Supporting all NHS Trusts to achieve NHS Foundation Trust status by April 2014

Tripartite Formal Agreement between:

- United Lincolnshire Hospitals NHS Trust
- NHS East Midlands
- Department of Health

Introduction

This tripartite formal agreement (TFA) confirms the commitments being made by the NHS Trust, their Strategic Health Authority (SHA) and the Department of Health (DH) that will enable achievement of NHS Foundation Trust (FT) status before April 2014.

Specifically the TFA confirms the date (Part 1 of the agreement) when the NHS Trust will submit their "FT ready" application to DH to begin their formal assessment towards achievement of FT status.

The organisations signing up to this agreement are confirming their commitment to the actions required by signing in part 2a. The signatories for each organisation are as follows:

NHS Trust	–	Andrew North, Chief Executive Officer
SHA	–	Kevin Orford, Chief Executive Officer
DH	–	Ian Dalton, Managing Director of Provider Development

Prior to signing, NHS Trust CEOs should have discussed the proposed application date with their Board to confirm support.

In addition the lead commissioner for the Trust will sign to agree support of the process and timescales set out in the agreement.

The information provided in this agreement does not replace the SHA assurance processes that underpin the development of FT applicants. The agreed actions of all SHAs will be taken over by the National Health Service Trust Development Authority (NTDA)[1] when that takes over the SHA provider development functions.

[1] NTDA previously known as the Provider Development Authority – the name change is proposed to better reflect their role with NHS Trusts only.

The objective of the TFA is to identify the key strategic and operational issues facing each NHS Trust (Part 4) and the actions required at local, regional and national level to address these (Parts 5, 6 and 7).

Part 8 of the agreement covers the key milestones that will need to be achieved to enable the FT application to be submitted to the date set out in part 1 of the agreement.

Standards required to achieve FT status

The establishment of a TFA for each NHS Trust does not change, or reduce in any way, the requirements needed to achieve FT status.

That is, the same exacting standards around quality of services, governance and finance will continue to need to be met, at all stages of the process, to achieve FT status. The purpose of the TFA for each NHS Trust is to provide clarity and focus on the issues to be addressed to meet the standards required to achieve FT status. The TFA should align with the local QIPP agenda.

Alongside development activities being undertaken to take forward each NHS Trust to FT status by April 2014, the quality of services will be further strengthened. Achieving FT status and delivering quality services are mutually supportive. The Department of Health is improving its assessment of quality. Monitor has also been reviewing its measurement of quality in their assessment and governance risk ratings. To remove any focus from quality healthcare provision in this interim period would completely undermine the wider objectives of all NHS Trusts achieving FT status, to establish autonomous and sustainable providers best equipped and enabled to provide the best quality services for patients.

Part 1 - Date when NHS foundation trust application will be submitted to Department of Health

1st September 2013

Part 2a - Signatories to agreements

By signing this agreement the following signatories are formally confirming:

- their agreement with the issues identified;
- their agreement with the actions and milestones detailed to support achievement of the date identified in part 1;
- their agreement with the obligations they, and the other signatories, are committing to;

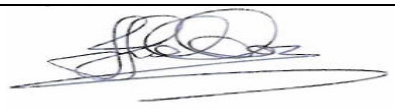
as covered in this agreement.

Andrew North, Chief Executive United Lincolnshire Hospitals NHS Trust	Signature  Date: 31 March 2011
Kevin Orford, Chief Executive, NHS East Midlands	Signature  Date: 31 March 2011
Ian Dalton, Managing Director Provider Development Department of Health	Signature  Date: 30 September 2011

Part 2b – Commissioner agreement

In signing, the lead commissioner for the Trust is agreeing to support the process and timescales set out in the agreement.

John McIvor, Chief Executive NHS Lincolnshire	Signature

	 Date: 31 March 2011

Part 3 – NHS Trust summary

Short summary of services provided, geographical/demographical information, main commissioners and organisation history.

Required information

Financial data (figures for 2010/11 should to be based on latest forecast)

	2009/10 (000)	2010/11 (000)
Total income	391,007	386,111
EBITDA	19,369	4,193
Operating surplus\deficit (normalised)	-4,002	-14,278
CIP target	14,631	18,334
CIP achieved recurrent	3,490	8,492
CIP achieved non-recurrent	2,414	1,302

The NHS Trust's main commissioners - NHS Lincolnshire

Summary of PFI schemes (if material) – N/R

Further information

United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest hospital trusts in the country. It provides secondary care services in both acute and community settings operating out of three main hospital sites – Lincoln County Hospital (838 beds), Pilgrim Hospital, Boston (547 beds) and Grantham Hospital (177 Beds). The Trust also provides a range of outpatient, day case and inpatient services from a range of community hospitals operated by Lincolnshire Community Health Services or local GP clusters. This includes: Louth Hospital, John Coupland Hospital (Gainsborough), Johnson Hospital (Spalding) and Skegness Hospital.

