorily explain why it is unable or has chosen not to adopt a particular good practice;
- There is sufficient evidence to support the existence of the good practices and, where discernable, that these good practices are having a positive impact on Board effectiveness;
- No Red Flags identified.

**Amber/ Green** if the following applies:

- Some elements of good practice in place and the evidence supplied to support the existence of the good practices is sufficient;
- Where discernable, the good practices that are in place do not yet appear to be having a positive impact on Board effectiveness
- Where good practice is currently not being achieved, there are robust Action Plans in place that are on track unless the Board is able to satisfactorily explain why it is unable or has chosen not to adopt a particular good practice;
- One Red Flag identified but a robust Action Plan is in place and is on track to remove the Red Flag or mitigate it.

**Amber/ Red** if any one of the following applies:

- Some elements of good practice in place but evidence supplied to support the existence of good practices is insufficient;
- Where good practice is currently not being achieved, Action Plans are insufficient (i.e. Action Plans are either not in place, not robust or are not on track) and/or the explanation provided as to why the Board is unable or has chosen not to adopt a good practice is unsatisfactory;
- Two or more Red Flags identified but robust Action Plans are in place that are on track to remove the Red Flags or mitigate them.

**Red** if the following applies:

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

# Stakeholder perceptions of Board effectiveness/impact

| External Feedback (Commissioners, the SHA, PCT and Cluster, External Audit, Internal Audit) | |
|---|---|
| ► The CEO / Chair are visible, they speak at forums and the quality of print communication from the Trust is good. The Executive team is considered strong and engages well with external stakeholders.<br>► The Board has a good understanding of issues the Trust faces.<br>► The Trust provides clear communication on its strategy. It has a good reputation and GPs are happy to refer patients there.<br>► The Trust has made a good strategic decision to become a community service provider in addition to acute services. | ► The Trust should decide what its key differentiator will be in the future given that there are other FTs in the area. It needs to articulate how it will be sustainable in the future and its fit in the health economy.<br>► The Board has clear ideas on changes it needs to make, but needs to increase the pace of change. |
| **Internal Feedback (Staff focus groups, Patient user group leads)** | |
| ► The Chair of the Board, Chief Executive and other Board members are visible to staff and appear to make time to listen.<br>► Communication with staff from the Board is a two-way process; top down and bottom up through the established channels.<br>► Staff are clear on the strategy and values of the organisation. The Trust aims to provide a seamless care pathway through integration of services.<br>► They believe that the Trust is innovative and encourages new ideas.<br>► The demographic mix of staff adequately mirrors the wider community.<br>► The Board is focused on quality, it is also clear that quality is high on the agenda of the CEO.<br>► Patients feel well cared for and in a number of cases, are able to name the consultants / nurses they have interacted with. They feel they were treated with dignity and were involved in the decision on treatment options available.<br>► The patients also felt that there is a good atmosphere in the Trust and that staff look happy.<br>► The Trust is receptive to comments / suggestions. | ► The staff feel they could have been engaged more in the design of the new organisation.<br>► The Board should enhance technology infrastructure to suit the level of change the Trust is undergoing.<br>► The recent changes appear to be more financially driven and potentially can affect the ability of the Trust to provide essential services such as mental health care for children.<br>► The Board will need to consider how to communicate with “hard to reach” staff such as facilities staff who have no access to the intranet.<br>► Patients note that good service is not always consistent across the Trust. For example, getting scan results took a long time, individuals had to identify ways of finding these out for themselves and treatment out of hours (weekends, bank holidays, late night) was not always satisfactory.<br>► The routes to making comments / suggestions are not always clear to patients. |

# 1. Board composition and commitment

# 1. Board composition and commitment

## 1.1 Board positions and size

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| **Green** | **Green** | Not applicable |

| **Explanation of independent reviewer's RAG rating** | |
|---|---|
| Evidence of compliance with good practice | ► The Board is made up of six Executive Directors (EDs) and seven voting Non-Executive Directors (NEDs) including the Chair. Five of the EDs have voting rights, all voting positions in the Board are substantially filled. Associate Directors attend Board meetings when required to support the Executive Directors.<br>► The Board has a Senior Independent Director and has set out the specific duties and accountabilities for that role. The SID was confirmed during the February 2012 Board meeting.<br>► None of the NEDs have any past or current substantive connection with the Trust. They are considered independent as defined by Monitor's FT Code of Governance. The Board has a standing agenda item at each meeting to review members' declaration of interest.<br>► The terms of office of one of the NEDs ends in 2012, five of the NEDs have terms of office ending on various dates in 2015 and that of one NED ends in April 2016.<br>► A Corporate Secretary was appointed in January 2012 on an interim basis and the appointment confirmed on 1 April. According to the job description, the Corporate Secretary is responsible for establishing and maintaining the highest levels of corporate governance and will play a key role in the Trust's application to become a Foundation Trust .<br>► The Trust was created in April 2011 as an amalgamation of two predecessor organisations. Three of the NEDs were appointed on or after the effective date of the new Trust. |
| Action Plans to achieve good practice | ► Not applicable |
| Explanation if not complying with good practice | ► The termination dates of NEDs are set by the Appointments' Commission. Start and end dates will be discussed with the Council of Governors and a programme of steady transition will be agreed. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Not applicable |

# 1. Board composition and commitment

## 1.2 Balance and calibre of Board members

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Green | Green | Not applicable |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► The Trust has a mix of skills, experience and knowledge amongst the Board members which covers public sector, private sector and significant experience of governance in large, complex organisations.<br>► The Trust's self assessment in September 2011 indicated that the private sector experience on the Board was light, as only two of the six NEDs had private sector experience. This has since been addressed by the appointment of a new NED with relevant experience in May 2012.<br>► The NEDs come from a variety of backgrounds including business, voluntary and public sectors.<br>► The Board has a NED with a clinical background who is a Rheumatologist and was a lead clinician in the development of the first Clinical Skills Centre in the UK.<br>► The Trust was established in its current form in April 2011 and the Board includes individuals from the pre-existing Boards.<br>► Board members have experience operating at Board level, five of the seven NEDs and four of the five EDs are experienced Board members. The Trust provided details of the prior Board experience of the NEDs.<br>► The Chair is an experienced professional providing performance improvement services to financial services, other private sector and public sector organisations. He had previously been the Chair of the pre-existing Whittington Hospital since 2007.<br>► The Chair and two other NEDs have recent and relevant financial experience.<br>► Our discussions with the Board members and observation at the Board meeting, confirm that there is a good mix of NEDs and they provide a strong challenge to the EDs. The EDs and NEDs are clear on the Trust strategy and have a high level of self awareness of the current status of the Trust. |
| Action Plans to achieve good practice | ► The Chief Operating Officer will assume the lead executive role on Equalities from June '12 onwards. |
| Explanation if not complying with good practice | ► In consideration of the diversity of the composition of the Board in relation to the Equality Act 2010, a survey was conducted and the results of the survey were consolidated in May 2012.This shows an analysis of the make up of the Board members in respect of the 9 protected characteristics of the Equality Act. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Not applicable |

# 1. Board composition and commitment

## 1.3 Board member commitment

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| **Green** | **Green** | Not applicable |

| **Explanation of independent reviewer's RAG rating** | |
|---|---|
| Evidence of compliance with good practice | ► Board members have a good attendance record in Board meetings from April 2011 to May 2012.The Chair attended all Board meetings in that period. The Audit Committee meetings for May 2011 to March 2012 show a good attendance record of the members.<br>► The Board has an explicit Code of Conduct, the most recent one was updated in July 2010. An update to this is being documented in a draft Ground Rules document which will be presented for approval in the June 2012 Board meeting.<br>► Our conversations with the Board members indicate that the Board members have a large agenda and the capacity of the Executives appears stretched. The Chief Executive is committed to delivering the change in the new organisation, and there is a tendency to drive the change agenda too hard at risk of personal burn out. |
| Action Plans to achieve good practice | ► Not applicable |
| Explanation if not complying with good practice | ► Compliance with the Code of Conduct is not routinely monitored by the Chair, but the Trust believes that Board members are compliant with the expected behaviours. A requirement to monitor compliance will be included in the Ground Rules document which goes to the Board in June 2012. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Not applicable |

# 2. Board evaluation, development and learning

# 2. Board evaluation, development & learning

## 2.1. Effective Board level evaluation

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Amber/ Green | Amber/ Green | Not applicable |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► The Trust commissioned a review of its governance structure by Internal Audit which was reported on in April 2012. Internal Audit issued a "significant assurance" opinion on this with some recommendations.<br>► The Board evaluation by Internal Audit considered the traditional 'hard' (for example, governance structures, appointments process and benchmarking against Foundation Trusts) dimensions of effectiveness. The review did not consider the 'soft' (for example, relationships between Board members, effectiveness of challenge provided by Board members) dimensions of effectiveness. The Board has not considered the perspectives of a representative sample of staff and key external stakeholders.<br>► An internal assessment of the Board was also done in February 2012 by the Trust Secretary which identified areas of good practice and areas for further improvement in some "hard" and "soft" dimensions of effectiveness. In addition, a Myers-Briggs assessment of the Board members was done internally in May 2012.<br>► There was no review of the Board conducted in 2011 because the focus was on the reorganisation of the Trust and setting out the Whittington Health Strategy.<br>► In 2011, the Audit Committee was reconstituted as the Audit and Risk Committee and a new Board committee (Quality Committee) was created. |
| Action Plans to achieve good practice | ► The Trust is planning a further independently led effectiveness review after its authorisation.<br>► The Trust has implemented all but one of the recommendations from the Internal Audit review of Governance. It is in the process of addressing the remaining recommendation from Internal Audit which recommends an ongoing review of the agenda items of the Audit Committee to minimise unnecessary duplication of discussion of issues that are the principal remit of other Committees. |
| Explanation if not complying with good practice | ► As a result of reorganisation in the last year , the Trust did not conduct any review of the Board. It believes that there will be several Board evaluations as part of its authorisation process. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Not applicable |

