Merger of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust

Outline Business Case

17 MAY 2016

VERSION 2.0 FINAL

Version	Date Issued	Distribution
1.1	5 Feb 2016	PMB 10 Feb 2016
1.2	14 Mar 2016	PMB 16 Mar 2016
1.34	21 Mar 2016	March Trust Board
1.4	21 Apr 2016	April Trust Board
1.5	11 May 2016	PMB 13 May 2016
2.0	17 May 2016	Final May Trust Board

Abbreviations

AHP	Allied Health Professionals	MRI	Magnetic Resonance Imaging
BTA	Business Transfer Agreement	NHS	National Health Service
CCG	Clinical Commissioning Group	NHSE	NHS England
CCS	Cambridgeshire Community Services	NHS I	NHS Improvement
CPCCG	Cambridgeshire and Peterborough CCG	NHSLA	NHS Litigation Authority
CEO	Chief Executive Officer	NIA	NHS Improvement Authority
CIP	Cost Improvement Plan	NPV	Net Present Value
CMA	Competition and Markets Authority	NTDA	NHS Trust Development Authority
CQC	Care Quality Commission	OBC	Outline Business Case
CRG	Clinical Reference Group	OD	Organisational Development
DGH	District General Hospital	OOH	Out of Hours (GP service)
DH	Department of Health	PALS	Patient Advice and Liaison Service
EBITDA	Earnings before Interest, Taxation and Depreciation	PACS	Picture Archiving and Communication System
ED	Emergency Department	PAS	Patient Administration System
EoE	East of England	PBCIP	Post business case implementation plan
FBC	Full Business Case	PCT	Primary Care Trust
FRR	Financial Risk Rating	PDP	Personal Development Plan
FT	Foundation Trust	PFI	Private Finance Initiative
GP	General Practitioner	PMO	Programme Management Office
GRR	Governance Risk Rating	POD	Point of Delivery
HES	Hospital Episodes Statistics	PRCC	Principles and Rules for Cooperation and Competition
HHCT	Hinchingbrooke Healthcare NHS Trust	PSD	Provider Support Directorate
HR	Human Resources	PSHFT	Peterborough and Stamford Hospitals NHS Foundation Trust
HoT	Heads of Terms	PTIIP	Post Transaction Integration and Implementation Plan
IM&T	Information Management and Technology	PWC	Price Waterhouse Cooper
ISAS	Imaging Services Accreditation Scheme	QIPP	Quality, Innovation, Productivity and Prevention
IT	Information technology	SCBU	Special Care Baby Unit
JSNA	Joint Strategic Needs Assessment	SLA	Service Level Agreement
KPI	Key Performance Indicator	SLCCG	South Lincolnshire CCG
LHE	Local Health Economy	SNAP	Stroke National Audit Programme
LINks	Local Involvement Networks	TDA	Trust Development Authority
LTFM	Long Term Financial Model	TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006
MDT	Multi-Disciplinary Team	WTE	Whole Time Equivalent
MoU	Memorandum of Understanding		

Contents

1. Executive summary 7
2. Introduction and background 11
2.1 Purpose of this Outline Business Case (OBC) 11
2.2 Purpose of a full business case (FBC) 12
2.3 Background 14
2.4 Conclusions 29
3. The evidence for change 30
3.1 Clinical sustainability 30
3.2 Matching available capacity to meet demand 35
3.3 Financial sustainability 37
3.4 Support for closer collaboration 38
3.5 Constraints and dependencies 38
3.6 Project management 40
3.7 Conclusion 40
4. Options appraisal 42
4.1 Summary 42
4.2 Objectives of the Local Health Economy (LHE) 42
4.3 Background – previously considered options 42
4.4 Options for collaboration between PSHFT and HHCT 45
4.5 Assessment of short list options for collaboration 46
4.6 Appraisal of options 48
4.7 Summary of savings 48
4.8 Conclusion and recommendation 50
5. Benefits 51
5.1 Benefits summary 51
5.2 Phasing of costs, savings and CIPS 53
5.3 Risks 54
5.4 Conclusions 55
6. The Financial Case 56
6.1 The merged trust 56
6.2 PSHFT 60
6.3 HHCT 61
6.4 Sensitivity analysis 63

7. Clinical vision and organisational design 66
7.1 Our joint clinical vision 66
7.2 Areas the collaborating trusts will serve 67
7.3 Benefits for patients 67
7.4 Benefits for staff 72
7.5 Organisational structure 72
7.6 Future board arrangements and structure 73
7.7 Performance management 74
8. Programme timeline, governance and management 75
8.1 Programme overview 75
8.2 Plan to Full Business Case approval 76
8.3 Legal and regulatory approvals 77
8.4 Implementation planning - principles and approach 79
8.5 Communication and engagement 82
8.6 Post-Merger Integration and Implementation Plan (PMIIP) 82
8.7 Integration and Implementation Blueprint 83
8.8 Benefits realisation strategy 89
9. Risks 91
9.1 Risk Assessment and management 91
9.2 Current project risks 92
9.3 Risks of not proceeding 92
9.4 Risks of moving to a single organisation 92
9.5 Risks of proceeding 93
10. Appendices 96

Table of Figures

Figure 1 – NHS A&E performance FY04 to FY16 14
Figure 2 - NHS trusts end of year financial results FY10 to FY16 15
Figure 3 – Governance of the Cambs and Peterborough STP work 17
Figure 4 - Trusts at a glance 17
Figure 5 - Hospitals around HHCT and PSHFT 19
Figure 6 - HHCT and PSHFT catchment areas 20
Figure 7 - Cambridgeshire and Peterborough CCG population forecasts 21
Figure 8 - ONS forecast population growth for South Lincolnshire CCG area 21
Figure 9 - Clinical services by trust 22
Figure 10 - CQC ratings of PCH services from inspections in March 2014 and May 2015 .. 24
Figure 11 - HHCT CQC ratings Jan 2016 25

