Department of Health

Richmond House
79 Whitehall
London SW1A 2NS

Andrew Reed
Chief Executive
Ipswich Hospital NHS Trust

23 April 2012

Dear Andrew,

Tripartite Formal Agreement (TFA) Escalation meeting – Ipswich Hospital NHS Trust

Further to our useful escalation meeting on 16 March 2012, I am writing as agreed to record the main details we discussed. I have at annex 1, provided an overview of the full conversation.

As you are aware, the Trust has been red rated for three consecutive months following your organisation being withdrawn from the Monitor Foundation Trust (FT) assessment process and, therefore, you are not on track to achieve FT status as agreed in the TFA. This triggered the escalation discussion to cover the issues that caused the withdrawal from Monitor's process, and to discuss how to progress your organisation towards achievement of FT status.

Following your clear articulation of the issues your organisation has and is facing, I concluded the meeting as follows:

- the plan articulated to moving forward to FT status will need to be reflected in a new TFA. This will need to reflect the outcomes of the local discussion between the Strategic Health Authority (SHA) and Trust in early May 2012;
- the plan will need to articulate how the issues that caused the deferment with Monitor have and are being addressed going forward; and
- the plan will need to articulate how delivery against performance and FT requirements throughout 2012/13 and going forward will be achieved.

On this basis, and subject to the above being taken forward and the new TFA agreed by all. There should be no requirements for any further escalation meetings at this stage.

The next actions will be us working with NHS Midlands and East and your organisation to agree the new TFA (proposed date) and for this to be the new basis upon which you will go forward. This will need to be agreed with the SHA and sent to the Department for final sign off by the end of April 2012.

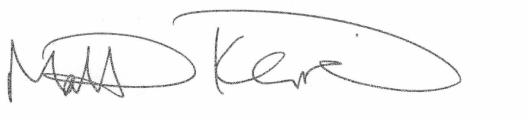
Delivery of this new plan, and evidence of the necessary progress being made towards moving forward with an FT application will continue to be monitored and determine whether any further interventions/escalation are necessary in the future.

We discussed the potential organisational and or personal consequences of not delivering the specific milestones and overall timeline agreed in your revised TFA and you stated that you, your Chair and the Board understand the implications very clearly.

I hope this accurately reflects our discussion and if you have any queries feel free to contact me.

With reference to Annex 1, please come back to Andrew Morgan or myself if you feel I have misrepresented or omitted anything material from our discussion.

Yours sincerely,



MATTHEW KERSHAW
DIRECTOR OF PROVIDER DELIVERY

CC:
Sir Neil McKay, NHS Midlands and East
Dale Bywater, NHS Midlands and East
David Flory, DH

ANNEX 1

Background

The Trust's agreed and published TFA stated that the FT application was in the Monitor assessment process. The application was then subsequently withdrawn from the Monitor process which triggered the red ratings through the TFA monitoring process and subsequently the escalation discussion.

The Trust entered the Monitor assessment process in May 2010 following which there were two quick deferments in relation to QIPP Primary Care Trust (PCT) and Quality Governance Framework issues. There was then a delay in relation to assessment resourcing and then a further delay due to the Dignity and Nutrition Inspection (DANI) reports.

Following issues of financial control emerging later in the year, the Trust decided to withdraw from the process.

There have been material changes to the Board over the last three years to ensure the organisation is fully equipped to move forward as an FT.

The Long Term Financial Model that was the basis of the previous application was based on the pre-QIPP agenda and is being revised to reflect where it now needs to be.

In terms of the DANI report, whilst accepting there were some areas for improvement that were highlighted, the Trust were surprised by the scale of some of the impact created by this locally and nationally. This was exacerbated by a particular patient's relatives input to the media coverage of this. The Trust had worked hard to address the issues raised though the Care Quality Commission had not been timely in revisiting the Trust to consider the improvements made. They had been back in since and overall things were on track, though there were some minor concerns to work through though not material to the FT application going forward.

Overall quality and performance has been good. There have been blips against some performance standards but the Trust had responded to these and continues to proactively monitor and focus on these.

The Trust has a big efficiency requirement to achieve as part of its journey to clinical and financial sustainability. The emergency tariff threshold (30 per cent of tariff rate paid over 2008/09 baseline) has been impacting on operating finances.

The Trust's contractual position is not as strong as desirable and Local Health Economy issues have not been wholly supportive of the Trust moving forward with their FT application. Part of this includes the PCT's use of the fines mechanism where this is triggered and all issues will need to be addressed as part of the journey to FT status.

In terms of financial performance the Trust started hitting problems in M3 of 2010/11 which got worse in M4 and M5. Delivery of Cost Improvement Plans is largely on track with £0.6million delivered versus plan of £7.0million and assurance of this gap being bridged.

Control against budgets has been big issue for Trust. This includes a period where 10 per cent of consultant medical staff posts were vacant, and many filled by locums. Sickness absence levels have been impacting on the Trust's ability to keep the necessary control. There have been some changes made to address Medical staffing issues, in particular in A&E. Some income has also been lost in relation to issues with high cost device tariff exclusions and the Service Level Agreement being based on historical use.

Key areas where budgets are being controlled better are around medical staffing and clinical supplies.

More generally, the Trust had been risk averse in relation to the delivery of service performance requirements, with financial performance put at risk. This has lead to significant issues financially in terms of the Trust's ability to manage the broad agenda. Also there has not been the necessary clinical engagement in the efficiency agenda previously.

Substantial work is now underway to get the right balance within the medical workforce. Related to this is decision to cease premium payments to medical staff which took effect in October 2011, apart from where pre-booked, along with eliminating agency-rates for consultant locums.

There had been some issues with advice provided in relation to who should chair the finance and performance committee i.e. exec or non-exec, which had not been helpful in getting governance requirements lined up. This has now been resolved.

The Trust was hit badly by norovirus in December 2011 and January 2012 resulting in staff sickness and bed closures and this has impacted on financial performance against the recovery plan.

The Trust is predicting a break-even position for year 2011/12 with support from SHA and PCTs. The Board are fully aware that they need to sustain financial balance and deliver a sustainable financial plan in year and for the long term to achieve FT status.

In 2012/13 the Trust will have 8 per cent CIPs. No more than 50 per cent of these have been agreed. The Trust is aware that it needs to begin delivering these from April 2012 given the loss of financial control in 2011/12. It is crucial that the Trust Board is clear on their accountability for this delivery and for the milestones and deliverables agreed in the revised TFA, when this is signed off.