Richmond House
79 Whitehall
London SW1A 2NS

Maggie Boyle
Chief Executive
Leeds Teaching Hospitals NHS Trust
St James's University Hospital
Beckett Street
Leeds LS9 7TF

15 June 2012

Dear Maggie,

Tripartite Formal Agreement (TFA) Escalation Meeting – Stage One
Leeds Teaching Hospitals NHS Trust

Further to our meeting on 24 May 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, having been red rated for four consecutive months in the TFA monitoring, has triggered the first stage of the agreed escalation process. The aim of the meeting was to discuss issues and get clarity and an agreement on the way forward to progress Leeds Teaching Hospitals NHS Trust to achieving Foundation Trusts (FT) status.

I identified the following areas of concern that need to be addressed:

- the reasons for the missed FT application date;
- the governance issues at the Trust that relate to the Trust's original TFA; and
- performance issues relating to:
    - accident and emergency (A&E);
    - referral to treatment (RTT);
    - Cancer;
    - MRSA; and
    - Financial performance.

Thank you for the frank exchange of information in the meeting which was helpful to gain a better understanding of the issues your Trust is facing.

I now need to have a discussion with David Flory, Senior Responsible Office for the FT pipeline and Ian Dalton, Chief Executive at NHS North of England ahead of a potential stage two escalation process in June.

The key objective for this meeting, if it is required, will be to discuss and agree with David Flory, Senior Responsible Office for the FT pipeline and Ian Dalton, Strategic Health Authority Cluster (SHA) Chief Executive, the strategy to be followed to help ensure the services provided by the Trust are clinically and financially sustainable for the long term.

I have copied this note to Mike Shewan so that he can work with you to prepare for the stage two meeting assuming that this is required.

With reference to Annex 1, please come back to either Jemma Griffiths (jemma.x.griffiths@dh.gsi.gov.uk) or me if you feel I have misrepresented or omitted anything material from our discussion.

Yours sincerely,

MATTHEW KERSHAW
DIRECTOR OF PROVIDER DELIVERY.

Cc:
David Flory
Ian Dalton
Mike Shewan
Jemma Griffiths

Annex 1

Introduction

I explained the purpose of the meeting was to provide the Department of Health and the Strategic Health Authority with an opportunity to discuss the Trust's current position, the reasons for it and the plan the Trust has in place to make the necessary improvements to continue its journey to FT status. I explained that the predominant reasons for the meeting were the missed FT application submission date, the Trust's four consecutive red RAG ratings and the existing performance issues.

I invited you to set out the strategic context and go through the details in your presentation. You explained that the Trust has undergone an external review which considered the required changes at the Trust and the length of time needed before the Trust would be ready to submit a robust FT application to the Department.

Decision to Defer

You stated that you and the Board focussed on consolidating services and strengthening governance in addition to progressing the FT application, due to the desire to maintain momentum and pace. You explained that you have confidence the organisation is now moving in the right direction. 'Managing for Success' has engaged with clinicians and there is a strong understanding of the need to push ahead to stop the dates being delayed anymore than is necessary. You stated and set out in your presentation that the key issues that resulted in the delay to the FT application submission were:

- failure to deliver the required Cost Improvement Plans (CIPs);
- failure to deliver key performance standards; and
- concerns regarding the embeddedness of your quality processes.

Financial Performance

You were asked how the decision was made in September 2011 to agree the April 2012 trajectory, as set out in the Trust's TFA, which was subsequently deferred in December 2011. You stated that due to your organisational challenges it had not been possible to identify the full four per cent target CIP's by December 2011. Given that the Trust could demonstrate that an Financial Risk Rating of three could just be maintained with the 3.5 per cent CIP's that had been identified, it was agreed with the previous SHA, to proceed with the TFA timetable. At a meeting with the new North of England SHA on 14 December it was made clear that the Trust could not proceed without the achievement of four per cent CIPs

You set out that there had been a number of iterations of the Integrated Business Plan (IBP) and Long Term Financial Model (LTFM), first in June

2011, then September 2011 and more recently in April 2012, I understand that you are in the process of receiving feedback on the latest drafts of these documents. I set out my concern that the IBP and LTFM, in their current forms, are still not strong enough to withstand the Department's and Monitor's scrutiny, you made clear that you agreed this was the case for the June and September versions, but felt that the latest version (April 2012), was more robust. You emphasised that four per cent CIPs per annum had been identified and this had resulted in a one per cent surplus and 10 days cash being maintained throughout the five year period (2012/13 to 2016/17).

You stated that in December 2011 the Trust didn't know how long it would need to defer its application for but had decided to work on the basis of three months. The subsequent publication of Monitor's new assumptions (17 April) had added £10 million per annum to the Trusts CIP requirement. More time would now be required to identify additional CIPs. I questioned that the Trust should have had some foresight about the publication of the new assumptions given this is done on a yearly basis. You explained that the Trust hadn't expected Monitor's new assumptions to have such an impact on the Trust's plans and indeed suggested that this echoed the level of surprise expressed by others.