Figure 12 - Better Care Better Value performance Q2 FY16 25
Figure 13 - PSHFT performance against national standards March 2016 26
Figure 14 - HHCT performance against national standards March 2015 27
Figure 15 - PSHFT and HHCT financial performance FY14 to FY21 27
Figure 16 - PSHFT Monitor risk ratings 28
Figure 17 - Definition of clinically sustainable services 30
Figure 18 – Clinical services sustainability 32
Figure 19 - Underlying causes of clinical unsustainability 33
Figure 20 – Specialities for focus 34
Figure 21 - PSHFT and HHCT forecast deficits 37
Figure 22 – Collaboration constraints and dependencies 39
Figure 23 - Long list of organisational form options across the LHE 43
Figure 24 – LHE key outcomes for organisation form changes 43
Figure 25 – Short listed stepping stones for organisation form changes in the LHE 44
Figure 26 - Options for collaboration between PSHFT and HHCT 45
Figure 27 - Short list of options for collaboration between PSHFT and HHCT 46
Figure 28 - Option appraisal criteria 47
Figure 29 - Option appraisal criteria weightings 47
Figure 30 – Summary of option appraisal 48
Figure 31 - Summary of back office costs and savings of each option 49
Figure 32 - Option appraisal scores and NPV 50
Figure 33 - Benefits of merger 51
Figure 34 - Merger savings 52
Figure 35 – Phased costs and savings 53
Figure 36 – Combined cost improvement programme 54
Figure 37 – Combined trust income and expenditure summary 59
Figure 38 – PSHFT historical I&E 60
Figure 39 – PSHFT forecast baseline I&E 61
Figure 40 - HHCT historical I&E 62
Figure 41 - HHCT forecast I&E 63
Figure 42 – Sensitivity analysis NPV 64
Figure 43 - First draft of a joint vision 66
Figure 44 – Clinicians view of the impact of merger on clinical sustainability 68
Figure 45 – Proposed governance meeting structure 74
Figure 46 - Indicative Timeline to implementation of Option 4 75
Figure 47 - Programme Overview - from OBC to FBC to Statutory Transaction 76
Figure 48 - Overview of approach - Transaction Approval & Implementation Planning 79
Figure 49: Indicative Timeline to implementation of Option 4 80
Figure 50 – Transition programme board governance and work stream structure 81

1. Executive summary

Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) and Hinchingbrooke Health Care NHS Trust (HHCT) both face significant sustainability challenges.

Sustainability challenge for PSHFT

In their assessment of PSHFT in 2013, the Contingency Planning Team appointed by Monitor found that while clinically and operationally sustainable, Peterborough and Stamford Hospitals NHS Foundation Trust is not financially sustainable in its current form.

PSHFT's financial position on 31 March 2016, i.e. the end of financial year FY16, is a deficit of £37.1m. Despite achieving above average cost improvements for the last few years, PSHFT will not be able to deliver a balanced budget for the foreseeable future without joint working with partners in the wider health economy.

The PSHFT recovery plan is based on three pillars: delivery of above average cost improvement; savings through collaboration with Hinchingbrooke; and agreement with the Department of Health that the £15m additional cost of the PFI not met by tariff should be separately funded.

The trust has a track record of delivering above average cost improvement for each of the past four years. External reviews have identified further savings, including Lord Carter which identified further opportunities to reduce bank and agency costs.

The Department of Health will need to commit to giving the trust long-term financial support at a level that provides stability for the trust. The National Audit Office (2012), the Contingency Planning Team (2013) and PriceWaterhouseCooper (2015) all identified the need for £25m additional ongoing tariff subsidy to meet the additional costs of the PFI. The trust currently receives £10m support in the form of a subsidy, and an additional £15m is required in future.

Monitor (2015) identified £10m potential joint savings from PSHFT working collaboratively with Hinchingbrooke through reducing back office and corporate costs.

A combination of all three will return the trust back to a position of financial surplus.

There are also clinical sustainability challenges for some services which could be mitigated through collaboration with Hinchingbrooke. Examples include gastroenterology and diagnostic imaging.

Sustainability challenge for HHCT

Hinchingbrooke Health Care NHS Trust (HHCT) is not sustainable in its current form, clinically or financially.

Despite the passion, commitment and hard work of the hospital staff, there are services that HHCT is currently struggling to provide sustainably for its local population. Amongst those most affected are clinical haematology (blood disorders), the Emergency Department (ED) and stroke services, primarily because it has not been possible to recruit to all of the permanent consultant posts for these services.

As a result of Hinchingbrooke's size and case mix, it is likely to face further clinical service sustainability issues in the near future. HHCT's emergency department is the third smallest in the country and relies significantly on locum doctors to provide a safe service. This is not a sustainable option in the long term.

Other services such as orthogeriatrics, neurology, cardiology and end of life care services are also significantly challenged due to the size of the teams delivering the services.

In the current configuration, HHCT is too small for the continued future provision of high quality sustainable modern healthcare to its local population. The HHCT Board recognises that alternative solutions are required to ensure that all the existing services continue to be provided locally on the Hinchingbrooke site in the future.

The financial challenge at HHCT is also significant.

- At 15.2%, it has one of the largest financial deficits as a proportion of turnover in the country; a FY16 deficit of £17.1m on £112m turnover
- The recent national financial efficiency work led by Lord Carter, identified HHCT as being the second most financially inefficient hospital in the country.
- HHCT annual reference costs are 14% greater than the average costs across the country of providing the same volume and case mix of activity.

There is a financial plan to recover this deficit over the next five years which relies on ambitious cost reduction, significant additional revenue from a proposed Health Campus, and collaboration with other organisations to reduce back office costs. However, even if fully delivered, the clinical sustainability issues remain.

The Local Health Economy

The Cambridgeshire and Peterborough CCG total population is forecast to grow by 10% between 2016 and 2021, with Peterborough growing by 11% and Huntingdon over 65 age group growing by 17%. As people age, they are progressively more likely to live with multiple illnesses, disability and frailty, and therefore we can expect increased pressure and demand for services and care at HHCT and PSHFT in the future.

The latest projections across Cambridgeshire and Peterborough show that the financial deficit across the NHS providers and commissioners is likely to be £250m by FY21 if things continue as they have done in the recent past. The system has incurred a collective deficit of £150m in FY16, which is one of the highest per person in the country.

Meeting the future demands on services, while maintaining and improving clinical sustainability for patients within the tight financial envelope, means there is a growing need for providers to work together and differently in the NHS.