# 2. Board evaluation, development & learning

## 2.2 Whole Board Development Programme

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Green | Amber/ Green | There is no substantive Board development programme. This is currently in draft form and has not yet been implemented. The only evidence to support the Trust's consideration of potential needs post authorisation is the need for a new NED. An NED has since been appointed. |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► The Board has a draft development programme dated April 2012. This is being refreshed to ensure it includes the relevant elements.<br>► The draft development programme includes topics such as principles of good governance and Board development, Board development strategy and activities planned in the future.<br>► A briefing document dated September 2011 on the requirements for authorisation as an FT is available to the Board members. In addition, the interviews with the Board members confirm that they are clear on the governance and regulatory framework requirements of an FT.<br>► The Trust is in the process of producing an advanced programme of Board development activity as part of the refresh of the programme to include considerations for the Board to reflect on its effectiveness and its supporting governance arrangements.<br>► Papers submitted to the Board on FT related issues include; FT membership development strategy, draft FT constitution, draft FT consultation document and FT cost improvement programme.<br>► An FT Board seminar is held approximately every two weeks. The minutes of the seminars held in January and February 2012 show that these are well attended.<br>► The FT Board seminars include updates on the preparation of the IBP and LTFM.<br>► In September 2011, the Trust considered the need to fill the vacant position of a NED post authorisation. Since then a NED has been appointed. |
| Action Plans to achieve good practice | ► The Trust has refreshed the draft programme of Board development in May 2012. This defines the Board Development Strategy and includes activities such as individual and collective coaching by June 2012, external Trust Board review by September 2012 and mock Board to Board in October 2012 and March 2013. |
| Explanation if not complying with good practice | ► Not applicable |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Not applicable |

# 2. Board evaluation, development & learning

## 2.3 Board induction, succession and contingency planning

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| **Green** | **Green** | Not applicable |

| **Explanation of independent reviewer's RAG rating** | |
|---|---|
| Evidence of compliance with good practice | ► All new Board members receive a tailored corporate induction which is complemented by the mandatory training programme. In addition, each Board member has meetings with key staff members.<br>► Details of the induction programme of the NED appointed in May 2012 have been provided by the Trust. The programme includes, an overview of the Trust, draft IBP, Board seminars, meetings with the CEO, Chair and relevant Directors and attendance at the induction programme of the Appointments Commission.<br>► Our conversation with NEDs appointed during the last year confirms that a structured induction process is in place.<br>► A succession plan has been completed in respective of a Medical Director who is scheduled to be seconded out of the Trust. The minutes of the February 2012 Board meeting documents the confirmation of the Senior Independent Director. |
| Action Plans to achieve good practice | ► The Director of HR and the Trust Secretary have been tasked with ensuring that induction arrangements for new Board members are appropriately designed for immediate implementation.<br>► The Trust plans to confirm the position of Deputy Chair n the June 2012 Board meeting |
| Explanation if not complying with good practice | ► With the merger of organisations on 1 April 2011, there followed a significant re-organisation of the Trust Board, Executive Committee and operations across the Trust. This reorganisation was completed in July 2011. As a result, comprehensive succession planning has not yet been undertaken in the new organisation, but will proceed and be completed by the end of 2012. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Not applicable |

# 2. Board evaluation, development & learning

## 2.4 Board member appraisal and personal development

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Green | Amber/ Green | The Trust does not have a formalised process for professional development of the Board members, this has been raised as a red flag. |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► The appraisal of the Chair is led by the Senior Independent Director. The Trust provided evidence of the appraisal of the Chair by the Executive and Non Executive Directors in respect of 2011/12 year; this was coordinated by the Trust Secretary.<br>► The 2011/12 assessment of the Chair is in progress. This is being coordinated by the Senior Independent Director. We understand that all Board members and the shadow Governors have been invited to take part in this assessment.<br>► Appraisals of the EDs and NEDs for 2011/12 were conducted in May 2012. The performance of the EDs are assessed against set objectives, actions and timelines for delivery on these actions. The performance of the NEDs were not assessed against defined objectives. However, it identifies goals and development needs for the coming year. The Trust has indicated that performance objectives for all Directors will be set by June 2012. |
| Action Plans to achieve good practice | ► A Myers-Briggs based engagement review for all Board members will be completed by September 2012.<br>► A 360 degree assessment process for EDs, Directors and teams will be completed by July 2012.<br>► The CEO and Chair will set individual objectives for 2012/13 for all Directors by June 2012. |
| Explanation if not complying with good practice | ► Board members do not consistently have Personal Development Plans. All Board members are aware of their responsibility to plan their own personal development. They have consistently acted upon this responsibility. A formal summary collective plan is being prepared.<br>► The Trust conducted a Myers-Briggs assessment of all Board members in May 2012. It is in the process of establishing a 360 degree assessment for Executive team members and Divisional Heads by June / July 2012. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► The Trust does not have a systematic approach to professional development for Board members. This will be addressed by the action plans above. |

# 3. Board insight and foresight

# 3. Board insight and foresight

## 3.1 Board Performance Reporting

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Green | Amber/ Green | The Trust has identified a number of action plans to achieve good practice. These are not yet in place. |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► On a monthly basis, the Board receives the Performance Dashboard which reports on performance and quality measures relevant to the integrated range of services. Each measure has comparative information and includes national and local targets as well as SLA indicators.<br>► Service line performance is reviewed in the private Board meeting. In addition, the dashboards are reviewed in detail by the Quality Committee before the Board meetings.<br>► The performance report shows a RAG rated variance analysis for overall and divisional performance. It includes relevant explanations and action plans to address areas where performance is below standard. The Trust has identified the need to triangulate quality and safety key performance indicators with performance, access and finance indicators.<br>► Other reports received by the Board are written updates from each Committee (Quality and Audit & Risk Committees) with relevant supporting information. The May 2012 report from the Audit & Risk Committee for example, reports on its review of the Board Assurance Framework.<br>► An action log is maintained and updates are discussed at the Board meetings. The log documents individuals responsible and timescales for resolution. The Board has a standing agenda to review action logs from previous meetings.<br>► The Audit & Risk Committee discusses key risks which are summarised in the Board Assurance Framework (BAF), which forms part of the reporting to the Board. The BAF as at March 2012 indicates that high level risks include; Delivery of high level care, Mandatory training and availability of capital funding. |
| Action Plans to achieve good practice | ► The Finance and Quality reports are not integrated. Finance and quality measures are summarised and reported to the Trust Board. The Trust is currently investigating how to improve the quality of data flows and as part of this, has appointed an interim Head of Performance to start in June 2012 with a view of implementing a revised reporting Dashboard in July 2012.<br>► The Trust's practices are being amended via the Board and a new Finance & Performance Committee. The Committee will be looking at:<br>  ► ways to improve the range of information about the Trust's individual services across service performance, finance, workforce, patient experience<br>  ► the use of benchmarking information to drive improvement<br>  ► an overview of service transformation, including market/commissioning trends/forecasts |
| Explanation if not complying with good practice | ► The Trust is in the process of improving the reporting and expects to implement a revised reporting Dashboard in June 2012. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Not applicable |

# 3. Board insight and foresight

## 3.2 Efficiency and productivity

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Green | Green | Not applicable |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► Prospective CIP schemes are identified with input from each division's Divisional Director and Director of Operations. A quality impact assessment is also done resulting in an assessment of risk. Low risk ("Green") rated CIPs are approved by Divisional Management, Medium ("Amber") risk rated CIPs are approved by the CIP Board and High risk ("Red") rated CIPs are assessed and approved at an extraordinary meeting of the Executive Committee which includes Non-Executive Directors.<br>► Each CIP scheme is monitored against its profiled target on a monthly basis. A summary of CIP performance is included in the Finance Report to the Trust Board each month. A review of individual CIP schemes which fall short of their year-to-date or forecast targets is carried out at the CIP Board. A quality impact assessment is also done and where the proposed saving is considered to present a great potential risk to patient experience or patient safety, it is rejected. An example of this in 2011/12 was the proposal to reduce the allocation of cleaning hours to clinical areas, which was rejected after consideration by the Trust Executive of the potential impact.<br>► The Board receives a CIP report through the Finance Committee and the CIP and Quality Innovation Productivity and Prevention (QIPP) Boards. The report documents the year to date performance and a year end forecast with the applicable risk assessment.<br>► The Internal Auditors have given an "Adequate Assurance" opinion on the review of the 201/12 CIP and 2012/13 QIPP programmes in a report dated May 2012. They indicate that systems and processes have significantly improved from the previous year and that their recommendations are aimed at further strengthening the development and monitoring processes around both the CIP and QIPP agenda.<br>► We note that with the challenging CIP target for the year, monitoring of CIPs should be done on a bi-weekly basis instead of monthly. |
| Action Plans to achieve good practice | ► CIPs are monitored by the Trust Board via the Finance Committee and the QIPP Board. The new Finance & Performance Committee will strengthen the approach in delivering CIPs. |
| Explanation if not complying with good practice | ► Not applicable |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Not applicable |