The Trust provides a broad range of clinical services including community services, population screening services, a comprehensive range of planned and unscheduled secondary care services, research and development.

The population of Lincolnshire is 750,000 and has one of the fastest growing populations in England. The population growth plan for Grantham alone equates to a 150,000 increase over the next five years based on Local Authority housing development plans. A significant part of the increase in population growth links to inward migration, this splits into three separate patterns: -

a) An increase in older age groups looking to retire to the county (this is a particular issue for the east coast) and has implications for the pattern of hospital based provision that will be required in the medium and longer term.
b) Economic migration into the south east of the county consisting of a younger population cohort
c) Development of commuter links e.g. Grantham

Due to changes in Emergency Care services at Newark Hospital significant changes in the flow of unscheduled care have been experienced with increases in non-elective admissions to Lincoln County Hospital for Newark area residents of 1100 per year with 2300 associated A+E attendances.

The main commissioner of services from ULHT is NHS Lincolnshire. From April 2011 the Trust is increasingly relating to the seven Clinical Commissioning Groups in Lincolnshire. There are 7 Clinical Commissioning Consortia in the county ranging from 250,000 population (1 consortia), to 160,000 population (1 consortia) with all other consortia covering 80-85,000 populations. The Trust is working to align its newly implemented clinical management structures to the Clinical Consortia particularly in relation to commissioning of services for each of the hospital sites.

The total annual income for the Trust during 2010/11 was £386m, with an in-year deficit of £13.8m before impairments of £0.5m. The income plan for the Trust in 2011/12 is £391m.

Part 4 – Key issues to be addressed by NHS trust

Key issues affecting NHS Trust achieving FT	
Strategic and local health economy issues	
Service reconfigurations	☐
Site reconfigurations and closures	☐
Integration of community services	☐
Not clinically or financially viable in current form	☐
Local health economy sustainability issues	☐
Contracting arrangements	☐
Financial	
Current financial Position	☒
Level of efficiencies	☒
PFI plans and affordability	☐
Other Capital Plans and Estate issues	☒
Loan Debt	☐
Working Capital and Liquidity	☒
Quality and Performance	
QIPP	☐
Quality and clinical governance issues	☒
Service performance issues	☒
Governance and Leadership	
Board capacity and capability, and non-executive support	☐

Current financial position:
ULHT was formally designated as financially underperforming at Q2 of 2010/11 as a consequence of the year end operating deficit, and is under SHA led intervention. The Trust is planning to achieve break-even for 2011/12, moving to sustainable monthly surplus from September 2012. The 2010/11 deficit was as a result of:

- Medical staff vacancies and the prohibitive cost of locum cover
- Growth in non elective activity
- Unmet CIP
- Lack of management capacity to progress the transformation required

Level of efficiencies
Historically the Trust has underperformed significantly against its cost improvement and productivity plans. Total CIPs of £20.4m (5.4%) are planned for 2011/12 increasing to 7.6% in 2013/14. This is requiring a step change in CIP delivery based on strong programme management arrangements and a clear performance management framework.

Working Capital and liquidity
The Trust's liquidity position is weak, with the 2010/11 deficit compounding an already relatively weak underlying position. An application for a working capital loan has featured as an integral part of the 2011/12 planning cycle.

Capital Plan and estates issues
The Trust faces a significant backlog in investing in estates, equipment and service infrastructure. As an illustration, backlog maintenance is currently assessed as £42m, before updating the five facet survey, which could reveal that there is further work above this figure. Internally generated resources to support future capital investment (be that depreciation or asset sales) will be insufficient to meet future investment needs particularly in light of the significant capital investment required to address the issues on the Pilgrim Hospital site associated with the maternity unit.
Alternative financing options, including securing long term loans will need to be pursued.

In 2008/9 the Trust adopted the DTZ methodology to asset valuation and asset lives. This had the effect of a significant one off revenue benefit but has left a legacy of requiring the Trust to annually 'de-recognise' capital assets in the revenue account, as well as classify certain building replacement works, previously charged as capital, as revenue. Potentially, this might be an issue for Monitor. Any reversal of this accounting treatment will have a significant impact on the trust's I+E in the year that it is applied.

