TFA Document

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

Tripartite Formal Agreement between:

- Mid Yorkshire Hospitals NHS Trust
- NHS Yorkshire and the Humber
- 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 – Chief Executive Officer
SHA – 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

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SHAs will be taken over by the National Health Service Trust Development Authority (NTDA)[1] when that takes over the SHA provider development functions.

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.

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

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

April 2014

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.

Julia Squire, Chief Executive, Mid Yorkshire Hospitals NHS Trust	Signature Date 28th September 2011
Bill McCarthy, Chief Executive, NHS Yorkshire and the Humber	Signature Date: 28th September 2011
Ian Dalton, Managing Director of Provider Development, DH	Signature Date: 29th 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.

Mike Potts, Chief Executive, NHS Calderdale Kirklees and Wakefield commissioning cluster	Signature Date: 28th September 2011

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Part 3 – NHS Trust summary

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

Mid Yorkshire Hospitals NHS Trust was established in April 2002, bringing together hospital services in Dewsbury, Pontefract and Wakefield. The Trust has a total annual income of £456m and serves a population of 550,000 people living in the Wakefield district and North Kirklees. It is also the provider of choice for some residents in bordering communities in Leeds and Barnsley. In 2010 the Trust expanded its portfolio to provide a range of community services including intermediate tier, therapy services and community ultrasound in Wakefield. The Trust also provides regional burns and spinal injuries and rehabilitation services. In April 2011, PCT provided community services in Wakefield integrated with Mid Yorkshire as part of the TCS programme.

The Trust's main commissioners are NHS Wakefield District and NHS Kirklees, which are part of the Calderdale, Kirklees and Wakefield District cluster.
In March 2011, the Trust completed the final phase of a major redevelopment programme involving the opening of two new PFI hospitals in Pontefract and Wakefield (Pinderfields) to complement the modern facilities at Dewsbury. This programme also included significant bed reduction and reconfiguration of Orthopaedic, Trauma, Neonatal, Intensive Care and Paediatric In Patient Surgical services which were the subject of consultation.

The clinical safety of the service configuration has been confirmed by the National Clinical Advisory Team which undertook reviews, most recently in July 2010. The outcome of this review was to confirm that services are currently clinically safe but that further rationalisation of services would need to be considered if they are to remain financially viable and clinically sustainable.
The Trust has unqualified CQC registration.

Financial data

	2009/10	2010/11
	Restated Accounts	Final Accounts / FIMS
	£m	£m
Total income	396	430
EBITDA	17.7	27.7
Operating surplus/(deficit) (normalised)	0.1	0.1
CIP target	26.7	37.6
CIP achieved – recurrent	11.2	22.0
CIP achieved – non recurrent	15.5	15.6

The CIP target for 2011/12 is £44m and £16m in 2012/13 and in recognition of the extent of this challenge a target of c£30m recurrent savings each year has been agreed as realistic, with a consequent need for £14m non recurrent support from the wider health economy in 2011/12. This element of the CIP is dependent on the delivery of transformation and reconfiguration plans.

The Trust's first full year of payment for the two PFI funded hospitals will amount to £38.8m – 9.1% of the Trust's 2010/11 income. Increases fixed in the contract at RPI increase CIP requirements disproportionately.

The Trust's strategic vision is to become an integrated care organisation offering effective, efficient, high quality care. This is underpinned by five key themes: integration of community services, increased productivity, partnership with other NHS and independent providers for clinical and non clinical services, rationalisation of hospital services, and divestment of services which are clinically and/or financially unsustainable.

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 / QIPP	☒
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	☒