Sustainability and transformation plan

Across the country, local commissioners are leading their health and social care organisations in working together to identify how these clinical and financial challenges can be met by developing Sustainability and Transformation Plans (STP) by June 2016.

Lincolnshire Clinical Commissioning Groups are doing this to cover the south Lincolnshire patients although it mainly focusses on the acute providers within Lincolnshire. PSHFT and

HHCT are directly involved with the STP that is being led by Cambridgeshire and Peterborough Clinical Commissioning Group and focusses upon:

1. End to end pathway redesign including primary and secondary care
    - Sustainable General Practice
    - Proactive care and prevention
    - Urgent and Emergency Care (CPCCG is a national Vanguard site)
    - Elective care design
    - Maternity and neonatal services
    - Children and Young People
2. Greater collaboration between HHCT and PSHFT
3. Financial incentives alignment
4. Utilisation of estate across Cambridgeshire and Peterborough
5. Increasing the effective use of staff skills and experience

Collaboration between HHCT and PSHFT

The STP work includes collaborative working between HHCT and PSHFT.

Material changes to how these services are designed and delivered may happen as a result of other commissioner led work streams, but this is **not** an area which will be decided by the outcome of this Outline Business Case, or Full Business case approval decisions. If as part of the wider STP work, significant changes to these pathways are proposed by the CCG, they would be subject to public consultation before implementation.

Maintaining core acute services at Hinchingbrooke Hospital

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 joint commitment from both trusts to ensure the ongoing provision of safe, sustainable core acute services from Hinchingbrooke Hospital.**

Key findings of the Outline Business Case (OBC)

This document describes the drivers, options and potential benefits of greater collaboration between Hinchingbrooke Health Care NHS Trust (HHCT) and Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT).

This business case shows that merger of HHCT and PSHFT will:

1. Support the ongoing provision of fragile clinical services locally on the HHCT site
2. Improve sustainability of some clinical services in PSHFT
3. Enable financial benefits of more than £9m to be achieved through the integration of back office functions
4. Improve staff experience with more realistic rotas, increased training and educational opportunities, and in so doing, improve retention and recruitment.
5. Offer more robust infrastructure for example through the single procurement and running of IT; greater flexibility of major equipment and more robust business continuity

6. Provide real engagement with the local community through the development of a membership strategy and body in Huntingdonshire. PSHFT has over 9,000 members with public and staff representation on the Council of Governors and the ability to appoint the Non-Executive Directors and hold the Board to account. This would be expanded to Huntingdonshire as a part of a merger.

Next steps

If the OBC recommendations are approved, a Full Business Case (FBC) for the merger of HHCT and PSHFT will be produced. Timelines agreed by both boards and the regulator for the next steps are:

- Engagement with the public will start from the OBC decision, and formally after the European referendum at the end of June
- by September 2016, complete a Full Business Case for decision by both Boards
- Further public engagement post FBC decision for six weeks
- from November 2016, if the FBC is approved by both Boards and the regulator, commence implementation
- Subject to all necessary approvals, the formal merger would take place on 1 April 2017.

The FBC will be the document upon which the final decision by the Boards will be made on the collaboration between the organisations. The FBC will then be sent to regulators for review and approval. This will include the main conclusions contained in the body of the OBC and a more detailed review of both organisations, the case for change and the opportunities and risks associated with any future transaction.

During the interim period, both trusts will work together to provide safe sustainable services, particularly in those areas already identified as being unsustainable.

To ensure these plans are considered and commented on both internally and externally, public engagement will be undertaken over a four month period.

These benefits, and others to be explored as a full business case is prepared, will be delivered through a merged organisation. This will be achieved by April 2017 with some benefits being realised from autumn 2016 and the full benefits being delivered over a four year timetable, i.e. autumn 2020.

Recommendation from Stephen Graves, CEO PSHFT and Lance McCarthy CEO HHCT

The Boards at both trusts are asked to approve this Outline Business Case which shows the clear clinical and financial benefits for both organisations.

In doing so the Boards agree to work together to deliver a Full Business Case (FBC) by the end of September 2016. The FBC will confirm the date (subject to approval) of a merged organisation. This is currently planned to be 1st April 2017.

2. Introduction and background

The aims and objectives of this outline business case, and what will be included in a full business case is described in this chapter. It also describes national and local background information which sets the scene for the case.

2.1 Purpose of this Outline Business Case (OBC)

Peterborough and Stamford Hospitals NHS foundation Trust (PSHFT) and Hinchingbrooke Health Care NHS Trust (HHCT) both face significant challenges.

In their assessment of PSHFT in 2013, the Contingency Planning Team appointed by Monitor found that 'while clinically and operationally sustainable, Peterborough and Stamford Hospitals NHS Foundation Trust is not financially sustainable in its current form.'[1]

The HHCT Board recognises the immediate and medium term clinical sustainability challenges faced by some of its services, as well as the significant financial challenges as it has one of the worst percentage deficits in the NHS. Although there is a very challenging plan to address the financial situation, up until now there has been no realistic plan to address its clinical sustainability issues.

Aim: This document describes the drivers and options and potential benefits of greater collaboration between Hinchingbrooke Health Care NHS Trust (HHCT) and Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT).

Objectives: The production of this document was agreed in a signed Memorandum of Understanding which describes how both organisations will explore greater collaboration to support the future delivery of sustainable services for the benefit of patients and taxpayers, and reduce duplication and costs.

The collaboration project between HHCT and PSHFT will:

1. Agree a shared vision for sustainable and safe clinical services
2. Identify savings opportunities through greater integration of back office and support functions;
3. Recommend organisational form changes which support delivery of these objectives and are:
   - deliverable and acceptable to patients and other stakeholders including staff;
   - aligned to the local health economy Sustainability and Transformation Plan; and
   - affordable, making the best use of public funds

---

[1] Monitor (2013) *Peterborough and Stamford Hospitals NHS Foundation Trust – Recommendations of the Contingency Planning Team* (September 2013) available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284289/Recommendations_Contingency_Planningteam.pdf

The project will deliver:

- by May 2016, an Outline Business Case for the approval of both Trust Boards which describes the patient benefits, clinical strategy and economic impacts from a proposed organisational form change[2]
- by May 2016, agreed joint CIP programmes for FY17 and FY18 that deliver robust sustainable savings for the taxpayer whilst not adversely impacting on quality of care.
- If the decision to proceed to develop a Full Business Case (FBC) is taken in May, public engagement will commence from the end of June 2016 until early September 2016 to discuss the financial and clinical case for change
- At the end of September 2016, the FBC will be taken to both Trust Boards for a decision in public whether or not to proceed to implementation.
- If the FBC is approved by both Boards and our regulators, a further period of engagement will take place to discuss and refine the Integration and Implementation plan.
- At the end of November, if the FBC has been approved by regulators, the Integration and Implementation Plan will be taken to both Trust Boards for approval.
- If the requirements above are satisfied, implementation can then start.

