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133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: nhsi.enquiries@nhs.net
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2 May 2017

[redacted]

By email
[redacted]

Dear [redacted]

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of 30 March 2017 in which you requested information under the FOI Act from Monitor. Since 1 April 2016, Monitor and the NHS Trust Development Authority are operating as an integrated organisation known as NHS Improvement. For the purposes of this decision, NHS Improvement means Monitor.

Your request

You made the following request:

1. On 15.6.10 the Chief Executive and Finance Director of North Lancashire PCT met Monitor at Westmoreland General Hospital to discuss the University Hospitals of Morecambe Bay NHST application to Monitor to be authorised as a Foundation Trust.

2. On the same day the Chief Executive and Finance Director of Cumbria PCT also met Monitor for the same topic of discussion at the same venue.

3. This FoI request is for the minutes of both of these meetings and any other documents and/or emails held by Monitor/ NHSI which summarise and/ or describe and/ or report on those meetings and/ or are concerned with the arrangement of those meetings AND which are dated in the month of May, June and July 2010. I include the month of May only to capture the notice given to the PCTs about the calling of these meetings, and July only to capture any information RELATED TO THOSE MEETINGS ONLY leading up to the 1.10.10 authorisation of UHMB.

Decision

NHS Improvement holds the information that you have requested.

NHS Improvement has decided to withhold some of the information that it holds on the basis of the applicability of the exemption in section 40 of the FOI Act as explained in detail below. Please note that we do not consider the letter dated 27 May 2010 to be strictly within the scope of your request; however, we have included this as it refers to the meeting between Monitor and NHS North Lancashire on 15 June 2010 and we have released this to you previously.

Section 40 – Personal data

I consider that some of the information in the meeting notes is exempt from disclosure under section 40(2) and 40(3)(a) of the FOI Act on the grounds that it contains personal data and that the first condition under section 40(3)(a) is satisfied, namely, that disclosure would amount to a breach of the first data protection principle (personal data shall be processed fairly and lawfully). This is an absolute exemption and consideration of the public interest test is not required.

The information withheld is names of junior staff that were part of the Assessment team, and contact details of individuals. The individuals would have a reasonable expectation that their names and contact details would not be published.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter and the attached information will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely

Miranda Carter
Director of M&A and New Organisational Models

NHS
North Lancashire

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Mr Tony Halsall
Chief Executive
University Hospitals of Morecambe Bay
Burton Road
Kendal
LA9 7RG

27 May 2010

Dear Tony

Just following up our telephone call yesterday which you made to inform me of the arrangements for going live with the Trust Lorenzo system this weekend. I hope that the handover/transition goes smoothly.

I took the opportunity to ask whether a response to my letter to you of 5 May was being dealt with. You said that a reply would be sent later in the day and as this has not arrived I wanted to log this with you.

As you know, Monitor will be meeting Kevin Parkinson and me to discuss UHMBT Foundation Trust application on 15 June and I think we need a clear response to the issues raised so that the PCT can form an appropriate view to feed into this process.

We discussed clinical quality issues at the Trust at the PCT Board held yesterday. Given the timescale involved, my Board wanted to have an early response to my letter and also to ensure that the issues raised were discussed and appropriately addressed. To this end we have confirmed a meeting with you and your team at 10am on 1 June. I look forward to seeing you then.

Yours sincerely

Janet Soo-Chung CBE
Chief Executive

Agenda for Meeting
Wave 2 Group 6

Agenda for meeting
NHS North Lancashire

Local Health Economy

1. What is your latest actual financial position and your expected end of year (underlying) surplus/deficit? What was your position last year (reported and underlying)? What are the main drivers of this performance?
2. Please describe any current and future pressures within the local economy. What is their expected impact on your performance and on the performance of the Trust?

Trust activity plan

Elective:	*4.7% reduction due to demand management; 1.5% increase due to repatriation*
Non-elective:	*3% reduction due to demand management*
Outpatients:	*12.3% reduction due to demand management*

3. Have you seen the revised IBP? Are you aware of model assumptions?
4. How would you describe your relationship with the Trust? Are there any areas where the relationship is not proving successful?
5. What are the key drivers of activity within the Trust? How do you forecast activity levels for the medium term?
6. How do the Trust's activity plans fit with the PCT's Strategic Plan?
7. How have you integrated the following into your LDP and what are the expected effects on the Trust?
    - Practice Based Commissioning
    - Demand Management Initiatives
        - PCT envisages savings of c. £4m over the period 10/11 to 12/13. UHMB has included it's assessment of the expected income impact.

