TFA Document

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

Tripartite Formal Agreement between:

- Hull & East Yorkshire Hospitals NHS Trust
- NHS Yorkshire & 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 SHAs will be taken over by the National Health Service

TFA Document

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.

TFA Document

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

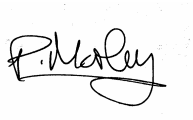
January 2012

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.

Phil Morley, Chief Executive, Hull & East Yorkshire Hospital NHS Trust	Signature  Date: 26 May 2011
Bill McCarthy, Chief Executive, NHS Yorkshire & the Humber	Signature  Date: 26 May 2011
Ian Dalton, Department of Health	Signature  Date: 6th 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.

Chris Long, Chief Executive, NHS Hull	Signature

TFA Document

	 Date: 27 May 2011

Part 3 – NHS Trust summary

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

TFA Document

Required information

Current CQC registration (and any conditions):

The Trust has unqualified CQC registration.

Financial data (figures for 2010/11 should be based on latest forecast)
Note: financial date should not be the normalised position

	2009/10 £000	2010/11 £000
Total income	469,995	472,962
EBITDA	32,599	29,396
Operating surplus\deficit	7,601	4,701
CIP target	17,479	21,000
CIP achieved recurrent	12,776	14,060
CIP achieved non-recurrent	3,935	3,462

The NHS Trust's main commissioners are NHS Hull and NHS East Riding of Yorkshire.

Summary of PFI schemes: Three PFI schemes in operation; non are significant.

Trust Profile:

Hull and East Yorkshire Hospitals NHS Trust is one of the largest Trusts in the UK and is situated in the geographical area of Kingston upon Hull and the East Riding of Yorkshire.

The Trust was established in October 1999 through the merger of the former Royal Hull Hospitals and East Yorkshire Hospitals NHS Trusts. The Trust employs approximately 7,135 WTE staff (8,805 people) as at January 2011, has an annual turnover of £473 million (2010/11), and operates from two main sites; Hull Royal Infirmary and Castle Hill Hospital.

The Trust is a:

- cancer centre;
- cardiac centre;
- major trauma centre;
- tertiary / specialist centre;
- university teaching hospital; and,
- the major NHS partner in the Hull York Medical School.

The Trust's secondary care service portfolio is comprehensive, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are primarily provided to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The Trust also provides a number of specialist services to a catchment population of between 1.05m and 1.25m (varying by service) in a broader geographical area extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in Lincolnshire. The only major services not provided locally are transplant surgery and some specialist paediatric services.

The Trust is a major partner in the Hull York Medical School. It provides a comprehensive range of clinical teaching, training and development, and is expanding its research and development programmes, building on its international reputation in key areas (e.g. cardiology). In recognition of its role, The Trust will incorporate 'university' into its new name at the time it achieves authorisation as a Foundation Trust.

Part 4 – Key issues to be addressed by NHS trust

Key issues affecting NHS Trust achieving FT

TFA Document

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:

Service reconfiguration - The Trust's longer term strategy for clinical services will need to respond to regional reviews of clinical services. Service reviews may lead to new models of delivery that respond to the need to deliver care in different settings whilst maintaining quality and cost effectiveness. In some instances work will also come to the Trust from smaller local hospitals e.g. vascular centre status.

Local health economy sustainability issues – Cost effectiveness of services provided by the Trust are likely to be challenged as QIPP plans evolve. New commissioner arrangements will consider alternative providers and service models where quality and efficiencies are improved. Trust service delivery and development plans will need to respond to these pressures, ensuring the Trust is able to bid effectively to retain services as appropriately.

Contracting arrangements - The Trust needs to review its workload model against PCT expectations and set out the basis for its assumptions, ensuring these demonstrate reconcilability with PCT plans.

Level of efficiencies - An average annual 4% efficiency requirement will exist throughout the period of the LTFM. In addition, the earlier years of the plan have a greater target to improve the Trust's baseline financial position, improving its underlying income and expenditure performance and supporting an improved cash position. An assessment of the impact of QIPP will be made by the Trust and included within the LTFM.

Other Capital Plans and Estate issues - The Trust will need a strategy to ensure capital resources are sufficient to meet the organisational demand. It will be necessary to have an appropriate approach to investment decision making and risk management and to explore new sources of finance, possibly through partnership working.

Working Capital and Liquidity - The medium term plan will start to generate cash surpluses. It is assumed some of this will be required to support capital expenditure, with the balance required to fund capital items and improve the Trust's liquidity. The Trust may not be able to progress planned capital expenditure due to lack of availability of cash. Included within the

TFA Document

liquidity risk rating is the assumption that the Trust will have a £37m working capital facility. This is equivalent to 30 days operating expenditure.

QIPP – The Trust has recognised the need exists to have further dialogue with PCTs in relation to there QIPP proposals and recently updated medium term planning assumptions in order to ensure the Trust's planning assumptions are robust.

