PSHFT and Hinchingbrooke merger

THE JOURNEY SO FAR

Reminder: Our 'challenged' health system

'Cambridgeshire and Peterborough area is one of 11 challenged health economies in England'

- NHS England, Monitor and the Trust Development Authority

- The System-wide Sustainability and Transformation Programme, led by Cambs and Pboro CCG, began in 2014 to look at all NHS-funded, hospital-based, GP and community healthcare services – with the aim of developing services that are clinically, operationally and financially sustainable for the future
- Under this banner, in January 2016, Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS FT announced they were working collaboratively to reduce duplication and costs, and support the future delivery of sustainable services for the benefit of patients, staff and taxpayers

Background

APPENDIX 1

HHCT

- 1983 hospital opened
- 2005 new treatment centre opened
- 2005- Trust in financial deficit and clinically unsustainable
- 2005 SHA review of services
- 2009 EoE SHA announces HHCT franchise tender
- 2010 PSHFT joint bid with Serco to operate Hinchingbrooke hospital
- 2012 Circle awarded franchise and begin managing Hinchingbrooke
- 2015 CQC rates HHCT inadequate with lack of clinical sustainability
- 2015 Circle withdraw early from the contract citing unsustainable losses

PSHFT

- 2004 first wave Foundation Trust
- 2002-2008 In financial surplus
- 2010 move to PFI building, Trust reports a £45m deficit in 2010/11
- 2010 PSHFT joint bid with Serco to operate Hinchingbrooke hospital as a franchise
- 2012 Monitor appointed CPT finds PSHFT clinically and operationally sustainable but financially unsustainable
- 2012 NAO and CPT identify approximately £20-25m shortfall between PFI cost and tariff
- 2013 Project Orange to franchise PSHFT (Project Orange)
- 2015 CPCCG challenged health economy and Project Orange paused

- 2015 Strategic outline case recommends closer collaboration between HHCT and PSHFT
- 2016 HHCT and PSHFT commence business case

- **Summary**
- PSHFT is clinically and operationally sustainable, but with specific challenges BUT is not financially sustainable;
- HHCT is neither clinically or financially sustainable in its current form;
- Cambridgeshire and Peterborough is one of the most financially challenged systems in the Country.

'As the Accountable Officer I have a duty to look at the options to improve this Trust's and the whole health systems position, balancing the needs of patients, staff, the public and the taxpayer'

In doing so Lance and I have made the following statement:

'Both trusts are passionate about providing services which are better, safer and local. They are committed to providing high quality care that is easily accessible to the local population. There may be future changes, particularly as a result of the STP, but there is a commitment from both trusts to ensure the ongoing provision of safe sustainable core acute services from Hinchingbrooke Hospital

Outline business case

- October 2015 Monitor led strategic outline case suggests £10m savings from closer collaboration
- November 2015 HHCT and PSHFT boards agree to explore four levels of collaboration:
  - Option 1 - Do nothing for now
  - Option 2 - Shared back office function - leading an integrated back office
  - Option 3 - As per option 2, plus two boards, one executive team and one operational organisation
  - Option 4 - One organisation
- Project Management Board established
- Engagement between two Trust Boards
- OBC developed
- Option appraisal- option 4 preferred choice

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- Option appraisal- option 4 preferred choice
- **Recommendation: The Boards at both trusts are asked to approve this Outline Business Case which shows clear clinical and financial benefits for both organisations.**
- **The Boards agree to work together to deliver a Full Business Case by end September 2016. The FBC will confirm the date (subject to approval) of a merged organisation. This is currently planned to be 1st April 2017**

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CLINICAL SERVICES - SUSTAINABILITY

Clinical Case for Change

- Some services in both organisations are clinically fragile now, with further services at risk in the medium-term
- Contributory factors:
  - Smaller teams compared to teaching trusts and larger DGH's can make recruitment difficult
  - Agency spending caps
  - 7-day working
  - Junior Doctors contract and provision of compensatory rest
- Meeting future challenges requires looking outside traditional organisational boundaries
- For both organisations, integrated collaboration largely resolves the clinical sustainability issues

Clinical Case for Change

Merger joins all clinical teams under a single operational management structure:

- larger teams
- medical staff working equitably across locations
- shared workload, rotas and out of hours cover.

Merger maximises opportunities for:

- Single governance arrangements, clinical policies, management arrangements and operational procedures
- Greater flexibility for staffing and service provision across sites
- Greater opportunities for training and sub-specialism
- Support staff recruitment and retention
- Reduce agency
- Senior decision-makers at key points in the patient pathway
- Clinical consistency with shared best practice protocols

Our Joint Vision

Delivering excellence in care in the most efficient way in hospitals where it is great to work

Our Joint Strategy

Clinical Excellence

Doing the very best for our patients

Financial Sustainability

Getting value for money for taxpayers for our services

Operational Sustainability

Making the most of our hospitals for the future

Underpinned by Our Values

Across the populations of South Lincolnshire, Peterborough and Huntingdonshire we will…

Provide safe and timely care for our patients

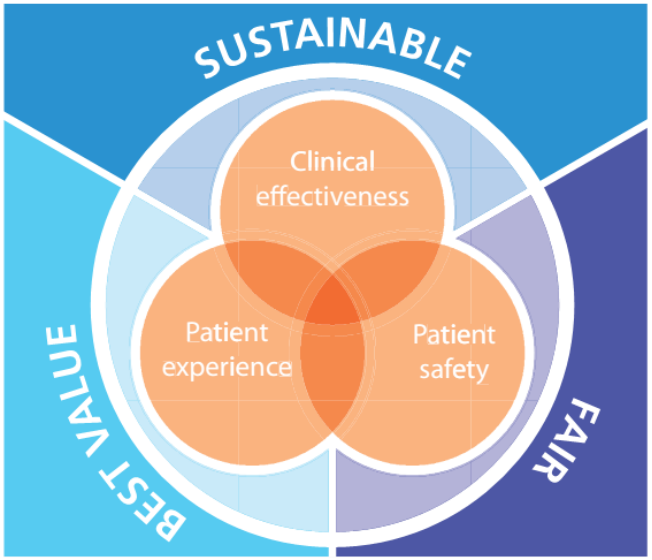
Ensure that our staff feel valued and have opportunities for development