Strategic and local health economy issues

- NCAT report 2010 recommended further review to ensure ongoing clinical and financial sustainability. Review undertaken April to Sept 2011 delivering 5 shortlisted options for pre consultation engagement in place with FTHEB, CCG leads and the Cluster. Options all involve significant reconfiguration to ensure delivery of clinical sustainability and financial efficiency. Road map developed defining key milestones.
- Transformational work streams with CCG leads began May 2011 health economy wide launch Nov 2011 to further address demand and redesign pathways .
- Strategic partnerships work underway – clinical review jointly commissioned with Barnsley FT with report due Nov 2011
- Clinical services strategy identified £7-9m savings of which £3m savings and clinical and performance benefits are not dependent on consultation process and could be realised in 12/13, however requires capital investment.
- Health Economy Foundation Trust Programme Board which includes all key stakeholders established and overseeing benefits delivery
- Integration of the community services acquisition completed in April 2011 and realisation of benefits underway
- Demand for services in Wakefield exceeds capacity and creates specific performance, pathway and financial challenges for the local health economy. Spare capacity in Dewsbury and Pontefract.
- Boundary issues are being discussed with Leeds and Barnsley to repatriate relevant patients and reduce A&E demand
- Clinical sustainability issues due to reduction in middle grade numbers
- SLA needs to ensure sufficient capacity in the system to meet demand to secure delivery of performance targets

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Financial issues

- Financial recovery plan being developed with commissioners to secure recurrent balance by end of 2012/13, based on £60m total CIP over the two years (8% p/a two years running). There is a requirement for £14m transitional support in 11/12
- Plan to be in recurrent balance during 13/14 subject to successful reconfiguration and transformation plans being delivered.
- PFI unitary payment equivalent to 9.1% of income increases annually creating added pressure.
- Liquidity issues will be managed through temporary borrowing requirement if necessary
- QIPP delivery and potential change in referral patterns following reconfiguration present financial risks to the Trust which are to be worked through with the Cluster in the second half of 11/12.
- Development of a coherent workforce plan and sustainable workforce remodeling that supports planned service reconfiguration and addresses issues such as significant variable pay and levels of absence is needed to ensure CIP delivery.

Quality and Performance

- The Trust is under-performing in three of the Monitor compliance target areas and has recovery plans in place which are on plan:
    - Referral to Treatment Time
    - Emergency care target
    - Stroke
- The Trust is experiencing particularly high emergency demand at its Pinderfields site since the new hospital opened, and capacity and demand are not aligned across the three sites.
- The Trust commissioned an external review of Obstetrics and the recommended actions needed are on target. All reviewed by CQC, cluster partnership and SHA as appropriate actions.
- The Trust Board is working with Deloitte and in April 2009 was reviewed against the Quality Governance Framework. The action plan from this review has been delivered and a follow up review has been commissioned for October.

Governance and leadership

- Board capacity and capability was independently reviewed in 2009. Changes have been made to the Chairmanship, membership and structure of the Board. Further development is under way.

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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)	☐

Strategic and local health economy issues

- Health economy wide transformation programme has been established to deliver the changes required in the current patient pathways, this is overseen by Health Economy Foundation Trust Programme Board (HEFTPB)

Quality

The MYHT board are overseeing a number of programmes of work to ensure that they are maintaining and improving the quality of care for patients. For example

- There is excess demand over planned capacity in new hospitals and patient flow changes following new hospitals commissioning causing operational pressures. Actions are in place to address these issues and SHA/Cluster visits have confirmed pressures and concluded no safety concerns and that the board to ward focus on quality and safety was evidenced. Since then other reviews including three by CQC have identified minor issues. Where concerns have been raised they have been actioned.
- Board leadership ensures that the work to improve HSMR is a priority.
- Stroke care has been supported by PCT investment (agreed July 2011). The action plan to deliver improvements is on target.
- Deloittes follow up review of Quality Governance against Monitor framework planned for Q3 2011.
- The Trust has worked with the Y&H quality observatory to conduct a piece of triangulation across all our inpatient adult experience data and recommendations will be implemented during 2011/12.
- The Trusts ongoing work to produce a clinical services strategy is being informed, shaped and led by clinicians to ensure quality and safely are at the forefront of any decisions made.
- Trust Board members undertake regular safety walk-rounds in clinical areas.

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Financial recovery

- Financial recovery plan to deliver £31.3m recurrent CIP (8%) in 2011/12 is in place and schemes to deliver £28m in place Sept 2011 (difference being met non recurrently)
- The Trust will require £14m transitional support in 2011/12 to meet break even duty.
- Additional measures to address in year overspend required and a paper detailing expedient measures has been agreed at MYHT September board meeting.
- Further workforce and non clinical opportunities identified in planning 2012/13 CIP, and route to delivery of 4/5% (national efficiency) for 2012/13 in place.
- Trust engaged with National PFI work undertaken by McKinsey's, now awaiting outcome. Trust has also commissioned review of its own PFI contract. Reports Nov 2011.
- All CIPs are risk assessed by the medical director and chief nurse and where appropriate include PCT cluster colleagues.

