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

Tripartite Formal Agreement between:

- Worcestershire Acute Hospitals 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 – 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

Submitted to DH May 2009 ***(currently deferred with Monitor – Reactivation planned for August 2012)***

Part 2a - Signatories to agreements

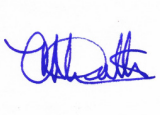
By signing this agreement the following signatories are formally confirming:

- 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.

Name, Job Title (Interim CEO of NHS Trust) Dr Mark Goldman, Interim Chief Executive	Signature  Date: 30 09 2011

Name, Job Title (CEO of SHA) Ian Cumming, OBE, Chief Executive	Signature  Date: 30 09 2011

Name, Job Title (Ian Dalton)	Signature  Date: 30 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.

Name, Job Title (CEO of Lead commissioner) Eamonn Kelly, Chief Executive	Signature

	 Date: 29 07 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): Worcestershire Acute Hospitals NHS Trust is registered with CQC with no conditions. Having received a CQC inspection in March 2011 indicating concerns with Privacy, Dignity and Nutrition on 2 medical wards, an action plan has been put in place resulting in a follow up report which now shows full compliance

Financial data (figures for 2011/11 should to be based on latest forecast).

	2010/11 £m	**2011/12** £m
Total income	321.8	320.4
EBITDA	24.5	24.0
Operating surplus\deficit *	0.3	0.0
CIP target	10.6	15.0
CIP achieved recurrent	10.6	15.0
CIP achieved non-recurrent	0	0

**-Operating surplus / deficit adjusted for the impact of IFRIC 12 and impairments*

The NHS Trust's main commissioners: NHS Worcestershire

Summary of PFI scheme

The Worcestershire Royal PFI site was opened in 2002. It is a 30 year contract which included the construction and initial financing of the facility as well as the ongoing provision of a comprehensive facilities management service. The annual unitary payment in 2010/11 was £25.5m, the equivalent of 8% of total Trust turnover. The existence of the PFI means that the Trust is unable to meet the Monitor Tier 1 Prudential Borrowing Limit requirements, and as such would require a Tier 2 Prudential Borrowing limit

Further information

Worcestershire Acute Hospitals NHS Trust was formed on 1 January 2000 following the merger of Worcester Royal Infirmary NHS Trust, Kidderminster Healthcare NHS Trust, and The Alexandra Healthcare NHS Trust. The Trust comprises of the Alexandra Hospital, Redditch (AGH), Kidderminster Hospital, Kidderminster (KH) and Worcestershire Royal Hospital, Worcester (WRH).

The Trust serves a base population of approximately 550, 000 in the main centres of Worcester, Redditch and Wyre Forest providing a wide range of secondary care services. Its main accident and emergency departments on the AGH and WRH sites and a Treatment Centre and Minor Injuries Unit on the KH site.

A comprehensive range of emergency and elective services are currently delivered across the two hospital sites of Worcester Royal Hospital (WRH) and Alexandra Hospital (AGH) including inpatient, day case and outpatient and diagnostic services. A more limited range of emergency and elective services are delivered from the Kidderminster Hospital (KH) site, including MIU, rehabilitation, short stay surgery and a range of outpatient and diagnostic services.

The Trust has one main commissioner, NHS Worcestershire, which provides 90% of the contract income for patient services and which acts as the co-ordinating commissioner for a number of smaller commissioners.

Since the amalgamation of the former PCTs into a single Worcestershire PCT in 2006, the Trust operates largely the same geographical boundary as both NHS Worcestershire and

Worcestershire County Council making for easier, far more effective partnership and joint working arrangements.

Community services (breast screening, surgical services at Evesham and Tenbury Community Hospitals, GP ward at Kidderminster Hospital (KH) and some specialist nurse teams) to the value of £7m transferred to the Trust as part of Transforming Community Services (TCS) on 1st July 2011. These are not of significant size in relation to the Trust's turnover and thus not expected to cause any material challenges.