Design our services to meet the changing needs of our patients

Clinical sustainability

Clinical Sustainability is defined as:

Provision of resilient, high quality, best value care locally both now and into the future in accordance with all relevant requirements



Clinical unsustainability is defined as one or more of

- Inability to recruit competent substantive staff
- Inability to match provision to demand
- Inability to meet required service and quality standards

Clinical sustainability

Services are under significant pressure in both Trusts, but HHCT services are particularly challenged:

- No specialist consultant cover for some services
- High staff vacancies in a number of wards / areas
- High use of agency / locum staff at premium cost – ability to provide cover now compounded by agency caps
- Senior Nurse leadership capacity is challenged

Clinically unsustainable services at HHCT

- **A&E** unable to recruit medical staff
  - 40% vacancy rate for middle-grade doctors
  - 66% vacancy rate for consultants
  - Nursing recruitment and retention
- **Haematology** – no haematology consultants; service covered by locum haematologists and two substantive haematology specialist nurse.
- **Stroke rehabilitation** – No specialist stroke physicians, and insufficient therapy support

'Fragile':

- **Back Pain** – discontinuation of spinal orthopaedic service and wider impact on system chronic pain services

Services at risk of becoming unsustainable at HHCT & PSHFT

Future challenges associated with

- Agency spending cap
- 7-day working
- Junior Doctors contract – compensatory rest

Services identified in the OBC:

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HHCT	PSHFT
Acute Medicine	Diagnostic Imaging
Cardiology	Interventional radiology
Diagnostic Imaging	Gastroenterology - 7 day bleed service
Interventional Radiology	Stroke
Nephrology	Ortho-Gerontology
Neurology	
Ortho-Gerontology	
Palliative care	

Conclusion

Compelling case for clinical collaboration to address service vulnerability, particularly for the population of Huntingdon who are currently disproportionately disadvantaged

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Clinical collaboration will strengthen the provision of a number of services across both sites to ensure long term, sustainable, high quality health services for the populations of both Peterborough and Huntingdon

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FINANCIAL REVIEW

PSHFT five year break even plan

- PSHFT forecast deficit for FY17 of £21.7m
- Deficit reduced by:
  - above average CIP for two years
  - NAO and PwC estimate additional £15m PFI subsidy on top of the existing £10m required from DH
  - £5m saving from collaboration with HHCT

OBC savings from merger

Departments	units	New baseline	Merger
CEO	£'m	3.7	1.8
Finance	£'m	5.9	4.9
HR	£'m	4.6	3.6
Nursing	£'m	4.8	4.7
Facilities	£'m	34.7	33.7
Ops	£'m	2.1	1.6
IT/IS	£'m	6.5	5.7
Clinical Support	£'m	63.8	63.5
CEO Challenge site leadership reductions	£'m	0.0	(0.02)
Additional 4% CIP reduction on pay in yr 2	£'m	0.0	(0.8)
Non-pay	£'m	0.0	(1.8)
TOTAL COSTS	**£'m**	**126.0**	**117.0**
Saving against baseline	£'m	0.0	**9.1**
WTE reduction	wte		-70

Process to agree savings and costs of al 4 options

- Overseen by collaboration PMB
- PMB updated on savings calculation and process at each meeting
- PMB approved key assumptions on certain category of potential savings
- Executive to Executive agreement by department
- CEO review and challenge
- CEO overall year 2 extra efficiency challenge and some grade reduction
- Option appraisal process considered impact of any variation of estimated savings on scoring and decision for option 4
- External consultancy have reviewed the calculations

OBC costs of transition

Category	Cost/£m				
	Yr1	Yr2	Yr3	Total	
				One-off	Recurrent
Redundancy	(0.3)	(1.4)	(1.1)	(2.8)	
Project Transition Costs	(1.0)	(0.9)	0.0	(1.9)	
Legal and due diligence costs	(1.8)	(1.5)	0.0	(3.3)	
IT Integration Costs	(1.0)	(1.5)	(1.5)	(4.0)	
CEO	0.0	1.9	0.0		1.9
Finance	0.3	0.3	0.3		1.0
HR	0.0	0.5	0.5		0.9
Nursing	0.0	0.1	0.0		0.1
Facilities	0.5	0.5	0.0		1.0
IT/IS	0.0	0.0	0.8		0.8
Ops	0.0	0.5	0.0		0.5
Clinical Support	0.0	0.3	0.0		0.3
CEO site leadership	0.0	0.0	0.0		0.0
Additional 4%	0.0	0.0	0.8		0.8
Non-pay	0.0	0.0	1.8		1.8
Total	(3.3)	(1.3)	1.6	(12.0)	9.1

What happens next

- If boards agree to explore merger, commence a Full Business Case
- Prepared over the summer and presented in September 2016
- Engage with staff and the public
    - During FBC development (June to Sept)
    - After FBC presented to Boards (Sept to Nov)
- Build Governor and Membership base in Huntingdon
- Regulator approval from December 2016 to February 2017
- Work with fragile clinical services (June to Dec)
- Build clinical case and early collaboration commences(June to Dec)
- Commence organisational development programme
- Merge April 2017
- Implementation and benefits 2017-2020