Contracting

8. What activity levels are agreed/expected to be agreed with the Trust?
    - What is assumed for the impact of demand management?
        - UHMB not accepting PCT proposals on:
            - Emergency readmissions
            - Excess bed days
            - NEL obstetrics
            - Zero day length of stay
    - Risk sharing arrangements:
        - Non-elective – 30% marginal rate applies to under/over activity compared to 08/09 baseline.
        - Elective – up to 1% over 09/10 baseline = 30% marginal rate; 1-2% = 50% marginal rate; >2% = 100% (full tariff)

- Outpatients – New: as elective marginal rates; follow-up capped at 75th percentile pro rata, but all charged at full tariff
- A&E – PbR applies in full.
- Non-PbR issues – maternity / excluded drugs and devices / chemotherapy / excluded outpatients

9. Have the CQUIN measures been agreed?
    - Commissioners wanted emergency acute beds at occupancy of 85%. Trust pushing back as dependant on others sometimes (c. £1.8m)
    - High impact nursing changes – difficult to reduce if no baseline.
10. What happens in case of over performance and underperformance?
11. What activity and performance data does the Trust share with you, how often is it provided, in what forum is data discussed?

<u>Investment Strategy</u>

12. Are you aware of any significant capital expenditure plans at the RLI in the future? Are you supportive?
    - A&E - built for 35k cases but handling 50k cases
13. Ward 50?
14. Cancer services at Kendal?
15. Cumbria diabetes?
16. RLI redevelopment?

<u>Foundation Trust</u>

17. What is your view on the Trust's FT application? What will be the main Challenges facing the Trust if it were to become a NHS FT?
18. Do you think your relationship would change?

[redacted]

From: Victoria Woodhatch
Sent: 16 September 2010 15:33
To: 'janet.soo-chung@[redacted]
Cc: 'Kevin.Parkinson@[redacted]
Subject: Monitor Meeting Note
Attachments: NHS North Lancashire_meeting note_100615 (2) send.doc

Dear Janet,

Please find attached a file note of our meeting in June. I would appreciate it if you could review it and confirm that it provides a fair representation of our discussion. If minor amendments are required could these please be added in track changes.

In addition we are currently preparing papers with a view to our Board taking an authorisation decision on UHMB at the end of the month. Given the time that has elapsed since we met we would like to give you the opportunity to provide further feedback via a brief catch-up call if you wish to do so. Any such call would need to occur in the next few days and in any event prior to close of business next Wednesday. Please let me know by the end of the week if you would like to put something in the diary.

Many thanks for your help.

Kind regards,

Victoria

Victoria Woodhatch | Senior Assessment Manager

Monitor - Independent Regulator of NHS Foundation Trusts

Direct Line [redacted] | www.monitor-nhsft.gov.uk
4 Matthew Parker Street, London, SW1H 9NP

University Hospitals of Morecambe Bay NHS Trust

NHS North Lancashire – Summary Note

15 June 2010

Attendees

- Janet Soo-Chung (JS) (NHS North Lancashire – Chief Executive)
- Kevin Parkinson (KP) (NHS North Lancashire – Director of Finance and Information)
- Tom Pickering(TP) (NHS North Lancashire – Director of Lancaster & Morecambe PBC group)
- Victoria Woodhatch(VW)(Monitor - Senior Assessment Manager)
- [redacted] (Monitor – [redacted])

Background

- JS has been in post since September 2009.
- PCT wanted to cover a number of areas during the meeting including
  - Process
  - Clinical quality issues
  - Strategic fit
  - Practise-based commissioning
- PCT unaware that the assessment had reactivated until very recently.
- PCT querying how the process had changed since the last phase of the assessment given health sector changes (financial downturn, QUIP, Francis findings, regulatory landscape etc).
- PCT felt IBP had been refreshed than rewritten.
- TP explained that he was the GP representative for 13 practices for the south-side of the PCT area. He stated that GPs:
  - Felt in a different place to six months ago;
  - Felt closer to what was going on the RLI site ; and
  - View of services in terms of quality and efficiency/economy had changed in that period.
- VW addressed these concerns as follows:
  - Monitor was unaware that UHMB had not informed PCT of the reactivation, and was considering changing the reactivation process to explicitly put the onus on applicants to contact commissioners upon reactivation.
  - Monitor was rolling out enhanced / formal Quality Governance framework and this would be reflected in an update to the Monitor's *Guide for Applicants* later in the summer.
  - Monitor's generic assumptions had been updated to reflect the current and projected economic conditions, but there was some flexibility to adjust these depending on local arrangements.
  - As a general rule, Monitor held separate meetings with commissioners unless they were explicitly joint commissioning activity (e.g. specialist commissioning groups).