# 3. Board insight and foresight

## 3.3 Environmental and strategic focus

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Green | Amber/ Green | The Trust has identified a red flag in respect of a lack of monitoring of progress towards delivering the Trust's strategy. |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► The Chief Executive presents a written report to the Board monthly which considers external factors that affect the Trust. For example, the February report highlights the latest updates in National policy, engagement with GPs on integrated care and updates on Communications in respect of the Trust's FT application consultation process.<br>► The Board reviews lessons learned from enquiries and has considered the impact on the Trust. For example, in response to an update from Mencap, Death by Indifference: 74 lives and counting (2012), the Board has identified action plans to ensure that the Trust's approach is consistent and embedded across all services. It also considered the "Our Hospitals Charter" which endorses the fact that people who have learning disabilities have the same rights to expect good health care and to be well.<br>► In addition, the Board has considered action plans from lessons learned from Mid-Staffordshire and Six Lives: the provision of public services for people with learning disabilities.<br>► The Trust's IBP (version dated March 2012), includes details of market analysis, a SWOT and PESTLE evaluation. This was discussed by the Board members in January 2012.<br>► The Board also considers environmental factors in its Board seminars. For example, the agenda for the Board seminar held on 22 February indicates discussions held on Workforce Strategy, Equalities Plan, Downside Case and CIPs.<br>► The Board Assurance Framework (BAF) identifies the key strategic risks of the Trust and is reviewed by the Board, *(see comment under section 3.1).* |
| Action Plans to achieve good practice | ► Not applicable |
| Explanation if not complying with good practice | ► Not applicable |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► There is no regular process to monitor progress towards delivering the Trust's strategy. There will be a quarterly update on the achievement of the Trust's strategic goal for 2012/13. A quarterly update on the delivery of the Trust's 2012/13 objectives will be monitored by the Board in the August 2012, November 2012 and February 2013 Board meetings. |

# 3. Board insight and foresight

## 3.4 Quality of Board papers and timeliness of information

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Amber/ Green | Amber/ Green | Not applicable |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► Board meetings are held monthly and review monthly performance and quality indicators. The May 2012 Board meeting reviewed performance as at March 2012. The Board meetings are also supported by the Committee meetings and weekly CEO/Chairman meetings.<br>► The Board papers are circulated a week in advance of the meeting in accordance with the agreed and published timetable. The timetable identifies dates when the various inputs to the Board meeting will be circulated.<br>► The Board meeting agenda clearly indicates the purpose and proposed action for each item, for example, for approval or review. In addition, each Board paper clearly describes the action required from the Board.<br>► Board members have access to flash reports on the Trust's intranet. The Non Executive Directors are able to log on to the Trust's intranet remotely at any time. This provides access to live data on key metrics, for example, A&E and Waiting Times. In addition, the Executive team meet weekly where performance is also discussed. Outside of the regular meetings, Board members are notified by email if there are any urgent matters that require their attention.<br>► The Board papers are presented in a standard format and outline the decision or proposals by Board members, the rationale and preferred options as appropriate and details of which Committees completed a review prior to the paper being presented to the Board. For example, the case study on performance issues in the area of finance presented to the Board in March, documents the Board's understanding of the issue, the challenge / scrutiny process involved and how the issue was resolved. |
| Action Plans to achieve good practice | ► Concerns raised on record keeping in support of mandatory training will be investigated and an initial report made to June 2012 Quality Committee.<br>► An interim Head of Performance has been appointed (see comments on 3.1). They will review the reporting framework to provide a more integrated report and provide the Board with information relating to the preceding month with effect from July 2012.<br>► The commentary on performance is to be improved starting with June's reporting<br>► In addition, the Trust has commissioned an independent review of the Information team and quality of data. This will be done in June 2012.<br>► The interim Head of Performance will develop detailed action plans on resumption.<br>► The Trust has secured additional funding of £5m for improvement of its electronic patient records systems in the next 3 years. |
| Explanation if not complying with good practice | ► In March 2012, the Audit Committee deliberated on improvements required on the IT Governance Toolkit assessment for 2011/12. Challenges around data quality are being addressed as part of IT Governance toolkit. An expert has been commissioned to assist with the 2012/13 submission. Updates will be reported to the Audit Committee. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Not applicable |

# 4. Board engagement and involvement

# 4. Board engagement and involvement

## 4.1 External stakeholders

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Amber/ Green | Amber/ Green | Not applicable |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► The Trust's external stakeholder engagement strategy is documented in its draft Stakeholder Analysis and Communications plan approved by the Board on 25 April 2012. It documents the methodology used in prioritising its stakeholders and key message for each individual or group of stakeholders. The types of external stakeholders identified include those to: partner with; involve / satisfy; inform; and consider / monitor. The plan also documents the key messages and approach for each type of stakeholder.<br>► The Trust has a number of key communication tools to capture the views of external stakeholders including 'hard to reach groups' such as non-English speaking individuals and service users with learning disabilities. Methods documented include questionnaires on the Trust's website, advertorials, emails and flyer drops at doctors' surgeries.<br>► The Trust carried out an initial consultation with the public and results summarised in February 2012 show that there is support for the Trust to become an FT and that the membership arrangements were comprehensive and reasonable. The consultation also raised some suggestions from the public such as ways the governors could engage better with the public.<br>► The draft IBP has been shared with NHS London. Our conversation with NHS London confirms receipt of the draft IBP, but this is still the early stages of their engagement with the Trust.<br>► The Trust has also engaged in a number of reports in the media articulating the importance of it becoming a FT.<br>► The Trust has agreed commissioning terms with its commissioners, documented in the April 2012 Heads of Agreement between NHS North Central London and the Trust 2012-14.<br>► We note that the draft IBP still needs some additional work and input from clinicians and GPs. |
| Action Plans to achieve good practice | ► The next draft of the IBP will be completed by July 2012. This will then be used in consultation with external stakeholders. |
| Explanation if not complying with good practice | ► The IBP is still in draft and not yet ready to use in extensive public consultation. Key messages in the IBP have therefore not yet been deployed to external stakeholders. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Adverse publicity has been received during the last twelve months, but this has related to local media and to individual isolated instances. Whittington Health has a good safety record and continues to monitor the local media and to work with relatives and friends of patients on the occasions that things go wrong. |

# 4. Board engagement and involvement

## 4.2 Internal stakeholders

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Amber/ Green | Amber/ Green | Not applicable |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► A variety of methods are used by the Trust to enable the Board to listen to staff views including, CEO briefings, Chairman's forum, CEO blog and "Ask the Chief Executive"' newsletters, Trust website and staff feedback survey.<br>► The Chair, CEO and other Board members are considered visible by staff as they visit different locations and make themselves available to answer questions.<br>► The draft Stakeholder Analysis and Communications plan approved by the Board on 25 April 2012 also documents the strategy to reach out to internal stakeholders.<br>► Key priorities of the Trust were communicated to all staff on inception of the newly formed organisation on 1 April 2011 by the CEO in a welcome letter to all staff.<br>► The Trust uses a number of ways to acknowledge staff contribution. These include, regular staff appraisals, one to one meetings with line managers, CEO acknowledgement in the bulletin and staff briefings and clinical audit awards.<br>► There are CEO awards presented monthly to staff. These include: clinician of the month; employee of the month; team of the month; clinical team of the month; and student of the month.<br>► Staff are kept up to date with major risks that might impact on patients using the "Cat's eyes" quarterly risk management newsletter. Other means used include staff induction and mandatory training and visible leadership audits and feedback through ward dashboards.<br>► The 2011 staff survey by the Care Quality Commission shows the Trust's overall score 3.74 out of 5 and that it was in the top 20% of all Trusts surveyed.<br>► Clinicians play a key role in management and decision making in the Trust. The Medical Director and the Primary Care Medical Director are members of the Executive Committee. A number of the sub-committees are chaired by Clinicians, for example, Drug and Therapeutic, Medical Devices and Patient Safety. We note however, that the Trust will need to ensure that clinicians, GPs are more engaged in the development of the IBP |
| Action Plans to achieve good practice | ► In respect of the Trust's values, the Trust is currently reviewing the current Whittington Health employment promise with staff to redefine it during May 2012. |
| Explanation if not complying with good practice | ► The work on staff engagement on the IBP has not yet started, this will be done when the IBP reaches the appropriate stage of development. The staff engagement plant will be used to consult on the IBP. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► The Trust is addressing some concerns about patient experience in some of its outpatient clinics through a patient experience plan developed with the lead outpatient managers and approved on 10 May 2012 at the Outpatient Improvement Steering group. This will be part of an overarching improvement plan, the progress of which is also being monitored by the Outpatient Improvement Steering group. A deep dive is also being scheduled in the Board seminar progrramme. |