QIPP

The NHS Lincolnshire commissioning intentions for 2011/12 were based on minimum growth in elective referrals and a shared ambition to reduce non-elective admissions to the level of 2008/09 outturn by March 2013. The transformation of unscheduled care is being led within the Trust by the Urgent Care Programme Board underpinned by an explicit set of urgent care standards developed by 60 clinicians from across secondary and primary care. £10 million of demand management initiatives are being implemented across the health community in 2011/12 affecting both non-elective and elective levels of future demand. The successful implementation of the commissioning intentions across the health community is a key contributor to both the successful delivery of the Trust's CIP programme and to the delivery of key performance targets. The first four months of 11/12 have seen a 2% reduction in non-elective admissions and reductions in hospital length of stay are being achieved through the Lean initiatives within our transformation programme.

Quality and Clinical Governance issues

The Trust's current registration status is full registration with concerns.

A CQC review visit in June 2010 identified a number of minor/moderate concerns, there was no suggestion that any harm had come to any patient as a result of these concerns. The CQC then undertook a planned review of compliance following an unannounced visit in early February 2011. They found that the Trust was failing to comply with the following regulations/outcomes at the Pilgrim Hospital site, Boston and issued two warning notices in respect of:

Regulation 9 / Outcome 4 – Care and welfare of people who use services
Regulation 14 / Outcome 5 – Meeting nutritional needs

The Trust implemented formal corrective action to achieve compliance against these regulations. As part of a separate Safeguarding review (resulting in a formal police investigation) the CQC also undertook two responsive reviews in late Spring 2011 - one looking at Outcome 09 - medicines management, and one looking at Outcome 12 - requirements relating to workers.

On the 25th August the CQC published their Review of Compliance Report. The Report sets out the significant progress made by the Trust against the two outcomes subject to the previous warning notices.

The Compliance Review found the Trust compliant against Outcome 14 and Outcome 12, with moderate concerns in relation to Outcome 04. Major concerns were identified against Outcome 09. Specifically the CQC identified insufficient arrangements in place for the obtaining, recording, handling, using and safe administration of medicine.
The Trust will submit its action plans relating to Outcome 04 and 09 to the CQC within 28 days.

On the 28th July the Nursing and Midwifery Council instructed four Universities to immediately withdraw all nursing and midwifery students from their clinical placements at Pilgrim Hospital. The NMC expressed concern in their confirming letter about the quality of the training environment and were seeking a greater level of assurance through the placement monitoring processes operated by the relevant Universities. Following detailed discussions with the NMC and the Universities to seek a better understanding of the NMC concerns, the Trust is now working closely with the Universities to achieve a phased return of nursing and midwifery students to the Pilgrim site.

Service Performance Issues
Key service performance issues being addressed by the Trust in 2011/12 include:

More consistent achievement of the cancer waiting time standards, particularly the standard 62 day pathway and the 62 day screening pathway.
Within median waiting times, the key challenges against the 95th percentile are within Orthopaedics, Ophthalmology and delivery of diagnostic waits.
An in year challenge that has arisen is achievement of 95% of patients being treated, admitted or discharged within 4 hours of arrival at Accident and Emergency. Both the Lincoln and Grantham Hospital sites are delivering consistently against the 4 hour standard but there have been significant performance issues on the Pilgrim site. The turnaround actions within Accident and Emergency at Pilgrim Hospital are extensive and include whole scale redesign of patient flow within the department and across the hospital. Implementation of the turnaround plan continues at pace

Part 5 – NHS Trust actions required

Key actions to be taken by NHS Trust to support delivery of date in part 1 of agreement	
Strategic and local health economy issues	
Integration of community services	☐
Financial	
Current financial position	☒
CIPs	☒
Other capital and estate Plans	☒
Quality and Performance	
Local / regional QIPP	☐
Service Performance	☒
Quality and clinical governance	☒
Governance and Leadership	
Board Development	☒
Other key actions to be taken (please provide detail below)	☐

Describe what actions the Board is taking to assure themselves that they are maintaining and improving quality of care for patients.

A revised performance reporting framework has been implemented across the Trust which includes the following key features:

- A corporate performance framework to inform the Board
- Performance dashboards for every Clinical Business Unit and Directorate which includes three domains of service quality, service performance and use of resources.
- Implementation of a performance clinic system and associated escalation process

The Trust Board receives detailed monthly against the balanced scorecards together with information on agreed action plans.

The Trust Board has also established a new Governance structure which supports it in improving the quality of care through a process of risk management, control and assurance. In particular, it has established a Governance Committee sub-committee with specific responsibility for ensuring the development and maintenance of safe and high quality care and services.

