TFA document

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

Tripartite Formal Agreement between:

- Ipswich Hospital NHS Trust
- NHS East of England
- 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 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.

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

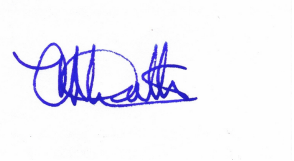
With Monitor

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 Reed (CEO of Ipswich Hospital NHS Trust)	Signature  Date: 25 March 2011
Sir Neil McKay (CEO of SHA)	Signature  Date: 31 March 2011
Ian Dalton Managing Director of Provider Development	Signature  Date: 7 July 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.

Dr Paul Watson (CEO of NHS Suffolk)	Signature  Date: 30 March 2011

Part 3 – NHS Trust summary

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

Required information

Current CQC registration (and any conditions): Full registration with no conditions

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

	2009/10	2010/11 Outturn
Total income	£226m	£233m
EBITDA	£17.2m	£15.2m
Operating surplus\deficit	(£5.3m)*	£1.26m
CIP target	£9.056m	£9.563m
CIP achieved recurrent	£7.946m	£6.066m
CIP achieved non-recurrent	£0.824m	£1.558m

*includes £8.6m MEA impairment surplus was £3.351m prior to impairment

The NHS Trust's main commissioners : NHS Suffolk

Summary of PFI schemes (if material):
The Trust has entered into a Private Finance agreement in respect of the provision of the Garrett Anderson Centre (GAC), which provides new Emergency Department, 22 bed Intensive Care facility, 40 elective surgery beds and 4 operating theatres with associated day case surgical unit.

The scheme has a capital value of £29.1m with the contract running from 28 March 2006 to 28 March 2036.

The annual unitary payment was £3.1m in 2009/10 comprising: Service element £630k; principal repayment £1,022k; interest on principal £1,066k, block maintenance £38k and contingent rent £334k. Annual depreciation is £645k.

Beds: 631 beds, (as of December 2010) in general acute, maternity, paediatric and neonatal services

Geographical area covered:
The Trust provides specialist ('secondary' or 'acute') healthcare to a core catchment population of approximately 356,000 people living in Ipswich and East Suffolk. Some of these services, such as midwifery, are provided in the community as well as in hospital, and as we develop closer working with local GPs we will see an increasing emphasis on providing services in this way. Our more specialised services, including vascular, spinal, radiotherapy and gynaecological cancer surgery, are provided to a population in excess of 500,000 within our extended catchment area covering West Suffolk, North Essex and Mid Essex.

Main commissioner (% of turnover) : NHS Suffolk (93.5%)

List previous FT applications

Date secured SHA Support: February 2010

Date secured Secretary of State Support: April 2010

Key decision dated. Monitor.
Initial Monitor assessment commenced: 13 April 2010
First postponement requested: 5 July 2010
Second Monitor assessment commenced: 13 August 2010
Monitor & Trust Board-to-Board: 5 October 2010
Second postponement requested: 4 November 2010
Third Monitor assessment commenced: 6 April 2011
Monitor made aware of two CQC moderate concerns; 28 April
Monitor and Trust agree to postpone Board to Board meeting due on 2 June: 27 May
Monitor to confirm new date for Board to Board meeting and Board decision making meeting (No Monitor decision making Board in August).

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	☐

Please provide any further relevant local information in relation to the key issues to be addressed by the NHS Trust:

Prior to being re-assessed, Monitor expects the Trust to have addressed all the issues in its postponement request letter (dated 18 Nov '10) and to have:

- Developed, implemented, embedded and audited compliance with appropriate processes and procedures to support good quality governance at the trust.
- Satisfied relevant external partners, including the East of England Strategic Health Authority, NHS Suffolk and the CQC that any financial viability or governance concerns have been addressed satisfactorily.
- Demonstrated current year financial performance consistent with maintaining a financial risk rating of 3 at, and in, the first year of authorisation.
- Reviewed the trust's base case in line with Monitor's implied efficiency guidelines.
- Agreed the scale, scope and detail of an appropriate mitigations plan that the Trust is prepared and ready to enact, with evidence of appropriate agreement with stakeholders.