# 4. Board engagement and involvement

## 4.3 Board profile and visibility

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| Amber/ Green | Amber/ Green | |

| Explanation of independent reviewer's RAG rating | |
|---|---|
| Evidence of compliance with good practice | ► The Chair, CEO and NEDs have conducted visits across the Trust with actions plans on issues identified documented. The action plan from these visits however, refer to visits as far back as 2009.<br>► The Trust has prepared a forward plan for Executive team members to visit various sites of the Trust from June 2012 to April 2013. In addition, a patient safety walkabout schedule for EDs and the Chair has been prepared which identifies locations to be visited. Areas planned include Antenatal Clinic, Victoria Ward, Pathology and Chemotherapy Unit. The schedule will be enhanced to include all NEDs.<br>► The Board meets in public monthly and these meetings are well attended by the Board members. Past meeting papers are available on the Trust's website.<br>► The Board conducts bi-monthly sessions with staff, coordinated by the Chair. |
| Action Plans to achieve good practice | ► There is a wide range of activities in place, such as, NEDs taking part in walkabouts and the CEO presentation of staff awards but these are not structured. A schedule for NED walkabouts is being prepared and will track action plans on a timely basis. |
| Explanation if not complying with good practice | ► Not applicable |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► There are no formal processes in place to increase the Board's visibility. An action plan will be presented to raise the profile / visibility of the Board and promote attendance at principal events attended by staff. Activities include:<br>► Meet the Chair session, with staff attending.<br>► Blogs written by the NEDs on the Trust's website. |

# 4. Board engagement and involvement

## 4.4 Future engagement with FT Governors

| Board RAG: | Independent RAG: | If RAG ratings are different, the reason(s) why are as follows: |
|---|---|---|
| **Green** | **Green** | Not applicable |

| **Explanation of independent reviewer's RAG rating** | |
|---|---|
| Evidence of compliance with good practice | ► The Trust's plan for the Council of Governors is documented in the Governance Rationale 2012 document dated May 2012. The Trust considers the size of the Council to be representative.<br>► The responsibilities of the Governors are clearly articulated in the Governors' responsibilities and code of conduct document dated February 2008.<br>► A shadow Council of Governors has been in place since 2008.<br>► A Membership Strategy is in place which defines the membership community (including demographic targets) and how membership of the Trust will be managed. The Strategy also indicates how the Board will engage with members, describing how the hard to reach groups in the community will be represented. Amendments to he Strategy were approved by the Board in November 2011. |
| Action Plans to achieve good practice | ► The Trust intends to develop a plan for Governor inductions and interactions with the Board in July 2012. |
| Explanation if not complying with good practice | ► The Trust has a strong track record of establishing and working with a shadow Council of Governors. Regular meetings are held with the Shadow Council f Governors and minutes of these meetings are available. |
| Where Red Flags have been highlighted, Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s) | ► Not applicable |

# Appendices

# Appendices

| List interviewees | |
|---|---|
| External Stakeholders | **GP Commissioners**<br>► Dr Jill Shattock, Haringey GP Consortium<br><br>**NHS North Central London**<br>► Brenda Pratt, Head Account Manager, NHS North Central London<br><br>**NHS London**<br>► Mark Brice - Programme Lead – FT, NHS London<br><br>**External Audit**<br>► Andrea White, District Auditor, Audit Commission<br><br>**MPs**<br>► Lynne Featherstone MP, House of Commons |
| Internal Stakeholders | ► We conducted two staff focus group meetings on 21 May 2012<br>► In addition, a patient, carer and volunteers focus group session was held on 21 May 2012<br>► All sessions were held in The Whittington Hospital Education Centre in London |
| Board Members | ► We conducted the Board member one to one interviews on 14, 17 and 21 May 2012.<br>► The Board observation and Board to Board sessions were completed on 23 May 2012. |

Appendix 2

Item circulated separately

Appendix 3

**DATED 1 April 2012**

# ACCOUNTABILITY AGREEMENT

**BETWEEN**

**Whittington NHS TRUST**

**and**

**NHS London**

# Table of Contents

## 1. Introduction

1.1. The purpose of this Accountability Agreement ("the Agreement") is to ensure that The Whittington NHS Trust ("The Trust") has a plan with a definitive timeline to submit a successful Foundation Trust application to DH in line with the timescale agreed in the Tripartite Formal Agreement (TFA), signed 27 May 2011.

1.2. The Agreement is a key supporting document to the TFA, describing the key deliverables that are likely to be pre-requisite to a successful FT application and the expectations of all parties towards their achievement.

1.3. The Agreement is made in the context of the NHS Operating Framework 2012/13 and NHS North Central London Commissioning Intentions 2012/13

1.4. The Agreement is between the Trust and NHS London SHA ("The SHA"); the NHS Primary Care Trust commissioning cluster ("the Cluster") is a co-signatory to the Agreement.

1.5. The Agreement sets out the project milestones and operational and financial performance, against which the SHA will ensure the Trust's sustained progress towards Foundation Trust authorisation. The performance framework used is consistent with the Single Operating Model for the FT pipe-line ("SOM") and on-going reporting arrangements for TFAs.

## 2. Rationale

2.1. It is acknowledged that the trajectory for achieving Foundation Trust status is both challenging and complex. However this trajectory must be adhered to in order to meet this national policy objective as described in the TFA.

2.2. The Trust's plans are set in the context of the local health economy managed via the Cluster; the Trust is therefore dependent on key actions which are the responsibility of the Cluster.

2.3. This Agreement provides the factual and interpretative framework for the SHA to have confidence that the Trust is on track to achieve FT authorisation. The Trust acknowledges that the SHA will intervene if there is a sustained failure to deliver either the required levels of operational and financial performance ("Performance") or deliver the agreed trajectory to a successful FT application ("Milestones").

## 3. Principles of the Agreement

3.1. The Agreement is structured around the SOM, which consists of the eight Domains used by DH in its assurance of FT applications, namely: legally constituted and representative; good business strategy; financially viable; well governed; capable Board; good service performance; good external relationships within local health economy; and quality of services. The DH eight Domains correspond to Monitor's three assessment criteria of Legally Constituted, Well Governed and Financially Viable.

3.2. The Agreement is set in the context of specific pan-London initiatives which include:

3.2.1. The scope to deliver productivity opportunities identified by the SHA for the Trust; and

3.2.2. Improvements in the standards of emergency surgery & medicine and maternity services across London (notably, increased senior medical cover at weekends and out of hours), forming a dialogue between commissioners and Trusts across London.

3.3. The Agreement covers Performance and Milestones including those also provided in the TFA, along the Trust's pathway to become a Foundation Trust. The monitoring process for the TFA will be fully integrated within the wider reporting arrangements described in this Accountability Agreement.

3.4. Performance will be routinely assessed on a Quarterly basis (consistent with TFA monitoring process), however note the process described below under Section 5 below that requires monthly monitoring where Performance raises "some / serious concern".

3.5. The management of the Agreement will include assessment against each of the eight DH Domains and a summary Risk Rating, determined by the SHA, which reflects the overall level of confidence held by the SHA, that the Trust will submit a successful FT application to DH within the timescale set out in the TFA.

3.6. The level of monitoring and review by the SHA will vary in proportion to the on-going success of the Trust in sustaining its TFA trajectory against agreed Milestones and on-going Performance, reflecting the "earned autonomy" expected of a future Foundation Trust.

3.7. The SHA and the Trust agree that patient safety and the quality of clinical services remains the most critical priority. None of the actions taken to implement the productivity improvements required (either expressly or by implication) by this Agreement will be required to be taken if such action will be to the detriment of patients.

3.8. Nothing in this Agreement alters the statutory status or obligations (whether statutory or contractual) of any of the organisations concerned.

## 4. Roles and responsibilities

Each of the parties to the Agreement will have the following roles and responsibilities:

4.1. **The Trust**

4.1.1. To produce Performance and Milestone reports to the SHA, ratified by its Chief Executive and by the Cluster.

4.1.2. To ensure its board is kept informed of the progress of this agreement.

4.1.3. To review and understand the economy's position in partnership with the Cluster prior to the submission of each Performance and Milestone report.

4.1.4. To undertake whatever actions are necessary to maintain compliance with the Performance Profiles and Milestones included in this agreement, including a pro-active approach to risk management.

4.1.5. To alert as appropriate the PCT cluster or the SHA of any circumstances or information that may have an effect on the ability of the Trust to comply with the Performance Profiles and Milestones included in this agreement as soon as practicable upon becoming aware of the relevant circumstance or information.

4.1.6. The Trust will supply accurate and complete information in accordance with the timetable and deadlines set by NHS London. Specifically, once the Trust has formally started its application process to FT ("Kick-off" meeting with the SHA), the Trust must routinely report its Financial Risk Rating (FRR) status and Governance risk rating on a monthly basis.

4.2. **The SHA**

4.2.1. To performance manage the accountability agreement and overall delivery of Milestones and Performance alongside its wider role in ensuring the delivery of all NHS required standards.

4.2.2. To target management resources, where possible, in preparing the Trust for FT authorisation e.g. Use of Organisational Development programmes following the undertaking of the Board Memorandum of the Board Governance and Assurance Framework.

4.2.3. To provide to the Department of Health on a monthly basis an Overall Risk Rating consistent with the evidence provided by the Trust against Milestones and Performance.

4.2.4. To work closely with the Cluster in performing its performance management role.

4.2.5. To correspond with the Department of Health and provide the necessary information and assurance, which may include requests for ad hoc information from the Trust or the PCT Cluster.

4.2.6. To take swift and necessary actions required in the event of failure to achieve the agreed Performance and Milestones.

4.3. **The Cluster**

4.3.1. To support the Trust and to work in partnership with the Trust prior to the submission to the SHA of Performance and Milestone reports.