Please provide any further relevant local information in relation to the key actions to be taken by the NHS Trust with an identified lead and delivery dates:

Action	Lead	Delivery Date
1. To implement a financial recovery plan which is embedded into the LTFM and which addresses the issues detailed in Part 4 above (relating to overall financial position, efficiency levels, capital plan/estate issues and working capital/liquidity) and delivers a normalised monthly surplus	Development of plans - Director of Finance, Procurement & Information. Implementation – Executive Directors (as identified for each element)	From September 2012
2. Implementation of transformational programme to deliver savings across unscheduled care, planned care, clinical workforce strategies and patient administration.	Director of Strategy and Performance	From April 2011
3. To develop a clinical strategy	Medical Director / Director of Strategy & Performance	30/5/2012

Action	Lead	Delivery Date
4. To implement a new performance management framework across the Trust at corporate and clinical business unit level.	Director of Strategy & Performance	From April 2011
5. Implementation of recovery plans agreed with SHA and PCT in relation to: i) Cancer waiting times ii) 95th percentile for 18 weeks iii) Delivery of quality markers in relation to management of high risk TIAs and time spent on stroke unit iv) A+E 4 hour standard	Director of Service Delivery	i) August 11 ii) August 11 with Orthopaedics end of Nov) iii) Feb 2012 iv) November 2011
6. To develop a revised estates strategy	Director of Facilities Management	30/8/12
7. To determine the asset valuation decision and the I&E implications of reversal.	Director of Finance, Procurement & Information	31/03/12
8. Establish and implement a board development programme which supports achievement of competencies required for the board assessment.	Director of Human Resources and Organisational Development	1/11/11
9. CQC compliance i. Implement remedial action plans in relation to the findings of the CQC February 2011 compliance visits for the Pilgrim and Lincoln hospital sites ii. Submit remedial action plans in relation to 25 August Compliance Report. This specifically relates to outcome 04 and outcome 09. iii. Implement remedial action plans relating to August 2011 Compliance Report	Medical Director	i) work commenced and complete by 31 March 2012 ii) 20th September 2011 iii) work to be completed by 31 March 2012
10. Nursing and Midwifery Council i. Development of agreed action plan to address NMC concerns in relation to clinical placements at Pilgrim Hospital ii. Implementation of the agreed action plan in conjunction with the Universities	Director of Nursing and Patient Services	i. Drafted by15 September 2011 ii. Work started in August 2011

Part 6 – SHA actions required

Key actions to be taken by SHA to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Local health economy sustainability issues (including reconfigurations)	☒
Contracting arrangements	☐
Transforming Community Services	☐
Financial CIPs\efficiency	☒
Quality and Performance Regional and local QIPP	☐
Quality and clinical governance	☐
Service Performance	☐
Governance and Leadership Board development activities	☒
Other key actions to be taken (please provide detail below)	☒

Please provide any further relevant local information in relation to the key actions to be taken by the SHA with an identified lead and delivery dates.

The SHA recognises the significant challenges faced by the Trust and will continue to play an active, supportive and facilitative role during the FT preparation period to support progress towards FT. This includes for example:

- Support for handling reconfiguration proposals
- Facilitate the transfer of assets between organisations subject to the approval of a business case
- Provide strategic estates advice

Subject to complying with the requirements of the SHA capital approval process, support to be provided for business cases and long term loans/external sources of funding as appropriate. For example delivery of health community QIPP plans.

Part 7 – Supporting activities led by DH

Actions led by DH to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Alternative organisational form options	☐
Financial NHS Trusts with debt	☐
Short/medium tem liquidity issues	☒
Current/future PFI schemes	☐
National QIPP workstreams	☐
Governance and Leadership Board development activities	☐
Other key actions to be taken (please provide detail below	☒

Please provide any further relevant local information in relation to the key actions to be taken by DH with an identified lead and delivery dates:

Actions
• The LTFM demonstrates delivery of the Monitor FRR metrics required for authorisation; this assumes that a working capital loan of £15m repayable over five years is approved by DH. With the support of NHS Lincolnshire, the Trust has agreed a contract & contract value for 2011/12 that has enabled it to develop a balanced plan for 2011/12 and beyond, Having met the requirement for a working capital loan the DoH is asked to look favourably upon the loan application that underpins the financial plan submitted to the department.
• The Trust is reliant on longer term loans to fund capital developments required to support its transformational programme and estates strategy. Based on the LTFM developed to 2015/16, such loans are affordable and the Trust is able to comply with the DH loan criteria.
• Support for handling service reconfiguration proposals that may emerge from on-going public consultations.
• Work with the Trust to find a solution in respect of any decision to revisit the asset revaluation methodology detailed in part 4 as it proceeds through the FT application process.