The total annual income for the Trust during 2010/11 was £321.8m and a small surplus of £0.3m was delivered before impairments and the impact of IFRS.

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:

There is a recognised need to work more closely with the three Clinical Commissioning Groups as well as the West Mercia Cluster on options for a more coherent configuration of services across the county. This will ensure continued quality and safety as well as the best use of resources. The Trust and its main commissioner have agreed to jointly commission a strategic review of the current configuration of acute services which will form the foundation of the Trust's clinical strategy, underpinning its Integrated Business Plan. The appointment of a new Director of Strategy in October 2011 will be a key driver to commence the scoping work around process and timetable

The Trust has more recently experienced significant challenges in achieving the emergency access standard of a maximum 4 hour wait and received a performance notice in June 2011. The Trust is working closely with its partners in the local health economy to resolve patient flow. The Trust's action plan has been revised and refocused to ensure turnaround of the position.

The Trust's financial position is challenging. The Trust planned for a revenue surplus of £1.8m in 2010/11 but this was revised to break even, following in year cost pressures and slippage in savings plans. The Trust finally achieved a small surplus in 2010/11 of £0.3m, following the additional income of circa £6m from NHS Worcestershire in respect of additional activity delivered. Due to the reliance on additional support, the Trust received an 'except for' value for money opinion from its external auditors, albeit with a recognition that Trust Board have now responded appropriately.
The Trust's financial plan for the next 3 to 4 years focuses on bringing the Trust back into recurrent revenue surplus. Given the unmet savings plans carried over into 2011/12 coupled with the need to meet a 4% tariff deflator, the Trust Board has approved a plan to breakeven in this financial year, before moving into surplus in 2012/13. The Trust has agreed a contract

package with the PCT that includes some transitional support in 2011/12, to mitigate risks around service changes and delays in reducing semi fixed and fixed costs.

The Trust's most significant financial challenge is in liquidity, evidenced by an individual Financial Risk Rating score of 1. This is a legacy issue resulting from historic accumulated deficits that have not been eliminated. The net cumulative deficit of the Trust as reported within its 2010/11 financial accounts is £18m. It is worth noting that the Trust did receive a working capital loan for £25m from the Department of Health (DH) in March 2007 with a 5 year repayment period commencing 2007/08. The £20m repayment to date has been met through a combination of financial surplus and working capital movements, which has led to some difficulties in operational cash management. The final loan repayment of £5m is due in 2011/12, although due to fact that a breakeven position is forecast, the Director of Finance is in discussion with the SHA regarding the options for handling the liquidity impact on the Trust. Whilst the Trust plans to move to financial surplus from 2012/13 and intends to realise value from its asset base, the legacy cash deficit means that the Trust has limited headroom with which to mitigate material downside risk. This will need to be addressed as part of the Trust's application.

A Department of Health (DH) commissioned 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. Initial feedback from the DH review has not highlighted any additional issues, therefore the existence of a PFI is not expected to be a major obstacle to achieving FT status.

There have been significant Board changes in the Trust with the appointment of a new Chairman in November 2010 (previously a Non Executive Director (NED) since October 2008), four new NEDs appointed in January 2011 and a new Director of Finance commenced in May 2011. In addition, the Chief Executive retired at the end of July 2011. Interviews for a replacement are scheduled for September with a likely start date early in the new calendar year. The post will be covered in the interim by an experienced former Foundation Trust Chief Executive. The Trust has also recently seconded a consultant into the newly created post of Director of Patient Safety for a period of 6 months and has appointed a Director of Strategy commencing in the Autumn. Given the amount of change, Board Development will be a critical success factor for the Trust. This has already commenced with the assistance of an experienced facilitator, and will be enhanced further early in 2012, once the new Trust Board is complete.

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.