Performance

- Alongside agreement of the 11/12 Service Level Agreement recovery plans are in place to deliver and sustain performance in key areas: 18 week waits, emergency care, and stroke. Development of a sustainable SLA and delivery of Cluster demand management schemes will ensure capacity matches demand going forward.
- Delivery of emergency care targets predicated on A&E boundary changes and where this is not possible contingencies are being developed.

Governance and leadership

- Board development programme for 2011/12 scheduled with support from external consultancy. Includes skills/gap analysis and development sessions
- The requirement to further strengthen clinical leadership and management capacity and capability is recognised and underway.
- Vacancies arose in April for Director of Finance and Director of HR posts. Substantive appointments have been made in Q2 of 2011/12. Director of Operations/Deputy CEO post out to advert.
- Additional capacity to support skills transfer in performance and productivity improvement, strategy development, and financial management and leadership has been put in place as part of a Foundation Trust support package supported by the SHA and NHS Institute.

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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)	☒

- The SHA sits on the Health Economy FT Board and is providing both scrutiny and system leadership in ensuring local organizations agree and deliver the required programme of work together.
- The SHA is working with the cluster to ensure transitional support in place
- The SHA is supporting work to deliver a clinical service strategy including potential reconfiguration and partnerships
- The SHA is contributing to the national work on PFI and will work with the trust in resolving the outstanding PFI issues as a result of the national financial review
- The SHA is funding an FT support package and is keeping delivery and support under review
- The SHA to explore options re: capital support in order to draw down some early clinical and performance benefits from the clinical services strategy.

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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 term liquidity issues	☐
Current/future PFI schemes	☒
National QIPP work streams	☐
Governance and Leadership	
Board development activities	☐
Other key actions to be taken (please provide detail below	☐

A national financial review of Trusts with a PFI hospital is taking place to gain a common understanding of any issues that might be an obstacle to passing the financial elements of the FT assessment process.
Some elements contained within the TFA will be subject to the outcome of this review in enabling any issues outlined in this agreement to be resolved. This will be confirmed on a case by case as the PFI work is completed and communicated.

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

Date	Milestone
July 2011	SHA Review of Q1 Service and Financial performance - Action plan for Q2 agreed.
August 2011	Initial stakeholder pre-engagement on hospital services reconfiguration completed
September 2011	Hospital services reconfiguration emerging preferred options presented to MYHT and Health Economy FT Boards In year financial recovery plan agreed by MYHT Trust Board, Cluster Board & SHA Cluster/MYHT Winter Plan agreed with NHS Yorkshire & the Humber
October 2011	**SHA commissioned external review of progress towards FT** Options for hospital services reconfiguration presented to Cluster Board. Start of pre-consultation engagement. SHA Review of Q2 Service and Financial performance – Action/recovery plan for Q3 agreed Substantive Director of Finance in post. Quality Governance second stage of review commences
November 2011	Whole system transformation event Work programme commences to support development of other key strands of MYHT clinical services strategy – integration, partnerships, service development and divestment. SHA commissioned independent review completed Substantive Director of HR and OD in post
December 2011	Hospital service reconfiguration business case for single preferred option agreed by MYHT, Cluster and Health Economy FT (HEFT) Boards
January 2012	SHA Review of Q3 Service and Financial performance – Action/recovery plan for Q4 agreed Whole system transformation plan signed off by HEFT, Cluster and MYHT boards
February 2012	SHA SCAP (Service Configuration Assurance Process) of hospital services reconfiguration commences
April 2012	SHA SCAP of hospital service reconfiguration completed SHA review of Service and Financial performance – End of Year (Q4) Action/recovery First draft IBP and annual plan for 2012/13 agreed. 2011/12 CIP delivery on target against plan Contracts with Clusters aligned and signed off **Review with DH, SHA, Cluster and MYHT of FT project plan and options**
May 2012	Clinical service strategy public consultation commences (15 weeks) Public Consultation on FT begins SHA Board to Board (1)
June 2012	MYHT Quality Account sign off by MYHT Board Draft self-certification of compliance with Monitor Quality Governance Framework Board assessment and development plan completed
July 2012	Q1 All Service and financial performance targets fully delivered, SHA review
August 2012	Public consultation on Clinical Service Strategy completed,
October 2012	Clinical Service Strategy final report published and agreed by Cluster, MYHT and HEFT Board. Q2 All Service and financial performance targets fully delivered, SHA review
November 2012	Business case for Clinical Services Strategy signed off by MYHT and Cluster Boards Implementation Clinical Services Strategy phase 1 Board development review
January 2013	Q3 All Service and financial performance targets fully delivered Review self certification of compliance with the Quality Governance Framework Draft IBP and LTFM submitted to SHA
April 2013	HDD part1 Begin membership recruitment Contracts with Clusters aligned and signed off.

