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

Tripartite Formal Agreement between:

- George Eliot Hospital NHS Trust
- NHS West 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 – Kevin McGee, Chief Executive Officer
SHA – Ian Cumming, SHA Chief Executive
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

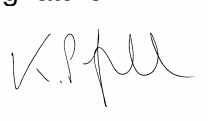
FT solution/status concluded by March 2013

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.

Kevin McGee Chief Executive George Eliot Hospital NHS Trust	Signature  Date: 28/09/2011
Ian Cumming Chief Executive NHS West Midlands	Signature  Date: 28/09/2011
Ian Dalton (Managing Director of Provider Development, DH)	 Signature Date: 29/09/2011

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.

Stephen Jones Chief Executive of Arden Cluster	Signature 

	Date: 28/09/2011

Part 3 – NHS Trust summary

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

Current CQC registration (and any conditions): Registered without conditions

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

	2009/10 £m	**2010/11**** £m
Total income	105.3	108.3
EBITDA	8.1	6.5
Operating surplus\deficit*	1.1	0.1
CIP target	3.3	3.2
CIP achieved recurrent	3.3	2.8
CIP achieved non-recurrent		

*Breakeven performance adjusted for impairments and IFRIC 12
**Based on final accounts

The NHS Trust's main commissioners The trust's main commissioner is NHS Warwickshire. NHS Leicester County & Rutland and NHS Coventry are the other two major commissioners

Summary of PFI schemes (if material) No PFI schemes

Required information
George Eliot Hospital NHS Trust is an integrated acute, community and primary care service provider comprising George Eliot Hospital in Nuneaton, 4 APMS primary care practices in north Warwickshire and a number of community services including Community Dental Services for Warwickshire and the Urgent Care Centre based at Leicester Royal Infirmary.

The acute services serve a resident population of 290,000 in Nuneaton & Bedworth, North Warwickshire and Hinckley & Bosworth, albeit with different levels of market share in each district. It also attracts referrals from North Coventry. It provides a comprehensive range of services with annual activity of 65,000 A&E attendances, 20,000 planned admissions, 19,000 emergency admissions, 160,000 outpatient attendances and 2,500 births. It was the first NHS Trust to win a primary care contract competitively to establish a new APMS practice from scratch. Following TCS, its 4 primary care practices will have total lists of 12,000 registered patients.

The trust had a historic deficit of £7.2M in 2005/06 now reduced to £2.6M. The total income in 2010/11 was £108.3 M. A break even position was achieved after 4 successive years of surpluses.

The trust's main commissioner is NHS Warwickshire. NHS Leicester County & Rutland and NHS Coventry are the other two major commissioners. The indices of multiple deprivation show that people within Warwickshire, Nuneaton & Bedworth and North Warwickshire experience the highest levels of deprivation in the County with the majority of wards being in the most deprived 25% nationally. There are high standardised mortality rates in Nuneaton & Bedworth and North Warwickshire for diseases such as CHD, Acute MI, Hypertension, Diabetes and Asthma where an integrated approach to providing healthcare across sectors will enable these long term conditions to be addressed.

In 2010/11, the trust received £4M of non-repayable financial support from NHS West Midlands. This income offset the impact of significant and unplanned demand management

reductions implemented by commissioners in the second half year and an exceptional injury benefit claim for a former employee settled by NHS Pensions.

The acute contract for 2011/12 reflects the health economy strategy of reducing acute expenditure and means that cost reductions will be required to offset this activity reduction in addition to general efficiency and delivery of a surplus consistent with a satisfactory financial risk rating. This is explained further in Part 4 below.

In the first quarter of 2011/12, the trust has achieved financial break-even in line with its phased plan and would be rated as green against the Monitor Compliance Framework.