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:
The Board gets assurance that it is maintaining and improving quality of care for patients through a number of means:

- Patient safety is the board's number one priority. The Board made a public pledge that it will not compromise patient safety for financial balance. This has been further strengthened by the recent appointment of a Director of Patient Safety.
- Quality performance indicators are reviewed at Board meetings. Robust action plans are presented to address any performance issues.
- Quality performance indicators are monitored in the intervening months between Board meetings via the governance route through to the Board's Quality Assurance and Scrutiny Committee (QASC).
- A QIPP Board has been established which ensures that Quality Impact Assessments are in place which are screened by senior clinicians.
- Board directors and shadow Governors undertake Patient Safety walkrounds.
- Board directors undertake PRIDE walkrounds to ensure that staff live the Trust's values:
  Patients at the centre of all we do
  Respect everyone
  Involve stakeholders in our work
  Deliver safe effective services
  Efficient use of resources
- Patient safety is the first item on the Board agenda and the Board receives a patient story at each meeting.
- Patient experience and results from surveys are monitored by QASC. Results of national patient surveys are reported to the Board.
- Ensuring that issues arising the complaints process are dealt with and understood at ward / department level.
- The Trust will now be self assessing itself against Monitor's Quality Governance Framework to ensure our governance processes match best practice.

CQC registration : Worcestershire Acute Hospitals NHS Trust is registered with CQC with no conditions. Having received a CQC inspection in March 2011 indicating concerns with Privacy, Dignity and Nutrition on 2 medical wards, an action plan has been put in place resulting in a follow up report which now shows full compliance
Lead: Helen Blanchard Director of Nursing & Midwifery
Delivery Date: July 2012

Financial
The Trust's key financial priorities are:

- Robust contract monitoring and referral management to ensure that the Trust delivers the targets set out in the contract (Ongoing)
- The savings programme is a key organisational priority. This is being overseen by the QIPP Board which is led by the Trust Chairman with non executive and executive membership. The QIPP Board scrutinises the savings plans with a particular emphasis on quality impact assessments. External Advisors, Deloitte, have been appointed to support the delivery of the savings target (Ongoing).
- The Board to actively manage performance through regular performance reviews of the divisions (April 2011).

- Further embedding of SLR via the Deloitte contract(Sept 2011)
- Improvement in liquidity through delivery of savings targets from 1st April, and cash mitigation strategies (from April).
- Update of LTFM to reflect 2010/11 out turn, TCS, QIPP plans and a revised downside scenario ensuring the plans demonstrate financial viability (July 2011)
- Identification of downside scenarios and mitigation strategies to bring into play should slippage on savings occur (June 2011)

Lead: Chris Tidman, Director of Finance / Deputy Chief Executive
Delivery Date: (March 2012)

Performance

A & E access standards:
Embed the monitoring and delivery of revised quality indicators.
The Trust supports the principle of the change from the total waiting time in A&E to a broader range of quality indicators. This has been embedded into performance monitoring from July 2011. The Trust is now working closely with its health economy partners to ensure that it can meet its trajectory to meet contractual targets.
Lead: Frances Martin, Hospital Director (AGH)
Delivery date: July 2011.

Governance & Leadership
Implement a comprehensive and intensive board development programme.
- Non Executive Director Inductions (local & national) – completed by February 2011
- External facilitated board development – from May 2011
- Foundation Trust application development – from September 2011
- Appointment of new Director of Strategy to lead on QIPP

Lead: Tosca Fairchild, Trust Secretary
Delivery date: (see above)

Workforce

Ensure the transformation of the Workforce to meet the CIP programme and QIPP.
Workforce transformation and reductions in costs are a key component for achieving the Trusts financial objectives. The PCT's commissioning strategy aims to achieve £60m savings through QIPP with a 120-150 reduction in beds over the next 3 years. This will have a direct affect on workforce numbers. We will:

- *Continue to ensure through the QIPP board workforce reduction plans do not put patient safety at risk.*
- *Review workforce projections in light of feedback from the September workforce return, progress with QIPP schemes and progress with the PCT demand management schemes and commissioning plans (October 2011)*
- *Identify as part of the downside scenarios and mitigation strategies any implications from slippage on savings and/or demand management schemes not fully delivering. (October 2011)*
- Work with the SHA on the next iteration of the workforce plan (in preparation for the FT application), and refine as necessary. (September 2011)

Lead: Jeff Crawshaw, Director of Human Resources & Organisational Development
Delivery date: October 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 will continue to work with the Trust to support and monitor delivery against its financial and quality performance against the key milestones identified

The SHA is contributing to the national work on PFI and will work with the Trust in resolving any outstanding PFI issues as a result of the national financial review.