For the duration of the timeline described above, the project will input to and receive guidance on the clinical service reconfiguration plan being developed by Local Health Economy (LHE) system partners.

The Outline Business Case (OBC) includes processes, procedures and timelines for the delivery of back office and support function savings; identification of the organisational form changes for the two organisations; and a shared vision for future clinical service provision.

The business case makes recommendations to the boards of both trusts on the preferred level of collaboration to achieve these objectives.

2.2 Purpose of a full business case (FBC)

Subject to the approval of the OBC, an FBC will be produced according to timelines agreed by both boards and the regulators. The FBC will be the document upon which the final decision by the Boards will be made on whether the two organisations should merge. If it is approved, it will be sent to regulators for review and approval.

The FBC will include the main conclusions contained in the body of the OBC but with a more detailed review of both organisations, the case for change and the opportunities and risks associated with any future transaction. Significant additions will include:

2.2.1 Patient pathways

For those clinical services that are currently rated as being unsustainable (see section 3.1) at either organisation, the FBC will set out in some detail how these will look and feel to

[2] The MoU proposed that both Boards would consider the OBC at their April meetings, however as this occurred at a time of purdah it was delayed to the public board meetings in May

Huntingdon, Peterborough and Stamford patients. It will also set out how and in what timeframe the clinical collaboration and service sustainability can be achieved for the benefit of patients and staff.

2.2.2 Public engagement

During development of the FBC there will be public engagement on the case for change and the preferred option. Public views will be gathered in face to face meetings and other forums, to ensure the best possible understanding of what concerns need to be addressed. Information gathered will be used to shape the Full Business Case.

2.2.3 Financial Analysis

Financial analyses and information which will be in the FBC include:

Long Term Financial Model (LTFM)

A LTFM will be prepared for both trusts and for the merged trust which shows in detail the future finances over the next five years. It will include revenue and expenditure and detailed assumptions about economic conditions and future spending scenario's. This will help boards and regulators understand the financial position of both trusts in the long term if no strategic change takes place.

Savings

The savings associated with the recommended option in the OBC will be analysed in greater detail. This will include how the clinical and financial benefits identified in this document will be delivered, together with an updated analysis of the associated savings. This will also be compared to the FY17 budgets of both organisations.

There will be a detailed non-pay review of the possible long term IT savings, and a fully costed and externally assured and benchmarked review of the costs and timeframe of integrating IT systems.

Assets and Liabilities

A high level review of both organisations' assets and liabilities will be completed so both boards understand the risks and opportunities of the merged organisation.

2.2.4 Governance

Proposals will be drawn up of how the enlarged organisation will be run and governed. This will include details on day to day delivery of services, maintaining high standards of quality care, how the enlarged workforce will be managed and operational performance managed. This will be achieved consistently across the new organisation ensuring that patients receive the same level of service and care in the new trust.

2.2.5 Competition and Markets Authority (CMA)

The CMA will formally feedback its analysis of any competition issues that might be relevant to both organisations merging, and if any action is required by them, this will be included in the FBC. The implementation plan assumes that this will only require a phase 1 review.

2.2.6 External Assurance

External assurance of the financial details contained in the FBC will be provided to both boards. Assurance will be sought on the assumptions, finances, clinical pathways and the design of the future organisation.