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:

The trust had a deficit of £7.2M in 2005/06 and received a working capital loan of £6.8M in 2006/07. It achieved surplus of £1.0M- £1.4M in the period from 2006/07 to 2009/10. In 2010/11 it was set to maintain this performance. However, unplanned demand management action by NHS Warwickshire and reduced activity from NHS Leicester County & Rutland in the second half year led to elective income being reduced by £0.8M per month. It should be noted that this was not in accordance with the agreed contractual activity levels set in the 2010/11 contract. This caused a monthly deficit of £0.7M. NHS West Midlands allocated resources from its strategic change reserve because reducing acute activity is part of the commissioners' long term plans. The trust achieved break even with this support.

All providers in the local health economy are facing requirements to reduce acute expenditure and focus on prevention and admissions avoidance. The trust has agreed an acute contract with NHS Warwickshire for 2011/12 with income of £72.2M. This is around £1M greater than the contract outturn value for 2010/11 and is £1M lower than the plan for 2010/11. The total value of acute contracts for 2011/12 is £95M.The value of contracts for primary and community services is £6.8M. The aggregate impact of tariff efficiency, reduced activity, cost pressures and financial recovery to achieve a recurrent surplus requires significant cost reductions of around £11M (10% of income) in 2011/12. The trust will make final repayment of its working capital loan in 2011/12 and will achieve its cumulative breakeven duty the following year based on plans to achieve around 1% net margin.

The trust has acquired approx £6M of business under TCS including 3 APMS primary care practices and the county-wide community dental service for NHS Warwickshire, and hosting of the Urgent Care Centre for NHS Leicester City based at Leicester Royal Infirmary. Its total

community business is now around £6.8M including the existing APMS and services already delivered within the acute contract.

Delivery of the cost reductions is a significant task. The trust self-declared as being in turnaround in order to emphasise the urgency and scale of financial challenge it faces. It has set up a project management office using experienced NHS interim managers with director-level experience to drive forward the changes required over the next 18 months. Reductions in resources will not be at the expense of quality and patient safety and its cost improvement programme explicitly assesses clinical risks as well as delivery risks in respect of each project. Indeed the Trust is investing in additional nursing staff (£1.3M per annum) to improve the qualified to unqualified staffing ratios.

The trust has made significant improvements in quality over the period of financial recovery. Its HSMR has improved from 143 to just over 100. It has reduced C Difficile infections from more than one a day to an average of 3 per month in the last year and has not had an MRSA bacteraemia infection for 18 months. A recent "risk summit" involving NHS Warwickshire, NHS West Midlands and the Care Quality Commission concluded that there were no major quality concerns although a number of areas for continued improvement were agreed. The Trust recently had had two CQC visits. Firstly, as part of the national review of dignity and nutrition and secondly as part of a general compliance audit. Both visits identified that there were no significant areas of concern for the Trust.

The trust has had significant recent change in its executive directors. Both the Chief Executive and Medical Director have been replaced substantively and have been in post for the first quarter. The Director of Operations and Director of Nursing & Quality were appointed at the beginning of 2010/11. While the incoming Chief Executive is an experienced Chief Executive, these other directors are in their first executive appointments. However, both the Director of Finance & Performance and the Commercial Director have considerable board-level experience. An additional experienced director with previous commissioning and community services experience has joined the team on secondment to lead on major change projects. This team is now positioned to ensure the best outcome for the organisation's future.

The trust relies on partnerships to provide high quality local care and this would be an essential component for future health service provision. The recent SHA-led review concluded that it was highly unlikely from a clinical sustainability, patient, quality and financial sustainability perspective that the trust could exist as a standalone Foundation Trust in its present form. This position is supported by the board.

However, the SHA also concluded that the future form and the shape of clinical services should be measured against the needs of patients and a programme to clearly set out a clinical strategy is being led by the Arden Cluster. The strategy will cover the whole of Coventry and Warwickshire clinical services. The clinical model will be completed by January 2012 and be subject to consultation concluding in May 2012. The Trust recognises that in conjunction with all providers it will need to consider proposals for future clinical model changes that will be developed in a framework where access, quality, safety and sustainability will take precedence over organisational considerations, which may have a substantial impact on the configuration of services across the cluster and on the range of services commissioned from all individual providers in the cluster.