4.3.2. To sign off the Trust's Performance and Milestone reports to the SHA in a timely manner.

4.3.3. To inform the Trust and the SHA of any circumstances or information that may have an effect on the ability of the Cluster health economy to comply with the Performance Profiles and Milestones included in the TFA as soon as practicable upon becoming aware of the relevant circumstance or information.

## 5. Monitoring process

5.1. The SHA, Cluster and the Trust will each nominate a lead officer to coordinate the reporting, sign-off and review of required submissions.

5.2. The SHA lead officer (FT Programme Lead) will prepare a management report on a monthly basis which will describe an "Overall Status", working closely with the Cluster, reflecting progress against quarterly Performance and month-by-month FT trajectory project plan Milestones.

5.3. In the event that Milestones and / or Performance are compromised, the Trust will be required to propose immediate and appropriate action.

5.4. The Director of Provider Development will coordinate the SHA review of the monthly management report and reported Overall Status, consisting of:

5.4.1. progress against the project plan Milestones (Appendix 1);

5.4.2. review of governance arrangements (Appendix 2); and

5.4.3. progress against Performance Profiles (Appendix 3 ).

5.5. The Director of Provider Development will confirm this Overall Status based on the management report and discussion with the relevant Cluster and SHA Executive Directors of Performance, Finance, Medical and Nursing, using the terminology and criteria described below:

| Coding | Summary | Criteria and interpretation |
|---|---|---|
| "Green" | "No concern" | All milestones are being met; the Trust is on track to achieve FT in line with the TFA; and the Trust is delivering acceptable levels of Performance. |
| "Amber Green" | "Some concern" | A milestone may not have been met, however the Trust remains on track to achieve FT in line with the TFA and / or<br><br>the Trust is delivering broadly acceptable levels of Performance. |
| "Amber Red" | "Serious concern" | If more than one milestone is missed and / or<br><br>there are serious doubts about the Trust's ability to remain on track to achieve FT in line with the TFA and / or<br><br>there are areas of serious concern about Performance |
| "Red" | "Lack of confidence" | If the Agreement is clearly off-track against the TFA trajectory and / or<br><br>there are sustained and serious concerns about Performance |

5.6. Where the Overall Status is "some concern", remedial action should be clearly agreed and the progress of the remedial action reviewed the following month.

5.7. Where the Overall Status at any point becomes one of “serious concern”, this needs to be notified immediately by letter from the SHA to the Trust Chief Executive, copied to the NHS Cluster Chief Executive, with an outline of the reasons for the serious concern and the timescales for required remedial action.

5.8. Where the “serious concern” arises as a result of quarterly Performance, the Trust and SHA will move to monthly reporting and review until the performance concerns raised are materially addressed i.e. a return to “Green” or “Amber/green”.

5.9. Where the Overall Status is at any point "Lack of Confidence" (i.e. first “Red Rating”) the SHA Executive Directors of Performance, Finance, Provider Development, Medical and Nursing will meet with the Trust signatory to the Agreement to determine what action will be taken and the Trust will be deemed to be under "Special Measures". “Special Measures” initiates the escalation process described below in Section 6.

5.10. The Trust may choose to Appeal the Overall Status rating by writing to the SHA Chief Executive within 7 days of the Overall Status being known and setting out the reasons for appeal, the proposed alternative Overall Status and the measures being taken to address the concerns giving rise to the (contested) Overall Status rating. The SHA Chief Executive will accept or reject the Appeal notifying the Trust in writing within 7 days. This decision will remain final.

5.11. It is a requirement of this Agreement that the Performance and Milestone ratings which underpin this Agreement will be reported on a regular basis to the Trust Board.

5.12. The (routine) outcomes of the monitoring process against the Agreement will be reported on a monthly basis by the Director of Provider Development to the Department of Health (DH).

## 6. Escalation

6.1. In the event that discussions between the SHA and the Trust, after an initial “Red Rating”, do not achieve a material improvement in performance against the Agreement, further escalation may be required, involving the NHS PCT Cluster Chief Executive.

6.2. In the event of insufficient progress resulting in three successive “Red Ratings” the following process will apply:

6.2.1. there will be a meeting between the Trust, SHA and DH National Director of Provider Delivery. There will be a follow up written confirmation of concern and immediate actions to address the issues; and

6.2.2. if there is no improvement by the next month, there will be a meeting between the Trust Chief Executive, SHA Chief Executive and the DH Senior Responsible Officer for the FT pipeline. A set of actions will be agreed at this stage and this could include a change of application date linked to other changes within the TFA and organisation.

6.3. If it is clear that the Trust is unable to submit its application for more than three months after the original date set in the TFA, a discussion about a change of date with associated ramifications will take place. When a new submission date is agreed, this will involve provision of additional support to the Trust, along with a

loss of autonomy for the Trust, with implications for board leadership to be agreed on a case-by-case basis.

6.4. The following general principles will apply in regard to the escalation process:

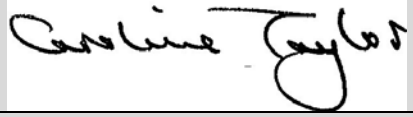
6.4.1. A missed overall DH FT application submission date would automatically trigger a "Red Rating" and a move immediately to an SHA and DH discussion, although the resolution would be agreed on a case-by-case basis;

6.4.2. As part of this Agreement between the SHA and the Trust, the DH will usually only be involved after three "Red Ratings". The SHA can request the involvement of the DH earlier than three months if they believe this is necessary, but if a Trust is "Red Rated" for three months or misses its overall DH FT application date, the DH will become involved immediately.

6.4.3. At each stage of the escalation process, the Cluster will be kept fully informed of developments.

6.4.4. The SHA retains the option of moving TFA milestones as long as the final DH FT application submission date is unaffected.

## 7. Confirmation of the Agreement

| | | |
|---|---|---|
| Principal signatory 1 - [The SHA] | Dame Ruth Carnall | [Signature] |
| | Chief Executive | [Date] |
| Principal signatory 2 - [The Trust] | Yi Mien Koh |  |
| | Chief Executive | 30 March 2012 |
| Co-signatory [The Cluster] | Caroline Taylor |  |
| | Chief Executive | 30 March 2012 |

**TRUST MILESTONES TO FT** **APPENDIX 1**

*[**NOTES:** Trust to submit their Project Plan to support delivery of the milestones in the Trust's Tripartite Formal Agreement and to complete the key deliverables table below in order to track progress towards Foundation Trust status.]*

## KEY DELIVERABLES

Please list the key deliverables to achieve your trust's TFA trajectory by year, quarter and due date in the table below. Expected deliverables are included. Please add any other deliverables specific to the delivery of your Trust's TFA.

Table 1: Key Deliverables to achieve Trust TFA Trajectory

| Key Deliverables | Year | Qtr | Date |
|---|---|---|---|
| *E.g. Signed accountability agreement* | *11/12* | *Q4* | *15 March* |
| | | | |
| **M&A TRANSACTIONS (if applicable)** | | | |
| Transaction governance arrangements (including resource plan to develop the Business Case and implement the merger) agreed by Trust Boards | **Not Applicable to Whittington Hospital NHS Trust** | | |
| Independent Chair appointed | | | |
| SRO appointed | | | |
| Options Appraisal / market testing completed | | | |
| Strategic Outline case (SOC) approved by Trust Boards | | | |
| SHA approval of SOC* | | | |
| Outline Business Case (including LTFM and commissioner support) approved by Trust Boards | | | |
| SHA approval of OBC* | | | |
| CCP submission | | | |
| Post merger integration plans (PMIP) | | | |

| | |
|---|---|
| Long term financial plan (LTFM) - assumptions agreed with cluster | |
| Full Business Case (including LTFM and commissioner support) approved by Trust Boards | |
| SHA approval of FBC* | |
| CCP recommendation to DH | |
| DH Transactions Board approval of FBC | |
| Merger completion | |
| * **NB** – as specified in NHSL Transactions Manual (Feb 2010) | |

| **Key Deliverables** | **Year** | **Qtr** | **Date** |
|---|---|---|---|
| **SERVICE RECONFIGURATION (if applicable)** | | | |
| **Reconfiguration approval process*** | **Not Applicable to Whittington Hospital NHS Trust** | | |
| Programme Brief and Case for Change | | | |
| NHS L approval to proceed to NCAT and Health Gateway Review | | | |
| National Clinical Advisory Team Report | | | |
| Health Gateway Report | | | |
| NHS L approval to proceed to PCBC | | | |
| Pre consultation Business Case (PCBC) | | | |
| Public Consultation Document | | | |
| Four Tests Review | | | |
| NHS London approval to launch consultation | | | |
| Public consultation launched | | | |
| Response to consultation document | | | |
| IRP Decision if referred | | | |
| ***NB:** as specified in NHS London's Reconfiguration Guide | | | |
| **Trust capital business case approval process** | | | |

| | |
|---|---|
| Strategic Outline case (SOC) approved by Trust Board | **Not Applicable to Whittington Hospital NHS Trust** |
| SHA approval of SOC* | |
| Outline Business Case approved by Trust Board | |
| SHA approval of OBC* | |
| Full Business Case (including LTFM and commissioner support) approved by Trust Boards | |
| SHA approval of FBC* | |
| DH Approval* | |
| Treasury Approval* | |
| ***NB**: In accordance with NHS delegated limits guidance | |