<u>QIPP</u>
The Trust have provided input to the system QIPP plans in a number of ways:

- The Chief Executive and HR Director have both provided regular attendance at system QIPP meetings. This has enabled the Trust to contribute in terms of direction and detail to the work-streams and their potential impact on the Trust in terms of Quality, Productivity and Workforce.
- The Trust has been an active member of work-stream planning and governance meetings.
- The Trust has provided input from its own QIPP team (PIE) to ensure that projects running within the Trust are aligned and contributing to the overall system plans these references have been captured and embedded within the system QIPP plan.

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.

The Trust's quality priorities have been determined through a combination of sources. Significant time was invested to ensure that these reflected key patient safety measures, learnings from patient experiences, national clinical priorities, clinical audit and consultation with staff and users. There is clear engagement with Commissioners to drive continued quality improvement through CQUIN to meet local, regional and national goals.

The Terms of Reference of the Trust Board of Directors mandates the inclusion of quality performance at every Trust Board meeting. The Board receives monthly quality reports including vital elements such as Serious Incidents Requiring Investigation (SIRI) and complaints. The range of quality measures reported has increased significantly during 2010 through the development of a dashboard and narrative report for quality. This facilitates an increase in awareness of performance and encourages a high level of challenge by Board members along with members of the public attending public Trust Board meetings.

The Trust Board has a clear governance structure supported by sub-committees chaired by Non-executive Directors and operational groups. These groups also provide challenge and detailed review on quality performance. The Trust can demonstrate significant engagement of our Non-executive Directors at many levels of the organisation in order that they can observe at first hand the standards of healthcare being delivered to our patients. The Chairman and Board members undertake both announced and unannounced ward and department visits to speak to patients, carers and staff members about care delivered and received whilst in Ipswich Hospital.

The Board sub-committees, in particular the Healthcare Governance Committee (HGC) and Audit Committee provide scrutiny and assurance of quality to the Trust Board. The Healthcare Governance Committee, in conjunction with the Trust Management Team, has the responsibility to review data from its sub committees and the Risk Management Committee in order to identify trends and common themes that may anticipate areas of actual or potential risk.

There is sustained engagement of the Non-executive Directors in the SIRI process. This is demonstrated by attendance and involvement in Serious Clinical Incident Group (SCIG) meetings which are called to review and classify incidents and formulate action plans in order to ensure that the key learning points are implemented throughout the organisation. This supports the awareness of quality by members of the board.

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:

- Clarify 2010/11 year end position (Andrew Reed – March 2011)
- Clarify 2011/12 financial position and update LTFM (Andrew Reed – March 2011)
- Further year of detailed CiPs required (Andrew Reed – April 2011)
- Clarify estate plans and backlog maintenance (Andrew Reed – April 2011)
- Deliver C.Diff below ceiling for 2010/11 (Andrew Reed – March 2011)
- Maintain service performance and understand the impact of the new Monitor 2011/12 Compliance Framework (Andrew Reed –March 2011)
- Update self assessment under Monitor Quality Framework (Andrew Reed – March 2011)
- Continue to address and clear CQC concerns (Andrew Reed – July 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.

- Support the Trust through Monitor assessment (Steve Dunn – 2011)
- Participate in Monitor interviews with SHA and SHA/CQC (Steve Dunn – spring 2011)
- Share learning from QEHKL authorisation (Steve Dunn – April 2011)
- Run monthly PMR meetings with the Trust until they are authorised (Steve Dunn – ongoing)
- Monitor delivery of CQC action plan – monthly via PMR meetings – Steve Dunn
- Annual Plan review meeting – 6 May 2011 – Steve Dunn

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 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:

None

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

Date	Milestone
March 2011	Update LTFM and IBP (S Watson)
April 2011	Restart Monitor assessment (Andrew Reed)
August 2011	Deliver CQC action plan (Andrew Reed)
October 2011	Potential authorisation (Monitor)
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. Any missed milestone will lead to a Chair and CEO escalation meeting between SHA and Trust.	

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.

The agreed actions of all SHAs will be taken over by the National Health Service Trust Development Authority (NTDA)

Part 9 – Key risks to delivery

Risk	Mitigation including named lead
Delivery of 2011/12 financial plans	Trust / PCT discussion (CEO)
Develop two years detailed CIPs and downside mitigations	Work progressing at the Trust (Finance Director)
Review against Monitor Quality Framework	Review work with RSM Tenon (Nurse Director)
Address and clear CQC concerns	Delivery of Trust action plan (Nurse Director) PCT assurance (PCT Nurse Director) CQC note good progress (CQC)
Further Monitor delay	Monitor to run the Board to Board meeting and take a decision on the Ipswich application