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:

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.

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

Date	Milestone
Quarter 2 2011/12	TFA to July Trust Board & SHA
Quarter 2 2011/12	Formally agree deferral with Monitor – Aug 2011
Quarter 2 2011/12	Agree A&E action plan and trajectory for delivering the 4 hour target and the 5 Quality Indicators
Quarter 2 2011/12	Plans in place to deliver QIPP to meet breakeven duty
Quarter 3 2011/12	Trust strategy developed and agreed by the Trust Board.
Quarter 3 2011/12	Self Assessment against Monitor Quality Governance Framework and action plan agreed
Quarter 3 2011/12	New Director of Strategic Development to start in post / Strategic Review of Acute Configuration to be jointly commissioned by Trust and PCT
Quarter 3 2011/12	Revised LTFM to be developed as part of mid year financial review
Quarter 4 2011/12	New Chief Executive to start in post
Quarter 4 2011/12	Deliver financial plan
Quarter 4 2011/12	Deliver Quality Account indicating compliance with Monitor Quality Governance Framework
Quarter 4 2011/12	Ensure the Trust is delivering against its performance framework and has action plans to mitigate risk on under delivery.
Quarter 4 2011/12 to Quarter 1 2012/13	Begin stakeholder engagement work on commissioner led service reconfiguration plans.
Quarter 4 2011/12 to Quarter 1 2012/13	Board Development work on FT preparation
Quarter 1 2012/13	Updated LTFM post completion of contract negotiations and budget setting.
Quarter 2 2012/13	SHA Quality Review visit
Quarter 2 2012/13	Final IBP & LTFM and self certificates signed off by Board and Quality assured by SHA
Quarter 2 2012/13	Board to Board with SHA
August 2012	Reactivate application with 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 slippage on CIP delivery to be recovered through additional cost controls.

The SHA will follow the normal escalation route if a key milestone is missed and no improvement made.

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 formally has the authority).

Part 9 – Key risks to delivery

Risk	Mitigation including named lead
Financial delivery	• Programme Management approach to savings delivery. • Performance management framework and accountability for financial management. • Focus on cost control. • Use of corporate mitigation strategies as required. • Cash management strategies and mitigations to improve liquidity. • Further development of organisational wide financial management capability **Lead:** Chris Tidman, Director of Finance
Quality performance	Delivery of emergency access targets are reliant not only on operational focus and delivery within the Emergency Departments and the wider hospital system, but also on the supporting infrastructure in place to offer alternatives to A & E attendance and also discharge pathways to free up acute bed capacity,. Risk mitigated through: • Clear action plan with timelines, escalation trigger points and accountabilities • Weekly health economy meetings focussed on performance data and ensuring best practice is being applied. • Close working with Adult and Community Services and primary care to ensure timely discharge and the availability of appropriate community, residential and nursing home facilities for rehabilitation and longer term care. • Development of ambulatory care pathways to minimise inpatient admissions and facilitate care closer to home **Lead:** Lisa Davies Jones, Hospital Director (WRH & KH) and Frances Martin, Hospital Director (AGH)
Service reconfigurations	Service reconfiguration may bring a risk to the continuity and effectiveness of service delivery. Mitigated through: • The use of evidence-based practice and improving outcomes guidance when deciding on the configuration of services. • Robust project planning to include risk assessment and the development of standard operating procedures. Any reconfiguration of inpatient services may be subject to wide consultation which may delay implementation. This will be mitigated through development and implementation of a communication strategy to ensure full engagement of stakeholders.

	Lead: Director of Strategy