Finance

- 2009/10:
    - Budget of £550m and £1.5m surplus delivered.
    - At mid-year projections pointed towards a £10m-£12m deficit, but the PCT elected to put itself in turnaround.
- 2010/11:
    - Total budget of c. £580m.
    - Budget inherited recurring problems from previous year.
    - 5.7% growth on budget been taken up by the main areas of growth:
        - Increasing activity
        - Continuing care
        - Specific specialist pathways
        - Specific issues e.g. PCAS coming on stream
    - Net position is 'flat cash'
    - £3m available for investment.
- Commissioning priorities for 2010/11:
    - Care closer to home
    - Not doing activity in secondary care when:
        - It can be done elsewhere in primary care
        - It doesn't need doing
    - Increasing productivity in secondary care
    - Decreasing capacity in secondary care to ensure sustainability
- Going forward, there are shortfalls in each year, driving a need to reduce the size of local secondary care provision.

IBP

- Differences in scoping:
    - UHMB is only taking out 80 beds across Morecambe Bay.
    - UHMB predicting that PCT will not deliver (in full) on demand management plans.
    - UHMB predicting increased demographic growth.

  The net impact of the latter two assumptions is flat growth, which PCT believes is unsustainable.
- Whether or not demand management works, 'the funding pot' is still limited.
- IBP potentially reflects a healthier view of the LHE than the PCT believes to be true.

2010/11 contract

- Contract is agreed but PCT is reluctant to sign until UHMB signs contract with NHS Cumbria. *(Contract now signed)*

- PCT have signed contract with Blackpool FT, but not Lancashire Teaching FT (for which Central Lancashire PCT is the lead commissioner).

Demand management

- PCT query whether IBP 'stacks-up'.

- While previous track-record in respect of demand management has been poor there has now been a material change - increased level of engagement with GPs, who now feel aligned,

empowered, and closer to the budgetary side. PCT now has schemes generated and owned by GPs.

- Specific examples:
    - Urgent Care Network: PCT now have GPs in A&E. These GPs are now challenging fellow GPs on admission.
    - CQUIN: for 2010/11, care plans: to be in place within 48 hours included expected date of discharge. GPs are now questioning quality of care and patient dignity.
    - Rehabilitation review: confirmed shortage of community beds and alternatives post-discharge. Audit (completed six weeks ago) found that at any one time, there were 50 patients with a LOS greater than 50 days, many of whom shouldn't have been admitted in the first place.
    - End-of-life care: PCT is considering investment in nursing homes and community nurses.
- 2009/10 demand management plan for UHMB was £1.5m. PCT can identify areas where this was delivered, but it was taken up by additional activity.
- 2010/11 onwards:
    - Projections from UHMB IBP appear based on now outdated strategic plans (as at December 2008).
    - 10/11 amount of £4.7m appears reasonable.
    - 11/12 amount of £1.4m is closer to £5m.
    - 12/13 onwards amount of £1.2m is closer to £3m - £4m per year.
- 2010/11 PCT schemes:
    - 20 schemes have been developed across the PCT (not all for UHMB). All are either ready to run or are recurrent funding from 2009/10.
    - PCT has budgeted £6m to generate schemes in 2010/11. There is enough money ring-fenced for investment to deliver the savings target for 2010/11.
    - PCT will not be financially viable if the schemes are not delivered.
    - GPs want to go further than amount planned for 2010/11, and are starting to talk about how they can use the money saved to invest in services.
- 2011/12 PCT schemes:
    - No investment fund identified yet as is dependent on progress made in 2010/11.

Working with NHS Cumbria

- At Level 2 level in LHE (Level 2 being Lancaster + South Cumbria), PCT is in discussions with NHS Cumbria on reconfiguration of services. As a result of these discussions, albeit at early stages, it is clear that UHMB will not be the same shape and size in the medium-term.
- No plan for public consultation as yet, but this may be required in future depending on the answers.
- GPs believe that running on three sites leaves you fragile clinically and economically. Example of only 3 cardiologists (with one leaving).
- IBP attempts to present UHMB as a conventional DGH; it actually has three DGHs in three very different areas, and there is a need to engage with primary care.
- PCT was disappointed with UHMB's pitch for provider arm.