| **FOUNDATION TRUST ASSURANCE (ALL TRUSTS)** | | | | **Progress update** |
|---|---|---|---|---|
| **Trust Self Assessment Phase** | | | | |
| TFA Governance Arrangements agreed by Trust Board | **2011/12** | **Q1** | **May** | Completed |
| SHA introductory meeting with Trust to agree entry into FT pipeline (Gateway 1) | 12/13 | | **N/A** | |
| BGAF Self Assessment completed by Trust | **2011/12** | **Q4** | **March** | Completed |
| BGAF action plans developed and agreed by Trust Board | **2012/13** | **Q1** | **April** | Complete following internal assessment |
| Board Development and Performance Monitoring Programme agreed by Trust Board | **2012/13** | **Q1** | **May** | Approved and ongoing |
| Trust Self Assessment against Monitor's Quality Governance framework complete and agreed by Trust Board | **2012/13** | **Q1** | **May** | Completed in June |
| Quality governance action plans developed and agreed by Trust Board | **2012/13** | **Q1** | **May** | Will be developed once RMS Tenon report received |
| Clinical Strategy approved by Trust Board - completed | **2011/12** | **Q3** | **Dec** | Completed |
| Estates Strategy approved by Trust Board | **2012/13** | **Q1** | **June** | Presented to TB seminar in June |
| Workforce and OD Strategy approved by Trust Board | **2011/12** | **Q4** | **March** | Completed |

| | | | | |
|---|---|---|---|---|
| Service Contract agreed between Trust and Cluster | **2012/13** | **Q1** | **April** | HoT signed |
| Draft IBP/LTFM developed with enabling strategies and approved by Trust Board | **2012/13** | **Q1** | **May** | First draft presented to TB |
| Consultation document approved by Trust Board – completed | **2011/12** | **Q3** | **November** | Completed |
| **Key Deliverables** | **Year** | **Qtr** | **Date** | |
| **FOUNDATION TRUST ASSURANCE (ALL TRUSTS)** *continued* | | | | |
| **Trust Self Assessment Phase** *continued* | | | | |
| Response to consultation document approved by Trust Board | **2012/13** | **Q1** | **May** | Drafted and to come to July TB |
| Membership strategy approved by Trust Board - completed | **2011/12** | **Q3** | **October** | Completed |
| Board of Governors, elections and appointment process developed and approved by Trust Board | **2011/12** | **Q3** | **October** | Completed |
| Constitution developed | **2011/12** | **Q3** | **October** | Completed – needs refresh post H&SC act |
| Monitor Board self certification assessment and action plans | | | | |
| - Working Capital review | **2012/13** | **Q1** | **May** | Underway by KPMG |
| - Board statement Clinical quality, service performance | **2012/13** | **Q1** | **May** | Completed |
| - Board Statement of quality governance Arrangements ** | **2012/13** | **Q1** | **May** | Completed |
| **Due Diligence Phase** | | | | |
| IBP – Formal submission to SHA approved by Trust Board including supporting enabling strategies | **2012/13** | **Q1** | **June** | Submission on 29 June |
| LTFM - Formal submission to SHA approved by Trust Board | **2012/13** | **Q1** | **June** | Submission on 29 June, 2012 |

| | | | | |
|---|---|---|---|---|
| CIP Programme submission to SHA (5 years with first 2 years detailed) agreed by Cluster and approved by Trust Board | **2012/13** | **Q2** | **October** | |
| Trust Base Case assumptions and QIPP agreed with SHA and Cluster | **2012/13** | **Q2** | **October** | |
| Trust Downside assumptions modeled and agreed with Cluster including mitigations | **2012/13** | **Q2** | **October** | |
| BGAF Independent Supplier Report* | **2012/13** | **Q1** | **May** | Received June 2012 |
| Trust BGAF action plan updated post independent review and approved by Trust Board | **2012/13** | **Q2** | **June** | Completed |
| Independent Account HDD1 Report | **2012/13** | **Q1** | **May** | Underway by Deloittes and report due by end June |
| Trust HDD1 action plan approved by Trust Board | **2012/13** | **Q1** | **June** | To come to TB in July |
| Quality Governance Independent Review Report | **2012/13** | **Q1** | **May** | Completed |
| Trust Quality Governance action plan updated post independent review and approved by Trust Board | **2012/13** | **Q1** | **June** | To come to TB in July |
| Readiness review meeting (Gateway 2) | **2012/13** | **Q2** | **30 July** | |
| IBP/LTFM update for HDD2 submitted to SHA | **2012/13** | **Q2** | **August** | |
| SHA Quality & Safety Gateway Review completed | **2012/13** | **Q2** | **September** | |
| Independent Accountant HDD2 Report | **2012/13** | **Q2** | **September** | |
| Trust HDD2 action plan developed and approved by Trust Board | **2012/13** | **Q2** | **September** | |
| Commissioner convergence letter | **2012/13** | **Q3** | **October** | |
| Constitution - legal opinion obtained and approved by Trust Board | **2012/13** | **Q1** | **June** | Completed – refresh required post H&SC Act |
| Monitor Board self certification assessment and action plans<br><br>- Working Capital review | **2012/13** | **Q2** | **September** | |

| | | | | |
|---|---|---|---|---|
| - Board statement Clinical quality, service performance<br><br>- Board Statement of quality governance Arrangements ** | **2012/13**<br><br>**2012/13** | **Q2**<br><br>**Q2** | **September**<br><br>**September** | |
| IBP/LTFM updated for SHA B2B submitted to SHA Gateway 3) | **2012/13** | **Q2** | **October** | |
| **Key Deliverables** | **Year** | **Qtr** | **Date** | |
| **SHA Approval Phase** | | | | |
| Successful SHA Board to Board (Gateway 4) | **2012/13** | **Q3** | **November** | |
| SHA Approval (CMG/CIC) Gateway 5) | **2012/13** | **Q3** | **December** | |
| SHA NHS FT applicant support form with supporting documentation | **2012/13** | **Q3** | **December** | |
| FT application submitted to DH | **2012/13** | **Q4** | **1 January** | |
| ***NB** All trusts must MUST complete BGAF in 2012/13 | | | | |
| ****NB** Monitor Self Certification reviews are being brought forward to SHA FT assurance phase | | | | |
| **PERFORMANCE AND MILESTONE REPORTING TO SHA (ALL TRUSTS)** | | | | |
| Monthly TFA reports | 12/13 | All | SHA t/table | |
| Performance and Governance Tracker submissions* | 12/13 | All | SHA t/table | |
| ***NB:** Frequency subject to Performance and progress to FT | | | | |

**END**

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**TRUST GOVERNANCE ARRANGEMENTS** **APPENDIX 2**

*[**NOTES**: Trusts are asked to describe the governance arrangements for delivering their Tripartite Formal Agreement and to submit their TFA project risk register. The project risk register will not form part of the Accountability Agreement but will be requested on a quarterly basis]*

Please describe the governance arrangements the Trust has put in place to deliver the Trust's Tripartite Formal Agreement.

**A) Organisation Structure**


---

**The Whittington Hospital NHS Trust**

**FOUNDATION TRUST Programme Board**
**Terms of reference**
**March 2012**

**1. Overall Objective**

To meet all FT application milestones through to successful authorisation as Foundation Trust for Whittington Health by the deadline of 2013.

**2. Terms of reference**

2.1 To oversee project implementation to ensure that the Foundation Trust application process is delivered within agreed time lines, meeting key milestones and that the Trust Board is kept fully informed of progress

2.2 To steer the development of the Trust's five-year Foundation Trust Integrated Business Plan and long term financial model, ensuring all interdependencies are recognised and included, testing its assumptions, its commercial robustness and ensuring that the impact of any changes in the healthcare environment are incorporated

2.3 To oversee the integration of the components of the Trust's business development plan and to ensure that the longer-term strategy is consistent and applicable with the requirements for Foundation Trust status, particularly relating to long-term financial projections

2.4 To monitor and mitigate all risks to delivery of the FT programme

2.5 To report to Trust Board via Executive Committee on a monthly basis

2.6 To agree external reporting through the TFA

2.7 To ensure that the Trust's annual business plan and service agreements with PCTs are consistent with the assumptions underpinning the Foundation Trust application, particularly the working capital models

2.8 To evaluate progress with Governance arrangements including membership strategy and Trust Constitution recommending changes as required

2.9 To scrutinize and approve all Foundation Trust submissions keeping the Trust Board fully informed.

Deliverables:-

- Integrated Business Plan with supporting strategies
- Long term financial plan
- Due Diligence process and outcome
- Board development
- a robust project structure identifying work streams and responsible leads

## 3. Frequency

The Group should meet at least monthly

**Accountability**

The Group will report to Executive Committee and to Trust Board.

## 4. Resources

The weekly Project Management of the application process will be conducted through the Executive Team meeting supported by the Planning & Programmes Programme Management Office. The Executive Team is chaired by the CEO.