Part 8 – Key milestones to achieve actions identified in parts 5 and 6 to achieve date agreed in part 1

Date	Milestone
30/09/2011	Secure working capital loan
29/04/11	Completion of implementation of revised organisational structure
31/12/11	Shaping health for mid-Kesteven conclusions
2/1/12 - 31/3/12	Consultation on Shaping Health for mid-Kesteven conclusions
1/9/11 - 31/8/12	Estate strategy including 5-facet survey. The overall length of this work stream is linked to the need for three things to occur .Firstly the 5-facet survey, a more detailed space utilisation assessment and then the site configuration plans informed by the clinical strategy,
3/10/11 - 31/5/12	Clinical strategy and consolidated strategic direction. The overall length of this workstream is directly linked to the need to approach this work from a strong OD perspective. The proposed process for this work is designed to bring clinical teams together pan Trust and to use several of these meetings per specialty to inform the clinical strategy work. Because of the geography of the Trust it is then imperative that a stage is included that allows a more strategic assessment of the future service configuration on each of the three sites informed in part by the work of the pan trust clinical reference groups. The existence of seven clinical commissioning groups within Lincolnshire also means we need to allow sufficient time for stakeholder engagement within the process.
31/03/2012	Asset valuation decision
30/9/2012	Delivery of monthly normalised surplus
31/12/2012	Final IBP including LFTM
2011/12 financial year	Delivery of financial balance
1/2/2013	Final application to SHA Board
1/9/2013	Final Application to Dept of Health

Provide detail of what the milestones will achieve\solve where this is not immediately obvious. For example, Resolves underlying financial problems – explain what the issue is, the proposed solution and persons\organisations responsible for delivery.

Describe what actions\sanctions the SHA will take where a milestone is likely to be, or has been missed.

The SHA will apply its existing escalation policy for the delivery of the timeline detailed in this document.

Key Milestones will be reviewed every quarter, so ideally milestones may be timed to quarter ends, but not if that is going to cause new problems. The milestones agreed in the above table will be monitored by senior DH and SHA leaders until the NTDA takes over formal responsibility for this delivery. Progress against the milestones agreed will be monitored and managed at least quarterly, and more frequent where necessary as determined by the SHA (or NTDA subsequently). Where milestones are not achieved, the existing SHA escalation processes will be used to performance manage the agreement. (This responsibility will transfer to the NTDA once it is established)

Part 9 – Key risks to delivery

Risk	Mitigation including named lead
1. Non availability of liquidity i.e. working capital loan.	2010/11 Cash issues resolved with non recurrent year end support from NHS Lincolnshire and management of creditors. The contract & agreed contract value for 2011/12 enable a balanced plan in 2011/12 to meet the DH criteria for consideration for a DH working capital loan – this supports the cash position whilst the Trust implements its turnaround and transformational programme. From September 2012 – Planned Trust surpluses provides sufficient cash to support required liquidity **Lead: Kevin Turner, Director of Finance, Procurement & Information**
2. Failure to deliver service transformation and productivity improvement and failure to deliver efficiency plans.	Strong programme and performance management mechanisms established that focus on successful delivery. **Lead:** Jane Lewington, Director of Performance & Strategy i) Contingency of 1% is built into 11/12 financial plans ii) Further reductions to capital / non-recurrent spend (high risk) **Lead: Kevin Turner, Director of Finance, Procurement & Information**
3. Failure to access long term publicly funded loans to support essential schemes in respect of reconfiguration and transformation.	The development of strong business cases demonstrating sound basis for investment and ability to repay loans based on planning assumptions detailed in the long term financial model. Access to alternative sources of finance may mitigate the limited availability of publicly funded loans **Lead: Kevin Turner, Director of Finance, Procurement & Information**
5. Risk that the CQC quality concerns, identified in recent Compliance Reviews are not addressed.	i. Existing action plans developed and shared with CQC. ii. Governance sub-committee established dedicated process to oversee progress on the CQC action plans iii. New Governance Programme Board to be developed for Pilgrim site reporting to the Medical Director supported by additional on site capacity across the Governance functions. This includes strengthening of professional leadership. iv. Full Trust Board to receive regular reports from the Governance Committee **Lead: Dr David Levy, Medical Director**
6. Failure to secure the return of nursing and midwifery students to the Pilgrim Hospital site affecting future recruitment.	i. Agreement of joint action plan with the Universities ii. Regular meetings with the NMC to jointly assess progress against local action plans iii. Regular progress reports to the Trust Board **Lead: Sylvia Knight, Director of Nursing/Patient Services**