Estate

- RLI reconfiguration:
    - PCT has not been formally consulted or seen plans (except for A&E 'front-end').
    - GPs are fiercely-loyal to RLI and will fight to retain services there.
    - A&E reconfiguration needed.
    - For whole site, UHMB need to define service model, quantify that model, calculate how many beds are required and then reconfigure services.
- Ward 50:
    - Felt Trust's approach was not helpful /coherent.
    - UHMB's asking price was £1m/year of running costs, which was unacceptable to PCT UHMB offered to reduce this to £300k.
    - GPs wanted different model of care, rather than a community ward that looked like a hospital ward with hospital staff TUPE'd across.

CQUIN/quality

- Since November 2009 long-term concerns of GPS particularly around administrative practices i.e. Quality of referral letters, Cancellation of outpatients appointments, often at late notice
- Referral letters in a timely manner that were clinically useful were in 2009/10 CQUIN. When audited it was revealed that for every 100 patients discharged:
    - Only 50 had letters; only 25 of these were within a week of discharge, only half of these had sufficiently useful clinical information.
- In addition some concerns as to
    - Adequacy of medical equipment, particularly in A&E

    - Configuration of cover at RLI / adequacy of staffing levels
    - Level of engagement from UHMB with primary care and PBCs.
- Referral letters in a timely manner that were clinically useful were in 2009/10 CQUIN. When audited it was revealed that for every 100 patients discharged:
    - Only 50 had letters; only 25 of these were within a week of discharge, only half of these had sufficiently useful clinical information.

  If this was UHMB trying hard to achieve CQUIN, is this good enough? The PCT raised concerns with NHS North-West, but doesn't feel that these have been addressed.
- Reports in May 2010 of seven ambulances being stacked at RLI, and subsequent impact on cardiac arrest response times.
- GPs feel that UHMB abuses market position due to geography. They don't want to destabilise the RLI but have a lack of other options for referrals.

Board relationships

- Board has a strong operational team, but not always as responsive to concerns as they might be; going forward PCT would like to see them be more outward-looking, more strategic in plans and give more focus to improving on partnership working.

Agenda for Meeting
Wave 2 Group 6

Agenda for meeting
NHS Cumbria

Local Health Economy

1. What is your latest actual financial position and your expected end of year (underlying) surplus/deficit? What was your position last year (reported and underlying)? What are the main drivers of this performance?
    - a difference in what they are expecting to pay the Trust and what the Trust expecting to be paid (£5.4m: £3 million = cap on contract / £1 million = running the Langdale wards at WGH and £1 million = activity)
2. Please describe any current and future pressures within the local economy. What is their expected impact on your performance and on the performance of the Trust?
    - The PCT is planning a "Big Conversation" public engagement process during 10/11 for a period of 6-12 months to outline issues facing the health service and to secure views on how to move forward. This may trigger public consultation on service change in later years.
    - Resource modelling – Cumbria PCT to make £14m saving. £90m from reduction to tariff, and £43m over 4/5 years from demand management etc.
    - Integrated Care Pilot.

Trust activity plan

Elective:	*4.7% reduction due to demand management; 1.5% increase due to repatriation*
Non-elective:	*3% reduction due to demand management*
Outpatients:	*12.3% reduction due to demand management*

3. Have you seen the revised IBP? Are you aware of model assumptions?
4. How would you describe your relationship with the Trust? Are there any areas where the relationship is not proving successful?
5. What are the key drivers of activity within the Trust? How do you forecast activity levels for the medium term?
6. How do the Trust's activity plans fit with the PCT's Strategic Plan?
7. How have you integrated the following into your LDP and what are the expected effects on the Trust?
    - Practice Based Commissioning
    - Demand Management Initiatives
        - PCT envisages moving £13m to £14m of services (in income terms) over the period 10/11 to 13/14.

Contracting

Agenda for Meeting
Wave 2 Group 6

8. What activity levels are agreed/expected to be agreed with the Trust?
    - What is assumed for the impact of demand management?
    - Risk sharing arrangements:
        - PCT offer differs to the Trusts proposal of £125.2m by £1.5m in 2010/11 and £1.0m recurrently.
        - Pro[psals to TUPE staff from the Langdale wards, PCAS and Abbey View to the PCT provider arm will reduce this gap by £0.23m recurrently.
        - UHMB proposes equally carrying of risk between two organisations (£0.38m each).
9. Have the CQUIN measures been agreed?
10. What happens in case of over performance and underperformance?
11. What activity and performance data does the Trust share with you, how often is it provided, in what forum is data discussed?

<u>Investment Strategy</u>

12. Cancer services at Kendal?
    - In February 2010, the PCTs produced a draft specification that the Trust has responded to.
    - The earliest date envisaged for delivery of the new cancer centre would be 2012/13, subject to business case approval.
13. Children's Service partnership.