**B) Stakeholders**

Please complete the stakeholder table with the key stakeholders, their interest and how they are engaged in the Project/Programme.

| Key Stakeholders | Interest | Engagement/Communication mechanism |
|---|---|---|
| Commissioning cluster (NHS North Central London) | Co-signatory to TFA and AA | Meetings every three weeks relating to FT application support and milestone management. Have received consultation document, LTFM and Trust strategy. Negotiating contract values and mechanism, letter of support expected. |
| NHS London | Co-signatory to TFA and AA | Meetings every three weeks relating to FT application support and milestone management. Have received consultation document, LTFM and Trust strategy. |
| Islington CCG | Future commissioner | Attendance at meetings; Have received consultation document, LTFM and Trust strategy. Direct engagement by medical director (GP) |
| Haringey CCG | Future commissioner | Attendance at meetings; Have received consultation document, LTFM and Trust strategy. Direct engagement by medical director (GP) |
| Local Health Overview & Scrutiny Committees | Accountability mechanism for local healthcare provision | Attendance by Trust officers at JHOSC meetings. Have received consultation document, LTFM and Trust strategy. |
| Shadow Council of Governors, LINK; other responders to the public consultation | Representatives of the public and service users whom the FT will serve | Public consultation – public meetings, outreach activity attendances at community meetings. LINK and governors attend trust board and quality committee Direct engagement through shadow Council of Governors |

*The Whittington NHST Trust has developed a stakeholder engagement plan and this is available on request*

**Risk Management**
Please review the Risks table in the Trust's signed TFA and include the key risks (up to 5) to the delivery of the Trust's FT trajectory together with mitigation in the table below.

| No. | Key Risk | Risk Owner | Mitigation |
|---|---|---|---|
| 1 | 2012/13 payment mechanism, transitional support and funding quantum not agreed creating a potentially financially unsustainable organisation | Richard Martin (DoF) | • Contract negotiations ongoing<br>• Default position of PbR and Block for community services with values agreed<br>• Escalation to ensure WH as NHS London ICO pilot for new payment mechanism supported<br>• FT application stops and merger with another FT sought<br>• Negotiations concluded for 2012/13 and 2013/14 regarding income mechanism and quantum – further years subject to further discussion and agreement |
| 2 | CIP slippage/non achievement affecting the Trust's surplus and financial risk rating | Maria DaSilva (COO) | • CIPs are risk assessed for quality, deliverability and negative impact on reputation<br>• Detailed planning templates with milestones and leads. Individual schemes monitored in line with established methodology with track record of 100% achievement in 2011/12<br>• Work closely with unions to mitigate against industrial action delaying CIP delivery<br>• Market share growth strategy with marginal cost increases<br>• Use of non-recurrent measures to tackle short-term slippage.<br>• Continued use of vacancy scrutiny panel<br>• Discontinue AFC Increments |
| 3 | The Trust cannot demonstrate a fully mitigated downside case in its IBP | Richard Martin (DoF) | • Additional CIPs are risk assessed for quality, deliverability and negative impact on reputation<br>• Market share growth strategy with marginal cost increases<br>• Use of non-recurrent measures to tackle short-term slippage.<br>• Continued use of vacancy scrutiny panel<br>• Discontinue AFC Increments<br>• FT application stops and merger with another FT sought |

| No. | Key Risk | Risk Owner | Mitigation |
|---|---|---|---|
| 4 | A requirement for further detailed assessment arises from the BGAF assessment | Yi Mien Koh (CEO) | • Provide a comprehensive, but honest account to the initial BGAF assessment of good practice.<br>• Initiate action plans to address any gaps in assurance with detailed planning templates with milestones and leads. Individual schemes monitored in line with established methodology |
| 5 | The actions required by HDD require longer to complete and embed than existing timescales will permit | Richard Martin (DoF) | • Share LTFM with SHA and NCL early to get feedback and address any actions promptly<br>• Ensure sufficient finance staff capacity available to address key actions<br>• Initiate action plans to address any gaps in assurance with detailed planning templates with milestones and leads. Individual schemes monitored in line with established methodology |

**PERFORMANCE REPORTING FRAMEWORK** **APPENDIX 3**

*[**Notes:** Trusts will be asked to complete an excel Performance and Governance Tracker on a quarterly basis from Q1 2012/13. Some trusts may be asked to complete the tracker on a monthly basis dependent upon Performance and progress towards FT. This template sets out the framework for future performance reporting. The first submission against this framework will be Q1 2012/13 to be submitted in July 2012.*

**PERFORMANCE AND GOVERNANCE TRACKER**

| Target | National/ Local Standard | 2012/13 | | | | | | | | Progress against Plan Rag Rating | Progress against Standards Rag Rating | Action Plans | Progress and comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | QTR 1 | | QTR 2 | | QTR 3 | | QTR 4 | | | | | |
| | | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | | | | |
| **1. Finance targets** | | | | | | | | | | | | | |
| 1.1 Monitor Finance Risk Rating (FRR) | Monitor | | | | | | | | | | | | |
| 1.2 In Year Monitoring (CIP and Actual YTD) | SHA | | | | | | | | | | | | |
| 1.3 Progress against Trajectory (CIP and FOT) | SHA | | | | | | | | | | | | |
| 1.4 Local Health Economy stability | SHA | | | | | | | | | | | | |
| 1.5 Trust specific | Local | | | | | | | | | | | | |
| **2. Performance targets – service and quality*** | | | | | | | | | | | | | |
| 2.1 Performance Targets per Monitor Compliance Framework 12/13 | Monitor | | | | | | | | | | | | |
| 2.2 CQC per Monitor Compliance Framework 12/13 | Monitor | | | | | | | | | | | | |
| 2.3 NHSLA per Monitor Compliance Framework 12/13 | Monitor | | | | | | | | | | | | |
| 2.4Trust specific | Local | | | | | | | | | | | | |
| **3. Service Reconfiguration** (Where a Trust is undertaking service reconfiguration the Trust will be asked to agree performance measures with the Cluster). | | | | | | | | | | | | | |
| 3.1Trust specific | Local | | | | | | | | | | | | |

| 4. Board Capacity and Capability | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.1 Board composition per OHI criteria | SHA | | | | | | | | | | | | |
| 4.2 Board Capacity and Capability per OHI criteria | SHA | | | | | | | | | | | | |

*NB: Aligned with DH framework, including quality and patient safety dashboard

**TRUST: Whittington Hospital** **MONTH: MAY 2012**

| RAG KEY |
|---|
| RED |
| A/R |
| A/G |
| GREEN |

| | | |
|---|---|---|
| **Cluster Sign Off** | | **YES** |
| **By Whom:** | | **Andrew Grimshaw** |

| Date | TFA or AA | Milestone | Progress | RAG Risk to future delivery |
|---|---|---|---|---|
| **May 2010** | **TFA** | 2010-2013 Trust Board development plan approved by CEO and Chairman | | |
| **31 March 2011** | **TFA** | ICO Business Transfer Agreement signed by Trust and commissioners (GREEN) | | |
| **1 April 2011** | **TFA** | Community services transfer to Trust and ICO created (GREEN) | | |
| | **TFA** | Acute contract signed (GREEN) | | |
| | **TFA** | Newly appointed NEDs commence Trust Board duties (GREEN) | | |
| **24 May 2011** | **TFA** | Third NED appointed (GREEN) | | |
| **April, May and June 2011** | **TFA** | All NEDs have undergone induction and orientation to the ICO (GREEN) | | |
| **21 May 2011** | **TFA** | Haringey children's services contract signed by Trust and commissioners and services transferred to Trust (GREEN) | | |
| **June 2011** | **TFA** | 2011/12 QIPP plan approved by Trust Board (GREEN) | Trust Board received the detailed 2011/12 CIP. The Trust is currently reporting a surplus for the year to date (Months 1-8) and is forecasting achievement of the year end surplus control total. The total CIP required for 2011/12 is £19.6m of which £19.3m has been specifically identified against CIP schemes. Of the remaining £0.37m action plans are in place which will deliver equivalent savings through reductions in recruitment to vacancies and use of temporary / agency staffing. The Trust has achieved 99% of the year to date target at Month 8. Within the £19.6m forecast achievement, the non recurrent element represents only £1.6m (8%). | |
| | **TFA** | ICO senior management structure revised and new structure in place (GREEN) | The Executive senior management structure has now been revised and appointments made with new structure in place since 8 June 2011. The next tier of management organisational change completed in September and all appointments to posts have been made. Estimated severance costs for management restructure were lower than the funds set aside. | |
| | **TFA** | ICO service development priorities agreed and transformation work underway (GREEN) | The Trust Board has agreed its five year strategic vision and goals. These are underpinning strategy discussions within clinical divisions. Through a series of events service development priorities have been agreed. Activity and finance modelling are progressing and the trust has commissioned external consultants to assist in care pathway redesign. | |
| **July 2011** | **TFA** | | | |