In parallel with the work on the clinical strategy, the George Eliot board will lead a process to establish its future organisational form. The trust Chief Executive will be the Senior Responsible Officer and will lead the Project Board. The project will follow a process based on the Treasury 5 Case Model to establish a clear strategy and full business case for the preferred option. The business case will take account of the outcome of the Arden Cluster clinical strategy. This may lead on to a competitive procurement process being undertaken if there is no clear option based on partnership with an NHS organisation. The Trust will be supported by professional advisers with relevant experience.

A number of possible options based on a strategic partnership are emerging including (but not limited to):

- A merger with another similar sized NHS organisation where GEH would be an equal partner in a joint organisation;
- merger with a larger FT, with GEH operating as a locally accountable subsidiary of a group;
- The formation of a partnership with an independent sector organisation;
- A Social Enterprise.

This project, while led by the GEH board, will operate within an overarching governance framework involving the SHA and the Arden Cluster. These three organisations will form a Project Assurance Board responsible for overseeing the project strategy and major milestones. Collectively, the Project Assurance Board is expected to agree any recommendations of the Project Board prior to proceeding to the next stage. The George Eliot board will remain responsible for leading each stage of the project unless following decision at the Project Assurance Board there has been agreement that subsequent stages will be led by the SHA.

In addition to the Project Board, there will be a Quality Assurance Group to ensure that key stakeholders including patients and staff can assure themselves that proposals made as project outcomes will ensure that service quality and safety are maintained.

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 board will continue to focus on the delivery of high quality, safe and efficient services working within the financial resources available. The Board will deliver the milestones and commitments agreed within the signed TFA.

The board considers a patient story at the start of each meeting. It receives a quarterly report from the matron for each clinical division. Board members also gain direct feedback on services through regular walk-abouts where they observe practice and discuss quality and customer service issues with patients, visitors and staff.

The board receives a detailed monthly quality report showing performance trends against key indicators that underpin its quality strategy *Best Care, Best Outcome*. The key elements of the strategy are: do no harm, apply best practice and create a memorable experience. Key indicators relating to do no harm include: infection control, monitoring of the deteriorating patient, falls, nutrition, pressure ulcers, medication incidents, never events, and mortality. Other indicators cover CQUIN targets, NPSA alerts, implementation of NICE guidance, patient experience feedback and survey results, complaints and medico-legal claims. The board also receives a monthly report on SIRIs and a half yearly report that summarises the key learning from such events.

The board has a well established quality and risk committee consisting of non-executive directors with all executive directors in attendance. This meets monthly and considers many of the above matters in detail. This committee also considers the Assurance Framework in detail and reviews the corporate and divisional risk registers.

Finally, the board receives reports on external peer review, commissioner and similar visits and considers the executive response to these. It also considers significant national reports on patient quality and safety such as the report on Mid-Staffordshire General Hospitals and the recent Ombudsman Report on care of elderly patients in hospital.

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 will continue to work closely with the Trust and the Arden Cluster to secure a sustainable future organisational form for George Eliot Hospital.

The SHA will chair the proposed Project Assurance Board which will provide assurance to the SHA and proposed NTDA (when formed). The SHA also be represented on the Project Board.

The SHA has provided financial resources to support the proposed project process (as outlined in Part 4 pg 7)

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:	