<u>Foundation Trust</u>

14. What is your view on the Trust's FT application? What will be the main Challenges facing the Trust if it were to become a NHS FT?
15. Do you think your relationship would change?

University Hospitals of Morecambe Bay NHS Trust

NHS Cumbria

15 May 2010

Attendees

- Sue Page (NHS Cumbria – Chief Executive)
- Kevin Parkinson (NHS Cumbria – Director of Resources)
- Anthony Gardner (NHS Cumbria – Assistant Chief Executive)
- Hugh Reeve (NHS Cumbria - GP Locality Lead, South Lakes)
- Geoff Joliffe (NHS Cumbria - GP Locality Lead, Furness)
- Victoria Woodhatch (Monitor - Senior Assessment Manager)
- [redacted] (Monitor – [redacted])

General

- Cumbria is one of the national Integrated Care Pilots involving horizontal integration of GP and community services. There are six geographical groups in the county, with GPs leading on commissioning for each area with devolved budgets in place for 2010/11.
- Two years ago, the Trust was engaging well in South Lakes (due to the 'Save Our Services' campaign during and after the Acute Services Review at WGH) but in last 12m the PCT has found it more challenging to effectively engage with Trust and complex clinical engagement is needed to change model and pathways of care across the patch particularly at Barrow.
- PCT notes that Trust's business plan is very Trust-centric and feels more like a 'maintenance-plan'; in addition it does not seem to take account of future impact of PBC/ ICO changes.
- Trust has demonstrated good track-record operationally but PCT query their future ambition / strategic vision.
- The Trust states in their business plan that it "doesn't want to be an acute hospital, but a healthcare provider" but not really demonstrating support for that aim in practice.
- The ability to bring the 3 sites together and take them to cross bay working service by service will be key.
- Trust proposing £50m CIP plan; the PCT believes this may need to be as high as £65m.

Finances

- 2009/10 was a breakeven position (albeit with £4m of brokerage from the SHA to fund continuing care and specialist care).
- IN 2010/11, the PCT must pay back £4m to the SHA, and recover £2m from the Trust for 2009/10 year-end position.
- The PCT is in voluntary turnaround.
- The PCT is going to arbitration with North Cumbria NHS Trust over £20m of disputed activity from 2009/10.
- Cumbria PCT's QUIP gap is £165m over the next five years. Achieving this is not achieved by managing demand – it is achieved by taking out capacity.

Demand management

- The PCT and NHS North Lancashire jointly commissioned an assurance piece of work on the activity projections, which concludes that the Trust's assumptions are unrealistic. For example, the Trust is assuming 4% increase in population in South Lakes, which the PCT assumes it is 1% across the whole population (with a large increase in elderly people).
- The PCT spent a minimum of £10m on PCAS etc. in order to take the heat out of the system.
- Financial position means it is hard to be supportive of Trust FT application as their assumptions do not look affordable.

Integration of services

- The PCT has attempted to engage with the Trust on below issues but Trust has been slow to engage/respond (despite the precedent for joined up working being there (ie on WMGH).
    - Vertical integration in elderly care
    - Diabetes:
        - PCT wanted to use this as a model for chronic disease management (i.e. forerunner for COPD etc.) And move care into the community, with in-reach into specialities when required.
        - Services are now being provided in localities with staff TUPE'd from secondary care across to primary care, using in-reach into hospital as required.
    - Children's Services:
        - Trust lead the consortia of providers on the business case for provision of children's services in Cumbria; while recognise that too many children are being treated in hospital (particularly in Barrow) the projections in the LTFM show same number of admissions in year 5 as year 1
    - Barrow:
        - Need massive system change and review of sustainability

CQuin/Performance generally

- CQuin should be viewed not as a sum of money but a driver of quality within the system.
- Trust has sound clinical services and some are very good particularly at Lancaster; urology services are excellent (though this driven by strong clinical leadership and effective cross-site working) but Barrow probably not as good, with one or two exceptions ,- at Barrow general surgery is good, elderly care good and diabetes excellent ; poor areas include rheumatology and paedeatrics.

Other information

- The PCT's drugs budget was overspent. Part of the reason was hospital clinicians using expensive inhalers. The Trust needs to move towards evidence-based prescribing.
- PCT views is that there is a disconnect between top and middle management/ middle management and clinical services which makes it hard to get coherent way forward. E.g. cardiology services where Trust proposes to develop services but no mention of Primary PCI.
- GPs keen to integrating their IT systems with Lorenzo, but no real traction on this to date.