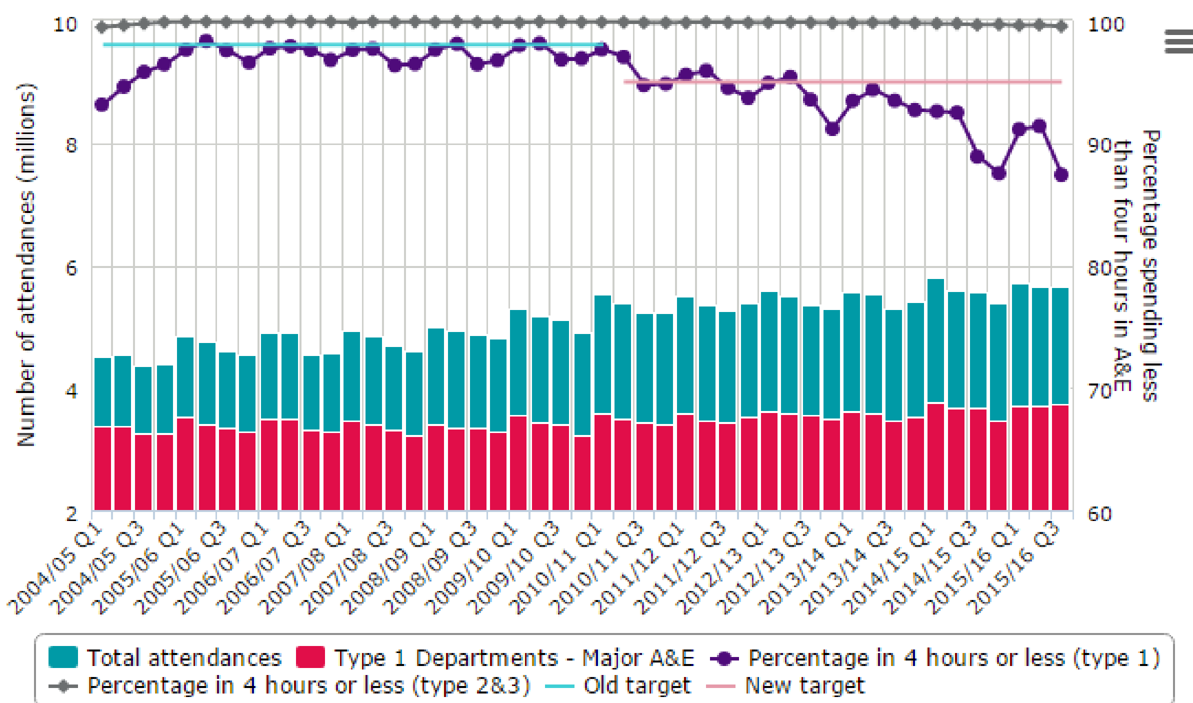
2.3 Background

2.3.1 National context

The demands on NHS services continue to rise with attendance at A&E being one measure of this. In FY04, the number of people nationally attending A&E was around 16.5 million including attendances at walk-in centres and minor injuries units (Figure 1). Since then, the overall number of attendances has increased significantly to 22.3 million in FY15, a rise of more than 35 per cent over the period. Until FY13, attendances at walk in centres and minor injury units accounted for the vast majority of this increase, but between FY14 and FY15 there were increases of 3 per cent in attendances at hospital A&E units.

Whilst the number of people visiting hospital is one reason for the rising demand, another is the ageing population which has resulted in longer stays not only in the A&E, but in the number of patients admitted to hospital, particularly in the winter months.

Figure 1 – NHS A&E performance FY04 to FY16



Source: Quality Watch (2016) http://www.qualitywatch.org.uk/indicator/ae-waiting-times

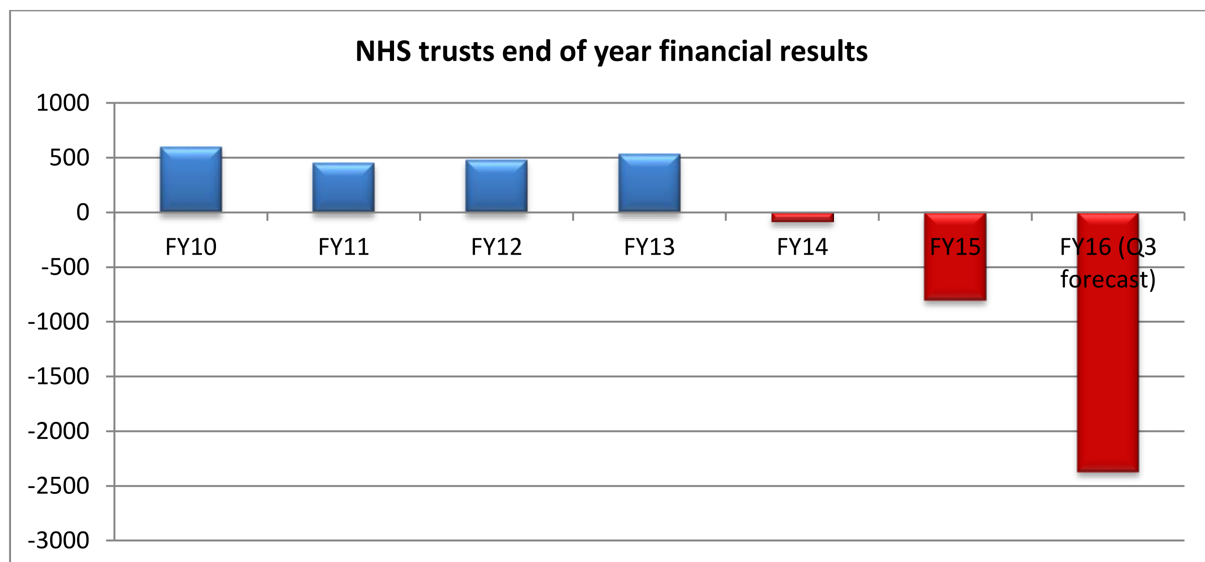
Rising demand has affected quality with the number of patients being seen and treated in A&E within the four hour standard dropping from between 96-98% between FY06 and FY11 to 88% in FY16 Q3.

The Care Quality Commission inspection processes have identified falling standards across the NHS. In 2012 the CQC[3] reported that 77 per cent of inspected hospital services, which includes acute, mental health and community hospitals, met all national standards. 21 per cent were not meeting at least one standard, and in one per cent of inspections, there were serious concerns.

By FY15, they reported 32 per cent were rated as either good or outstanding, while 57 per cent required improvement and 11 per cent were rated inadequate.

Government policy has been to protect health spending amidst an overall agenda of austerity but this means that there is an expectation that the health service will respond to rising demand for care within the agreed funding whilst maintaining standards. The rising demand for services with an above average efficiency requirement since 2009 has resulted in significant financial challenges across the NHS, particularly in the provider sector. This has become increasingly apparent since FY14 when the NHS reported its first deficit. The NHS forecast deficit for FY16 was in excess of £2.37bn at Q3 (Figure 2), with 89% of acute trusts currently in deficit.

Figure 2 - NHS trusts end of year financial results FY10 to FY16



As a result of all the national challenges – care quality, recruitment, finances, performance standards and the NHS Constitution – all parts of the country are developing system-wide Sustainability and Transformation Plans (STP) to explore areas such as greater innovation in community and primary care to drive reductions in inappropriate demand, and more collaboration between providers. The emphasis at the Department of Health is on re-establishing financial control through greater collaboration and whole health economy solutions, with less focus on the choice and competition elements of the Health and Social Care Act 2012.

---

[3] Care Quality Commission (2012) O*ur Market Report,* The Care Quality Commission (June 2012) Available at http://www.cqc.org.uk/content/our-market-report

All providers are being encouraged to work together to create safe, sustainable services in the face of rising demand. With this in mind, both Lincolnshire and Cambridgeshire are preparing Sustainability and Transformation Plans by the end of June 2016.

2.3.2 Sustainability and Transformation Plan (STP)

In the Cambridgeshire and Peterborough local health economy (LHE) the STP is being led by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), supported by all local health and social care organisations.

They have determined that the local health economy is currently unsustainable with economic pressures affecting all providers and commissioners. The latest projections show that the financial deficit across the NHS providers and commissioners in Cambridgeshire and Peterborough will be as high as £250m by FY21, if we continue to perform as we've done in the recent past. The system has already incurred a collective deficit of £150m in FY16, which is one of the highest per person in the country. It has been concluded that transformation of the current configuration of sites and services is required to improve value for money, whilst maintaining standards of care.