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

Date	Milestone	Responsibility
Sept 11	Commence project mobilisation. Procure project resources.	GEH
Sept 11	Establish framework for communication and engagement (subsequently incorporated into PID) and create initial narrative and key messages	GEH
29th Sept 11	GEH board approves Project Brief	GEH
Mid-Oct	Complete mobilisation. Approve Project Initiation Document (PID).	GEH
Nov 11	Complete Strategic Outline Case	GEH
Nov/Dec 11	Commence consultation on Paediatric & Maternity Services	Arden
Jan 12	Arden Clinical Model approved by boards and feeds into draft Outline Business Case	Arden
Feb/Mar 12	Agree healthcare contracts for 2012/13 onwards (subject to outcome of consultation on Arden Clinical Model)	GEH/Arden
Feb/Mar 12	Complete Paediatric & Maternity Services consultation and feed outcome into OBC	Arden
May 12	Complete Arden Clinical Model consultation and feed outcome into OBC	Arden
May 12	Complete Outline Business Case (subject to outcome of consultation on Arden Clinical Model)	GEH
June 12/Nov 12	Procurement/negotiation	GEH
Nov 12	Complete Full Business Case	GEH
Dec 12	Complete approvals	GEH
Jan 13/ March 13	Mobilisation/implementation	GEH/Partner
Apr 13	Project completion	GEH
	The milestones above assume that a competitive process will be followed. In the event that a preferred option of merger with an existing FT emerges at OBC stage, then the timescale may be shortened, subject to approval by Monitor.	

The SHA will be chairing the Project Assurance Board that will oversee delivery of the Project plan and key milestones.

Where milestones are not achieved, the existing SHA escalation processes will be used to performance manage the agreement.

Part 9 – Key risks to delivery

Risk	Implications	Mitigation	Lead Director
Delivery of financial turnaround and meeting required efficiencies	Trust is unattractive to potential partner organisations and choice of future options is limited or cost of implementation is increased	Establishment of PMO process has delivered short term success. 3 year CIP development will continue to be managed through PMO process	Chief Executive
Failure to maintain operational performance, quality and patient safety standards	Trust is unattractive to potential partner organisations and choice of future options is limited or cost of implementation is increased	Separate time allocation for key directors and managers involved in strategic change programme and focus of others on day to day operations The Trust Board are focussed on maintaining performance and the quality and safety of care	Chief Executive
Capacity and capability to undertake the project	Outcome does not meet the stated criteria or deliver value for money due to insufficient due diligence and analysis	Allocation of sufficient resources to ensure that key staff can be released to lead the work internally and specialist services bought in to support the programme	Chief Executive
Impact of project on quality and patient safety	Patient harm or deterioration of service quality due to strategic changes being proposed	Separate quality assurance group reporting to Governance Board	Director of Nursing & Quality/Medical Director
Lack of collaboration from potential partner providers	Limited options for future organisational model and potential reduction in value for money from final model	Early engagement and collaboration with potential partners to shape the options and develop the business cases (subject to not impairing subsequent competitive tendering)	Director of Finance & Performance
Withdrawal of partners resulting from due diligence work	Limited options for future organisational model and potential reduction in value for money from final model	Effective preparation for due diligence. Open and equitable access to information.	Director of Finance & Performance
Adverse public reaction	Loss of reputation and reduction in demand for services	Put in place public engagement and communications strategy working in conjunction with Cluster and SHA	Commercial Director/ Head of Communications

Risk	Implications	Mitigation	Lead Director
Adverse staff reaction	Loss of motivation, increase in staff turnover and inability to recruit	Put in place staff engagement and communications strategy; put in place effective organisational development and management of change processes	Director of HR/ Head of Communications
Inability to make key decisions due to risk that they will not be consistent with final model	Decisions on key investments such as capital, IT systems, contractual commitments are delayed and performance targets may not then be achieved	Redesign business case approvals process to evaluate and consider the implications of short vs. long term options and implications and demonstrate best value for money in context of strategic change. Involve potential partners in key decisions.	Director of Finance & Performance
Legal challenges to process	Process stopped due to challenge/ judicial review and/or additional expenditure incurred	Follow best practice guidance on stakeholder engagement process. If necessary appoint legal advisers at an early stage	Director of Finance & Performance
Final organisational model Is not authorised as an FT	Trust remains in a clinically or financially non-viable state and there is further risk to service delivery and quality	Appointment of professional advisors to ensure a successful outcome. Following the treasury 5 Case model with gateway reviews to ensure robust outcomes at each stage. Engagement with DH and Monitor on evolving options.	Director of Finance & Performance