| | | | |
|---|---|---|---|
| **August 2011** | **TFA** | Quality and safety dashboard developed (Green) | The Trust has a draft quality and safety dashboard that provides longitudinal information on KPIs from the wards, through to top level summaries. This has been approved by the Quality and Safety sub committee of the Trust Board. Changes have been made to the Trust Board dashboard with the first revised dashboard due to be presented to Trust Board in January 2012. |
| **September 2011** | **TFA** | FT public consultation begins (Green) | The FT consultation was launched on 1 November 2011 and will complete on 29 February 2012. Membership recruitment events are underway in parallel. |
| | **TFA** | Board to discuss recruitment plan for fourth new NED (GREEN) (21 September) | Decision at the 28 September 2011 Trust Board was to delay the recruitment of the 4th NED until after the organisation becomes an FT. |
| 03-Oct-11 | **TFA** | 2012/13 QIPP plan finalised (GREEN) | 11/12 CIP annual target £19.6m - M10 plan 100% achievement to date (£15.3m)<br><br>11/12 YTD surplus £1.4m against YTD target of £1.0m<br><br>12/13 CIP target has been revised downwards from £19.55m to £13.1m by reducing the target surplus for 2012/13 but maintaining the required Monitor risk rating. This revision has reflected the pace of transformation of clinical services with more ICO benefit being modelled in 2013/14. Of the revised £13.1m target the full amount has been identified.<br><br>13/14 CIP target is £15.3m of which only £1.1m is unidentified. The overall financial plan includes an assumption for severance that will be associated with the delivery of SAFE and transformation of care pathways.<br><br>14/15 CIP target has been developed to outline stage with full detailed to be developed by August Trust Board. |
| | **TFA** | | |
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| **January 2012** | **TFA** | Public consultation finishes (GREEN) | The period of public consultation will complete on 29 Feb 2012. | |
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| **May 2012** | **TFA** | Monitor Board self certification assessment and action plans - RSM Tenon | MQGF self assessment complete and TB to self certify on 23 May. RMS Tenon engaged to commence their independent review week commencing 28 May. |
| **May 2012** | **TFA** | BGAF - Independent Assessment - E&Y | E&Y independent assessment of BGAF commenced 14 May and will conclude 28 May - report to follow and be presenetd at Trust Board in June. |
| **May 2012** | **TFA** | Working Capital - Self Assessment/Self certification | KPMG appointed to complete by 31st May 2012 |
| **May 2012** | **TFA** | SHA - Trust Board Observation | SHA now observing the Trust Board on 26 September 2012 |
| **May 2012** | **TFA** | SHA - Board interviews | Scheduled and confirmed for 28th, 29th and 30th May '12 and 18 June'12. |

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|---|---|---|---|
| **June 2012** | **TFA** | SHA Interview with commissioners | tbc - New |
| **June 2012** | **TFA** | BGAF, MQGF, WC - action plans post independent review | By 30th June 2012 |
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| **June 2012** | **TFA** | SHA Audit Committee observation | 6 June 2012. |
| **July 2012** | **TFA** | SHA - Readiness Review Meeting | New - possibly July. |
| **August 2012** | **TFA** | IBP/LTFM update for HDD2 | August 2012 |
| **August 2012** | **TFA** | Monitor Board self certification assessment | By 31 st August 2012 |
| **Sept 2012** | **TFA** | NHSL agrees to commencement of ICO Historic Due Diligence part two | Deloittes - report Sept 2012. |
| **Sept 2012** | **TFA** | HDD2 action plans | Sept 2012 |
| **Sept 2012** | **TFA** | SHA - Completion of Safety & Quality gateway review | Sept 2012 |
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|---|---|---|---|---|
| **Aug 2013** | **TFA** | Authorised as FT | tbc | |

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| **COMMENTS - Overall Delivery:** | Your overall delivery RAG rating is AMBER/RED.<br>Commissioner agreement, on 12/13 contract was finally agreed in first week of April, before arbitration started. HDD1 has been delayed because Monitor has not allocated a firm of accountants. HDD1 will not start until May at the earliest, and spreading the B2B from CMG/CIC will delay application by 3 months. | |

**Compatibility Report for Whittington TFA tracker APRIL 2012 FINAL SIGNED ic.xls**
**Run on 25/04/2012 10:28**

The following features in this workbook are not supported by earlier versions of Excel. These features may be lost or degraded when you save this workbook in an earlier file format.

| **Minor loss of fidelity** | **# of occurrences** |
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| Some cells or styles in this workbook contain formatting that is not supported by the selected file format. These formats will be converted to the closest format available. | 7 |

**TRUST: Whittington Hospital** **MONTH: JUNE 2012**

| RAG KEY |
|---|
| RED |
| A/R |
| A/G |
| GREEN |

| | | |
|---|---|---|
| **Cluster Sign Off** | | **YES / ~~NO~~** |
| **By Whom:** | | **Andrew Grimshaw** |

| Date | TFA or AA | Milestone | Progress | RAG Risk to future delivery |
|---|---|---|---|---|
| **May 2010** | **TFA** | 2010-2013 Trust Board development plan approved by CEO and Chairman | | |
| **31 March 2011** | **TFA** | ICO Business Transfer Agreement signed by Trust and commissioners (GREEN) | | |
| **1 April 2011** | **TFA** | Community services transfer to Trust and ICO created (GREEN) | | |
| | **TFA** | Acute contract signed (GREEN) | | |
| | **TFA** | Newly appointed NEDs commence Trust Board duties (GREEN) | | |
| **24 May 2011** | **TFA** | Third NED appointed (GREEN) | | |
| **April, May and June 2011** | **TFA** | All NEDs have undergone induction and orientation to the ICO (GREEN) | | |
| **21 May 2011** | **TFA** | Haringey children's services contract signed by Trust and commissioners and services transferred to Trust (GREEN) | | |
| **June 2011** | **TFA** | 2011/12 QIPP plan approved by Trust Board (GREEN) | Trust Board received the detailed 2011/12 CIP. The Trust is currently reporting a surplus for the year to date (Months 1-8) and is forecasting achievement of the year end surplus control total. The total CIP required for 2011/12 is £19.6m of which £19.3m has been specifically identified against CIP schemes. Of the remaining £0.37m action plans are in place which will deliver equivalent savings through reductions in recruitment to vacancies and use of temporary / agency staffing. The Trust has achieved 99% of the year to date target at Month 8. Within the £19.6m forecast achievement, the non recurrent element represents only £1.6m (8%). | |
| | **TFA** | ICO senior management structure revised and new structure in place (GREEN) | The Executive senior management structure has now been revised and appointments made with new structure in place since 8 June 2011. The next tier of management organisational change completed in September and all appointments to posts have been made. Estimated severance costs for management restructure were lower than the funds set aside. | |
| | **TFA** | ICO service development priorities agreed and transformation work underway (GREEN) | The Trust Board has agreed its five year strategic vision and goals. These are underpinning strategy discussions within clinical divisions. Through a series of events service development priorities have been agreed. Activity and finance modelling are progressing and the trust has commissioned external consultants to assist in care pathway redesign. | |
| **July 2011** | **TFA** | | | |

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| **August 2011** | **TFA** | Quality and safety dashboard developed (Green) | The Trust has a draft quality and safety dashboard that provides longitudinal information on KPIs from the wards, through to top level summaries. This has been approved by the Quality and Safety sub committee of the Trust Board. Changes have been made to the Trust Board dashboard with the first revised dashboard due to be presented to Trust Board in January 2012. | |
| **September 2011** | **TFA** | FT public consultation begins (Green) | The FT consultation was launched on 1 November 2011 and will complete on 29 February 2012. Membership recruitment events are underway in parallel. | |
| | **TFA** | Board to discuss recruitment plan for fourth new NED (GREEN) (21 September) | Decision at the 28 September 2011 Trust Board was to delay the recruitment of the 4th NED until after the organisation becomes an FT. | |
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| **May 2012** | | Working Capital independent assessment | KPMG have undertaken the WC IA. Recommendations are being reviewed and the Trust is now in discussion with KPMG to agree final document and required actions. WC IA and action plans will be presented to the Trust Board in June |
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| **June 2012** | **TFA** | BGAF, MQGF, WC - action plans post independent review | BGAF - E&Y have completed their table top exercise and 1 : 1 interviews. Report due to be presented to TB seminar on 27 June. Action plans to be developed once report received.<br>MQGF - RMS Tenon have commenced their table top exercise and completed their 1: 1 interviews. Report due to be presented to TB seminar on 27 June. Action plans to be developed once report received.<br>WC - KPMG have undertaken the WC IA. Recommendations are being reviewed and the Trust is now in discussion with KPMG to agree final document and required actions. WC IA and action plans will be presented to the Trust Board in June |
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| **June 2012** | **TFA** | Legal opinion on Constitution | Constitution written by Bevan Brittan and approved by TB. Will be redrafted later in year to reflect any legislative changes post H&SC Act and prior to CoG elections |
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| Performance | | Finance | | TFA | Overall NHS London adjusted TFA |
|---|---|---|---|---|---|
| May 2012 DH Performance | NHS London adjusted | May 2012 DH Performance | NHS London adjusted | | |
| Performing | Performing | Performing | Performing | A/R | A/R |

*The NHS Performance Framework is described in The NHS Performance Framework Implementation Guidance April 20121.
Overall ratings will be completed by applying the following rules:
- If a Trust is “underperforming” on either quality or finance, the TFA RAG rating must be red;
- If a Trust is rated “performance under review” on quality or finance, the TFA RAG rating must be no better than amber/red.
- For Mental Health and Community trusts, local intelligence will be used to inform the RAG ratings.
SHAs may use local knowledge to supplement this information if performance has materially changed since the last Performance Framework scores were issued. The rules described above give the TFA RAG ratings but judgements will still be applied in moving trusts into the escalation process.
Department of Health - Aligning the Performance Management of Tripartite Formal Agreements (TFAs) with the NHS Performance Framework - April 2012
**DH Mental Health Performance Framework Rating is from Q3 2011/12 - For information only, does not currently contribute to the overall TFA reating.
TFA - if there is a slippage of up to 3 months in the overall timeline trusts will be RAG rated as AMBER/RED. If t
***Unpublished finance ratings.

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