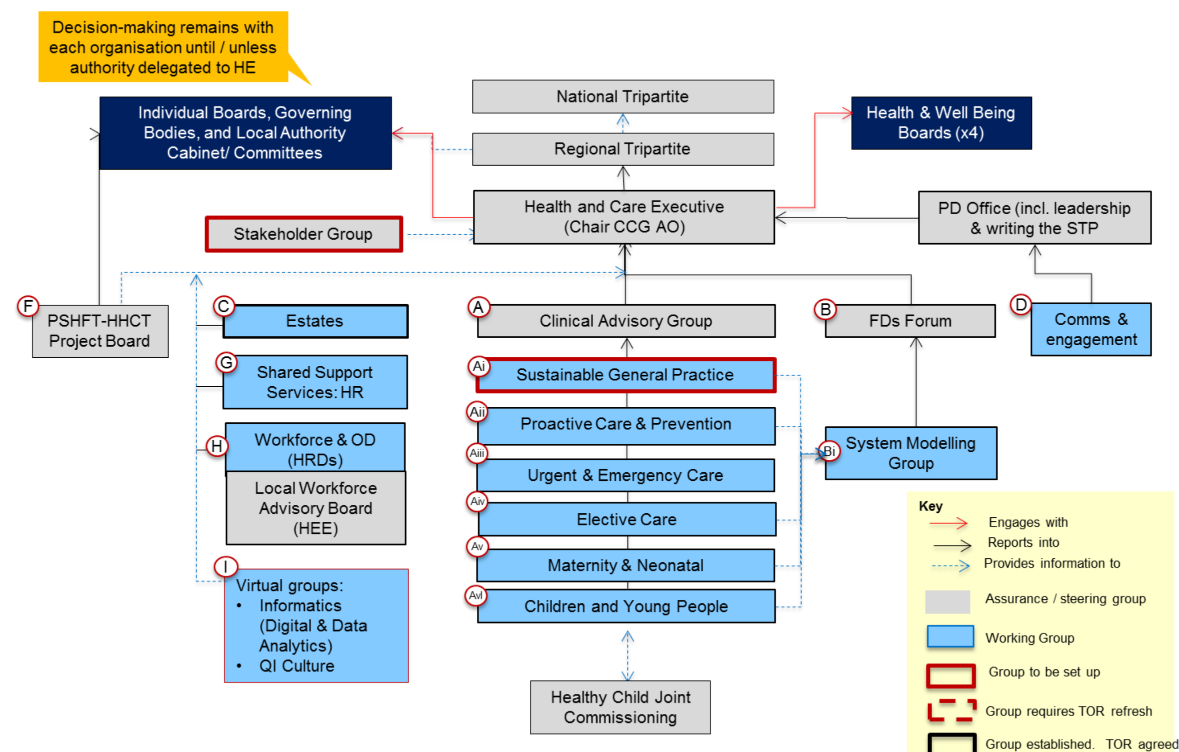
The scale of the local challenge means clinicians are being asked to identify every opportunity to keep people well, support more primary led care in neighbourhoods, make sure everyone is seen in the right setting if they have an urgent need, standardise and streamline planned care along best practice pathways, and concentrate expertise where this shows demonstrable impact on outcomes. We are also looking at every opportunity to share costs of what we purchase (such as drugs) and our estates, so most funds can be directed towards front line care.

The STP will be developed by June 2016 which will be informed by work being carried out by teams (Figure 3) focussing on:

1. End to end pathway redesign including primary and secondary care
    - Sustainable General Practice
    - Proactive care and prevention
    - Urgent and Emergency Care (national Vanguard site)
    - Elective care design
    - Maternity and neonatal services
    - Children and Young People
2. Greater collaboration between HHCT and PSHFT
3. Financial incentives alignment
4. Utilisation of estate across Cambridgeshire and Peterborough
5. Increasing the effective use of staff skills and experience

This business case supports the second point and will be used to inform the STP.

Figure 3 – Governance of the Cambs and Peterborough STP work



2.3.3 HHCT and PSHFT

Key facts about both trusts are shown in Figure 4.

Figure 4 - Trusts at a glance

	HHCT	PSHFT
Populations served	193,000	507,000
Main commissioners	CPCCG	CPCCG 57% SLCCG 22% NHS England 10% Others 11%
Forecast turnover FY16	£112.6m	£260.8m
Forecast surplus/deficit FY16	£17.1m	£37.1m
Surplus as % of turnover	-15.1%	-14.2%
Number of sites	1	2
Number of beds	235 + 21 day case in Treatment Centre	611 + 22 intermediate care at Stamford
Staff WTE	1,553	4,019
CQC overall rating	Requires improvement	Good
National performance standards YTD	Failing ED 4 hour wait and MRSA target	Failing ED 4 hour wait, and MRSA

HHCT and PSHFT provide services to a combined population of around 700,000 people living predominantly in Cambridgeshire, Peterborough and South Lincolnshire. Their FY16

combined income was £372m with a combined forecast deficit of £54.8m. Between them, they employ 5,572 WTE employees.

The main commissioner of services for both trusts is Cambridgeshire and Peterborough Clinical Commissioning Group although nearly a quarter of the PSHFT activity is commissioned by South Lincolnshire CCG.

Local providers

Neighbouring NHS hospitals include Cambridge University Hospitals, United Lincolnshire Hospitals (particularly Grantham and Pilgrim hospital at Boston), The Queen Elizabeth Hospital, Kettering General Hospital, Bedford Hospital and University Hospitals of Leicester (Figure 5).