Quality and clinical governance issues - Whilst HEYHT can demonstrate good improvement over the last 18 months, there is a risk that this does not translate quickly enough into visible results on national indicators (HSMR/Patient & Staff Surveys). Current trajectory would mean that 2010 survey results would inform DH application and not necessarily reflect the improvements made. It is also anticipated that the 2011 results will be available to inform the Monitor stage of the process.

Service performance issues – Current position of non-compliance with regulatory standards and quality governance indicators.

- Cancer 62 day target continues to be a challenge. *Mitigating action* – Intensive Support Team recently invited to advise Trust on specific specialties. A shared breach protocol has been agreed with neighbouring trusts to reduce the adverse impact of late referrals. Recent significant improvement in lung and urology pathways needs to be sustained; alongside a robust delivery plan to secure achievement of the 62 day target month on month going forward.

- MRSA target of 10 for 2010/11 has been exceeded by two – The Trust recognises at least 7 of these were avoidable and is taking action accordingly.

- Referral to Treatment Time – Validation work is ongoing to determine the scale of challenge in addressing the small cohort of backlog patients to be treated. Approach involves "flow in – flow out" process of review. Sustained delivery of new 18 week RTT targets secured from April 2011.

TFA Document

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.

Organisational Change – The Trust has recently agreed and commenced a restructuring at operational level. This will result in the operational Healthcare Groups having a medic as the accountable officer supported by a Director of Nursing and Director of Operations.

Organisational Development – The Trust has recently appointed a Head of Organisational Development and will develop an organisational development/leadership agenda that is being personally driven by the Chief Executive.

CRES –2011/12 The Trust has a CRES programme target of £23m with a "stretch target" of £25m.At this level it presents a significant challenge. Action to ensure delivery include:

- Improved governance arrangements and organisational restructure
- Investment in developments will only be approved if efficiency savings are in place
- Enhancing CRES target to create a contingency reserve
- Developing a workforce strategy that sets out how the workforce will be remodelled and changed over the coming years based on a productivity and efficiency metrics.
- External support to assist in the completion of process for 2011/12 and subsequent years
- Delivering additional work at marginal cost
- Going forward the Trust is intending to structure its CRES programme in such a way as to more directly link it to its strategic objectives and with medium term resource assumptions

Other capital and estate plans – potential for failure to maintain assets or introduce delays to schemes in capital programme. Action includes:

- Maintaining financial performance
- Reviewing and updating of Trust Estate strategy
- Strengthened approach to investment decision making and risk management.
- Strengthening of equipment prioritisation process

Local / Regional QIPP - Commissioners may not want to fund the activity levels identified in Trust plans. Action includes:

- Maintain strong relationships with commissioners
- Trust will demonstrate reconcilability with PCT financial plans and QIPP programmes

Service Performance - Non-compliance with Monitor key targets. Action includes:

- New Performance Management Framework developed.
- Improved monitoring of 62 day cancer pathway and re-establishment of Cancer manager position.
- Revisions to patient pathways to ensure diagnosis and treatment undertaken within permitted timescales.
- Workshop arranged to increase understanding and operational management requirements for sustaining 18 week standards.
- Individual service plans developed to strengthen 18 week performance.
- Focussed action to minimise the risk of avoidable MRSA cases.
- Early consideration of the implications and actions required to deliver new national A and E performance indicators

Quality and clinical governance – ensure compliance with the Monitor Quality Governance Framework. Action includes:

- External assessment of Trust as measured against Monitor's Quality Governance Framework. Action plans will be established from findings and recommendations together with regular Board level monitoring and review.
- Implementation of recently commissioned Mortality Reduction Action Plan
- Trust to develop a Patient Safety Strategy and continue to pursue effectiveness measures e.g. care of the deteriorating patient

Board Development - High level of turnover of NEDs plus lack of knowledge amongst newer NEDs of IBP/LTFM; and changes to Executive Directors and their portfolios. Action includes:

- Board development programme including external support and both individual and collective coaching, building on the external Board assessment process
- Formal meetings of Executive Directors and a series of Executive Director time outs to build understanding of roles and delivery of the agenda

TFA Document

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.

Secure representation from the Trusts commissioners – as a minimum the cluster commissioner will be represented – at future FT trajectory monitoring meetings. The QIPP for the main commissioner is understood; however, a greater degree of clarity and level of shared understanding of the impact of QIPP plans across the cluster needs to be secured.

Continue to support PCTs and NHS organisations across the region to work together to make resources available to support short and medium term challenges (e.g. liquidity/working capital) within different local health economies.

Facilitate discussion between Medical Directors at Trust, SHA and DH level to secure better understanding of quality assurance process as FT trajectories progress.

Ensure all aspirant foundation trusts are kept aware of and fully engaged in the developing FT assurance process; including the outcome of the current Monitor consultation on a new compliance framework.