You stated that the Trust Board had been reluctant to agree the delivery of 3.5 per cent CIPs and you made clear that you could have delivered 4 per cent but that this would have implications for the organisation as a whole and that your preference therefore, was to proceed with 3.5 per cent and have the buy in of the organisation.

You informed the meeting that the 2012/13 balanced plan, including four per cent of CIPs a £10 million surplus and £25 million of cash holdings, supported by the signed Service Level Agreement, had been signed off by the Trust's Board on 8 March 2012 and that local Clinical Commissioning Groups are supportive of the plans as set out.

You explained that the Trust was working to improve performance in a staged manner to enable its continuous improvement alongside the various FT application process culminating in the Trust performing at the required level to achieve authorisation at Monitor. However, you now understand that this method won't work as the standards required at Monitor are those expected by the Department as well and therefore need to be delivered as a matter of course.

I made clear that had the Trust allowed some slack and made more room in the trajectory that it may not have failed to achieve submission in April 2012. I also explained that as there has been failure on a number of performance issues the question is rightly being raised about the embededness of the changes implemented in October 2011.

It was explained that there has been commissioner sign up to the tariff for 2012/13 but not for 2013/14 and 2014/15. We made clear that the Trust

needs to give consideration given to the potential conflict and/or failure of CCGs to sign up to this.

It was set out that given Monitors new resource guidelines the Trust's financial performance, as it stands, is not at the required level to enable FT authorisation. As such, further work is needed to ensure that the finances are robust for the long term. I questioned you on the time required to make the necessary improvements. You stated that whilst this had yet to be agreed within the Trust, it could be achieved well within the 3 clean quarters that you understood would be necessary to demonstrate sustainable service performance.

Service Performance

You stated that Emergency Care is not where it needs to be for quarter 1 (94.1 per cent) as a result of a range of reasons including pressure on beds and the move of services. For A&E you explained that you need to provide greater Consultant cover leading to Consultants working shifts, which has been accepted by the consultants. This will also support our designation as a Trauma Centre. In addition, having looked across the country at best practice you decided the need in the slightly longer term to establish a large MSAA at SJUH to replace the two more remote smaller units. . To make this happen will require £5million capital finance and a shift in where services are offered. Consultants have been consulted about the need for change and their response has been a positive one. however the solution being proposed is a short term solution which will be followed by a long term change.

With regards to cancer it was made clear that there had been a lot of positive engagement but that the service was still not at the required level and is not yet as sustainable as we would like, mainly linked to late referrals.
In relation to RTT you explained that there would be an improvement by June 2012 but not for the whole of quarter one. The interim Chief Operating Officer is working to implement IMAS proposed new systems to improve the process. You set out the likelihood of there being a negative impact on backlog but were confident that this will managed to ensure that it doesn't escalate.

HCAIs were discussed and you explained that three out of the four cases of MRSA were avoidable and that the necessary measures are being taken to ensure that this isn't repeated. I made clear that the issue of MRSA on top of performance and financial concerns could create the impression that the Trust is losing grip and this was a significant risk.

You explained that the Trust has dealt with the formal issues raised by the Care Quality Commission and that the Trust is now compliant.

It was made clear in the meeting of the need for the Trust to improve its service performance to enable it to meet the required targets, particularly on RTT. If the Trust fails to do so, it will be a key issue in any stage two escalation meeting. The Trust's performance in this area will continue to be

monitored by the SHA and through the monthly TFA monitoring calls, which now incorporate the Performance Framework scores.

Governance

You made it clear that the Trust is looking to ensure that the necessary resourcing is in place to ensure that performance is managed as well as the development of a clinically and financially robust FT application and there is also a need to ensure that the steps are taken to ensure that appropriate replacements are found for the number of executive and non-executive staff leaving over the coming months.

You also referenced the independent review, currently underway and being managed by Diane Whittingham. This review is focussing on the structure of the organisation, whether it is 'fit for purpose' and whether there is enough clinical engagement and Management capacity within the organisation. The timing of the review has impacted on the Trust's ability to recruit a substantive Chief Operating Officer as the report will not be completed until the end of June 2012. The SHA will require an update on the key recommendations made in the report and this may have an impact on the need for a stage two escalation meeting.

Conclusion

I concluded by setting out my view that a 12 month delay was the most sensible course of action for the Trust, Mike Shewan agreed with this assessment.

I agreed to discuss the potential need for a stage two escalation meeting with David Flory and Ian Dalton where we would confirm this plan and to do this we would need to have your proposed updated TFA in advance of the meeting.

You agreed to revise your TFA following the stage one escalation with the recommendation of deferring for 12 months.