Figure 5 - Hospitals around HHCT and PSHFT

United Lincolnshire Hospitals NHS
Lincolnshire East CCG
South West Lincolnshire CCG
Queen Elizabeth Kings Lynn Hospital NHS FT
South Lincolnshire CCG
University Hospitals Leicester NHS Trust
Stamford Hospital
Peterborough City Hospital
West Norfolk CCG
East Leicestershire and Rutland CCG
Cambridgeshire and Peterborough CCG
Kettering General Hospital NHS FT
Corby CCG
Hinchingbrooke Healthcare NHS Trust
Nene CCG
Bedford Hospital NHS Trust
Cambridge University Hospital NHS FT
Map data ©2016 Google

Key

CCG boundaries

Catchment areas

The catchment area for both trusts is shown in Figure 6. HHCT provides care to 193,000 people from Huntingdonshire and the surrounding area. Peterborough and Stamford Hospital NHS Foundation Trust (PSHFT) serves a core population of over 300,000 people in Peterborough, South Lincolnshire and neighbouring areas with a further 200,000 people in the wider catchment.

There is a small overlap in catchments to the southwest of Peterborough around the A1 between Peterborough and Huntingdon which includes the villages of Yaxley, Stilton and Sawtry.

Figure 6 - HHCT and PSHFT catchment areas

Key

Hospital sites

CCG boundaries

HHCT

PSHFT

Catchment populations

Peterborough is one of the fastest-growing cities in the UK according to the Centre for Cities (2015)[4] study, with an annual growth rate of 1.6% between 2003 and 2013, which is equal top with Milton Keynes and over double the national average of 0.7%.

Data from the Cambridgeshire and Peterborough CCG[5] shows that the total population is forecast to grow by 10% between 2016 and 2021 as shown in Figure 7. The highest population growth is in East Cambridgeshire (13%) and Peterborough (11%). In contrast, growth in the over 65 age group is forecast to grow by 14% with the highest increases in Huntingdonshire and East Cambridgeshire (17% for both).

Figure 7 - Cambridgeshire and Peterborough CCG population forecasts

	Total Population				Over 65s			
	2016	2021	Change 2016-2021	% change	2016	2021	Change 2016-21	% change
Cambridge City	136,200	148,300	12,100	9%	16,200	18,500	2,300	14%
East Cambs	87,200	98,300	11,100	13%	16,900	19,700	2,800	17%
Fenland	98,300	104,000	5,700	6%	22,200	24,800	2,600	12%
Huntingdonshire	177,800	193,400	15,600	9%	33,800	39,400	5,600	17%
South Cambs	153,900	169,800	15,900	10%	29,600	33,900	4,300	15%
Peterborough	198,300	220,700	22,400	11%	28,400	32,200	3,800	13%
Cambs & P'boro Total	851,700	934,700	83,000	10%	147,300	168,300	21,000	14%

PSHFT is an important healthcare provider to the population of South Lincolnshire. Figure 8 suggests much lower overall levels of population growth (4%) in that area, but with an 11% increase in those aged over 65.

Figure 8 - ONS forecast population growth for South Lincolnshire CCG area

	Total Population				Over 65s			
	2016	2021	Change 2016-2021	% change	2016	2021	Change 2016-21	% change
South Lincolnshire CCG	145,839	152,224	6,385	4%	34,290	37,929	3,639	11%

[4] Centre for Cities (2015) *Cities Outlook 2015*, Centre for Cities (January 2015) Available at http://www.centreforcities.org/reader/cities-outlook-2015/3-city-monitor-the-latest-data/#figure-1-population-growth
[5] Cambridgeshire and Peterborough Health and Care System Technical Appendices Available at http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Five%20Year%20Plan/21-07-2015-Appendices%20-%20Change%20Document.pdf page 99

Trust services

Both trusts are district general hospitals; PSHFT is the larger of the two with a broader range of clinical services (Figure 9), with most of the inpatient services on the Peterborough City Hospital site, and significant outpatient services on the Stamford site, for example the pain management service based there is one of the largest in the region.

As is best practice, both trusts work closely with neighbouring teaching hospitals, especially Cambridge University Hospitals, to provide specialist services through in-reach and shared staff.

Figure 9 - Clinical services by trust

Service	HHCT	PSHFT
Accident & Emergency	□	□
Acute Medicine	□	□
Ambulatory Care	□	□
Audiology	□	□
Breast Surgery	□	□
Cardiology	□	□
Clinical haematology	□	□
Diabetes and Endocrinology	□	□
Diagnostic imaging	□	□
Ear, Nose and Throat	□	□
Endoscopy	□	□
Gastroenterology	□	□
General Medicine	□	□
General Surgery	□	□
Geriatric Medicine	□	□
Gynaecology	□	□
Lower GI	□	□
Lymphedema		□
MacMillan centre	□	□
Neonatal	□***	□

Service	HHCT	PSHFT
Obstetrics	□	□
Oncology	□**	□
Ophthalmology	□	□
Oral and maxillofacial		□
Pain		□
Paediatrics	□***	□
Palliative care	□	□
Pathology	□	□
Plastics and dermatology	□	□
Radiotherapy		□
Renal	□**	□
Respiratory	□	□
Rheumatology	□	□
Stroke	□****	□
Therapy services	□	□
Thoracic Medicine		□
Trauma and Orthopaedics	□	□
Upper GI	□	□
Urology	□	□
Vascular	□*	□*

*Networked service provided by CUHFT
**Outpatient service only
***Provided on the HHCT site by Cambridgeshire Community Services
****Stroke rehabilitation only, no acute care.

2.3.4 Hinchingbrooke Health Care NHS Trust

Hinchingbrooke Hospital opened in 1983, it has 235 general and acute beds, and in the dedicated Treatment Centre there are an additional 21 beds specifically for day cases, alongside 25 beds in the procedure unit. The trust also has an Emergency Department, a 40-bed maternity centre (in addition to the 235 general beds), and dedicated facilities for self-funded and private patients.

The level 1 Special Care Baby Unit (SCBU), and the children's services at the trust are provided by Cambridgeshire Community Services (CCS) NHS Trust.

From February 2012, Circle won the management franchise, making HHCT the first trust in the country to be managed by an independent healthcare company. At the end of March 2015, Circle withdrew their management of the trust due to financial unsustainability. Since April 2015 the trust reverted to the traditional management structure of an NHS trust.

The main purchaser of Hinchingbrooke services is Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG). The trust also provides some services to patients in Bedfordshire and Northamptonshire.

Hinchingbrooke employs approximately 1,550 staff in clinical and non-clinical roles with very limited outsourced services.