TFA Document

Part 7 – Supporting activities led by DH

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

TFA Document

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

Date	Milestone
July 2011	Draft IBP/LTFM, excluding downside scenario submission to SHA
August 2011	Final Draft IBP/LTFM to SHA
October 2011	Quarter 2 delivery of: - Overall Financial Plan including CIP to date - Quality & Safety Milestones - Compliance Framework Performance HDD Part 2 Board to Board
November 2011	Quality Governance Framework – Self Certification
December 2011	Mth 8 Performance - Overall Financial Plan including CIP to date - Quality & Safety Milestones - Compliance Framework Performance SHA Board Approval
January 2012	Formal Application to DH
March 2012	Monitor Phase

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

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

NHS Yorkshire and the Humber will be informed at the earliest opportunity of any potential for a milestone to be delayed or missed.

The SHA will arrange an urgent meeting with the trust to understand the position, assess the risk, and agree the remedial action necessary to avoid or minimise any delay.

In the unlikely event a delay is absolutely unavoidable the remaining milestones will be reviewed, with key events brought forward as necessary, to secure delivery of the FT application for the agreed DH submission date.

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

Part 9 – Key risks to delivery

Risk	Mitigation including named lead
Organisational Change – The Trust has recently commenced restructuring at the operational level supported by a leadership development strategy.	• The operational Healthcare Groups will have a medic as the accountable officer supported by a Director of Nursing and Director of Operations. • The Trust has recently appointed a Head of Organisational Development and will develop an organisational development agenda that is being personally driven by the Chief Executive. **Chief Executive**
CRES – 2011/12 CIP programme £25m provides significant challenge	• Improved governance arrangements and organisational restructure • Investment in developments will only be only approved if efficiency savings in place • Enhanced CRES target to create contingency reserve • External support to assist in the completion of process for 2011/12 and subsequent years • Deliver additional work at marginal cost • Workforce strategy that sets out how the workforce will be remodelled and changed over the coming years. • CRES to be more directly linked to Trust's strategic objectives and to take into account medium term resource assumptions **Director of Finance and Business**
Other capital and estate plans – potential for failure to maintain assets or introduce delays to schemes in capital programme.	• Maintain financial performance • Review and update of Trust Estate Strategy • Strengthened approach to investment decision making and risk management • Strengthening of equipment prioritisation process **Director of Infrastructure and Development**
Local / regional QIPP - Commissioners may not want to fund the activity levels identified in Trust plans.	• Maintain strong relationships with commissioners **Chief Nurse/Deputy Chief Executive** • Trust will demonstrate reconcilability with PCT financial plans and QIPP programmes **Director of Finance and Business**
Service Performance - Non-compliance with the 62 day cancer target	• New Performance Management Framework developed. • Improved monitoring of 62 day pathway and re-establishment of Cancer Manager position. • Revisions to patient pathway to ensure diagnosis and treatment undertaken within permitted timescales. **Director of Quality, Safety and Operational Delivery**
Service Performance – Delivery of new national A and E quality performance indicators	• Early consideration of the implications and actions required to deliver new national A and E quality performance indicators **Director of Quality, Safety and Operational Delivery**

TFA Document

Service Performance - Failure to achieve thresholds for 18 week referral to treatment times for admitted and non-admitted pathways.	• New Performance Management Framework developed. • Workshop arranged to increase understanding and operational management requirements for achieving 18 weeks standards. • Individual service plans developed to sustain 18 week performance. • Referral to Treatment Time Approach involves "flow in – flow out" process of review **Director of Quality, Safety and Operational Delivery**
Service Performance - MRSA Bacteraemia – Failure to meet the MRSA objective	• New Performance Management Framework developed. • Focused action to minimise the risk of avoidable MRSA cases **Medical Director**
Quality and clinical governance – need to achieve a score of above 4 on the Monitor Quality Governance Framework	• External assessment of Trust as measured against Monitor's Quality Governance Framework. Action plans will be informed by findings and recommendations with regular Board level monitoring and review. **Chief Nurse and Deputy Chief Executive** • Implementation of recently commissioned Mortality Reduction Action Plan **Medical Director** • Trust to develop a Patient Safety Strategy and continue to pursue effectiveness measures e.g. care of the deteriorating patient, **Chief Nurse and Deputy Chief Executive**
Board Development - high level of turnover of NEDs plus lack of knowledge amongst newer NEDs of IBP/LTFM; and changes to Executive Directors and their portfolios	• Board development programme including external support and both individual and collective coaching, building on the external Board assessment process **Chairman** • Formal meetings of Executive Directors and a series of Executive Director time outs to build understanding of roles and delivery of the agenda **Chief Executive**
Unable to adapt workforce quickly to changing activity and capacity demand. Workforce not sufficiently flexible	• Trust/Healthcare Group Workforce Plans integrated with finance, activity and CRES • Workforce Strategy to be developed based upon productivity and efficiency metrics **Director of Workforce**