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September 2013	Final draft of LFTM and IBP submitted to SHA Board development review Q2 All Service and financial performance targets fully delivered, SHA review
January 2014	HDD part 2 SHA Board to Board (2)
April 2014	Submission to DH

Delivery of the key milestones will be monitored through the Health Economy FT programme Board HEFTPB), and the MYHT Trust Board.
Where it is anticipated that a milestone may not be achieved, this will be resolved by the project executive supporting the HEFTPB whose members will be informed. NHS Yorkshire and the Humber will be informed at the earliest opportunity of any potential for a milestone to be delayed or missed. If the matter cannot be resolved an urgent meeting of the HEFTPB will be held to agree action to resolve the issue.

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)

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Part 9 – Key risks to delivery

Risk	Mitigation
Ability to secure support from commissioners and stakeholders for service rationalisation/changes required to ensure long term financial viability	• External healthcare consultancy support to undertake work to inform the development of a clinical service strategy • Health Economy Programme Board to develop and agree clinical service strategy based on rationalisation • Work with neighbouring Trusts and other providers to develop reciprocal arrangements/partnerships for service development • Estates strategy to identify how to shift more services to community/primary care optimising use of clinical space
Impact of changes in commissioning arrangements unknown	• Engagement of GPs through provider governance arrangements and HE FT PB
Ability to resolve deficit projected for 2011/12 within the year	• Approved and quality assured financial recovery programme in place
SLA income insufficient to cover levels of activity	• Demand and production/capacity planning to better understand cost of delivering individual services • Roll out of service line management to inform planning • Improve operational planning skills • Ensure SLA income ensures sufficient capacity to meet demand • Review services that generate a negative contribution
Liquidity/cash position	• Necessity of a loan requirement for 2011/12 to be explored
Effectiveness of systems for performance management and performance improvement	• Comprehensive review of performance system underway. • Data quality strategy in place • Performance improvement plans in place system-wide
Inadequate controls in relation to under performance	• Operating agreements for Clinical Service Groups(CSGs) in place • Development of earned autonomy approach to devolved management through Foundation CSG programme. • Whole system performance recovery plans signed off across the health economy via the FT programme board.
Demand management	• Agree demand management targets with primary care to develop alternative ways of meeting demand • Work with commissioners to secure appropriate level of SLA income • Programme in place to reduce length of stay in acute setting • Pathway redesign involving primary and community care to avoid hospital admission and reduce length of stay
Ability to meet national and local targets, impacts on patient experience and /or quality, reputation and income (CQUIN)	• Health economy approach to demand management • QA process for CIPs/QIPP to assess quality impact • Continuation of HSMR reduction plan • Delivery of Quality Account priorities • Performance improvement plans for all areas of under-performance • Flexible use of resources to enhance ability to cope with peaks in demand • System re-design to reduce length of stay and increase efficiency • Pathway redesign to ensure optimum use of specialist

	hospital services • Develop options for more flexible use of capacity to manage peaks in demand • Development programme for building relationships with GP commissioning consortia. • Strengthening of management capacity & capability through internal development programme and interim management support • Strengthen management capacity & capability generally across the health economy to address the scale of transformational change likely to be required.
Insufficient resource within the health economy to meet demand	• Work with commissioners and partners through Health economy programme Board to agree priorities • Rationalisation of services based on clinical service strategy review