2.3.5 Peterborough and Stamford Hospitals NHS Foundation Trust

Peterborough and Stamford Hospital NHS Foundation Trust (PSHFT) was formed on 1 April 2004 as one of the first 10 foundation trusts created under the NHS Act 2003, and is the successor organisation to Peterborough Hospitals NHS Trust. The trust moved into the new 623-bed Peterborough City Hospital in November 2010.

This move brought improved services and facilities to the city including a state-of the-art Radiotherapy Unit, an Emergency Centre with a separate children's emergency department, a dedicated Women's and Children's unit, an expanded cardiac unit, a new respiratory investigations facility and an additional MRI scanner. Inpatients at Peterborough City Hospital are cared for on modern wards where there is a mix of beds including single rooms with en-suite facilities and four-bedded ward areas, each with their own bathroom. This affords patients greater privacy than before and meets the NHS same sex accommodation criteria.

Stamford hospital provides a range of outpatient clinic and diagnostic services, a minor injuries unit, day case surgery, is the base for the trust's pain management services and has 22 inpatient beds.

The trust employs 4,019 WTE staff across its two sites. 180 staff are based permanently at Stamford Hospital, while the remainder are at the Peterborough City Hospital. In addition, facilities services at the Peterborough City Hospital site are provided through a contracted management service as part of the trust's Private Finance Initiative (PFI) contract.

2.3.6 Regulation

Both NHS providers operate in a highly regulated environment. In addition to meeting financial targets as part of the terms of authorisation, they are also required to meet national performance standards and are assessed for quality by the Care Quality Commission.

As a Foundation Trust, PSHFT is accountable to its governors and regulated by NHS Improvement. HHCT is accountable to the Secretary of State through NHS Improvement.

2.3.7 Quality

The trusts have different CQC ratings. As overall headline scores, HHCT are rated as 'Requires improvement' and are currently in special measures, whereas PSHFT has been rated 'Good'.

PSHFT had a CQC revisit in May 2015 to review identified areas following the main trust inspection in May 2014. The final report was received and published in July 2015 giving the trust an overall rating of 'Good'. A summary of their findings based on the initial inspection in 2014, with the updated scores for the areas they re-inspected in 2015 is shown in Figure 10.

There were areas of exemplary practice that the trust was commended for and some areas that were recommended for improvement particularly with regard to medical care in medical specialties. Stamford hospital was rated overall as 'Good' with all inspection domains rated 'Green'.

Figure 10 - CQC ratings of PCH services from inspections in March 2014 and May 2015

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

HHCT was revisited by the CQC in October 2015, following their earlier inspection in September 2014. On re-inspection, the overall rating was 'Requires Improvement'. Urgent and emergency care services are rated 'Inadequate'. The summary report is shown in Figure 11.

The CQC identified material improvements since their last inspection and reported that the leadership team was well placed to continue the improvements made recently. They recommended that the trust should remain in special measures, with a re-inspection planned in May 2016.

Figure 11 - HHCT CQC ratings Jan 2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

2.3.8 National performance standards

Operating performance across both trusts are generally similar (Figure 12). *Better Care Better Value* benchmarking indicators are compiled by NHS Quality Improvement, and are used to identify potential areas for improvement in efficiency[6].

Figure 12 - Better Care Better Value performance Q2 FY16

Performance Q2 FY16	Nat avg	HHCT	Rank[7]	PSHFT	Rank
Reducing length of stay[8]	13.94%	13.83%	80	13.18%	43
Emergency readmission (14 day)	5.43%	5.40%	78	6.74%	145
First to follow up ratio	1.96	1.47	22	1.71	49
Pre-procedure non elective bed days	1.57	1.58	88	2.00	146
Outpatient DNA	8.21%	5.31%	16	6.60%	42
Day case rate	78.12%	77.47%	87	77.0%	94
Pre-procedure elective bed days	0.26	0.16	77	0.10	33

The most recent data shows that both trusts have better than average:

- length of stay,

[6] For further information, detail and indicator definitions see http://www.productivity.nhs.uk/
[7] Ranked against all NHS organisations included in the indicator
[8] This indicator shows a percentage bed day saving and associated financial productivity opportunity to be realised (Lower is better).

- outpatient first to follow up ratios and ‘Did not attend’ rates,
- and pre-procedure elective bed days.

Pre procedure non-elective days and day case rates are both worse than average.

As well as efficiency measures, all trusts must meet national performance standards, and penalties are imposed where they fail to do so.

PSHFT met most of the national performance standards for the past 12 months with the exception of the A&E four hour standard (Figure 13).

Figure 13 - PSHFT performance against national standards March 2016

	Full Year Target	Q1	Q2	Q3	Q4	Full year actual
RTT 18 Weeks -% Incomplete Pathways within 18 weeks	92%	96.6%	95.5%	94.6%	93.6%	95.0%
All Cancers - 2 Week Wait	93%	95.8%	94.7%	96.4%	96.8%	96.0%
All Cancers - 31 day wait from referral to treatment	96%	99.2%	100.0%	99.4%	99.1%	99.5%
All Cancers - 62 day wait from referral to treatment	85%	86.8%	88.3%	87.9%	78.7%	86.1%
All Cancers - 62 day screening	90%	100.0%	97.2%	93.1%	89.1%	95.0%
All Cancers - Subsequent Treatment - Drugs	98%	100.0%	100.0%	100.0%	100.0%	100.0%
All Cancers - Subsequent Treatment - Surgery	94%	100.0%	100.0%	100.0%	100.0%	100.0%
All Cancers - Subsequent Treatment - Radiotherapy	94%	99.5%	100.0%	94.3%	99.5%	97.9%
All Cancers - Subsequent Treatment - All	96%	99.7%	100.0%	98.3%	99.7%	99.1%
Breast Symptomatic	93%	94.6%	95.8%	98.3%	97.6%	96.8%
A&E - Total time in A&E 4 Hours or Less	95%	91.0%	95.9%	94.4%	81.1%	90.5%
C-Diff rates - Inpatients	31	7	5	1	3	16

*Target to be met each month in the quarter

HHCT performance in Figure 14 shows that they met all national standards for the past 12 months with the exception of A&E four hour waiting time and 62-day cancer referral to treatment.

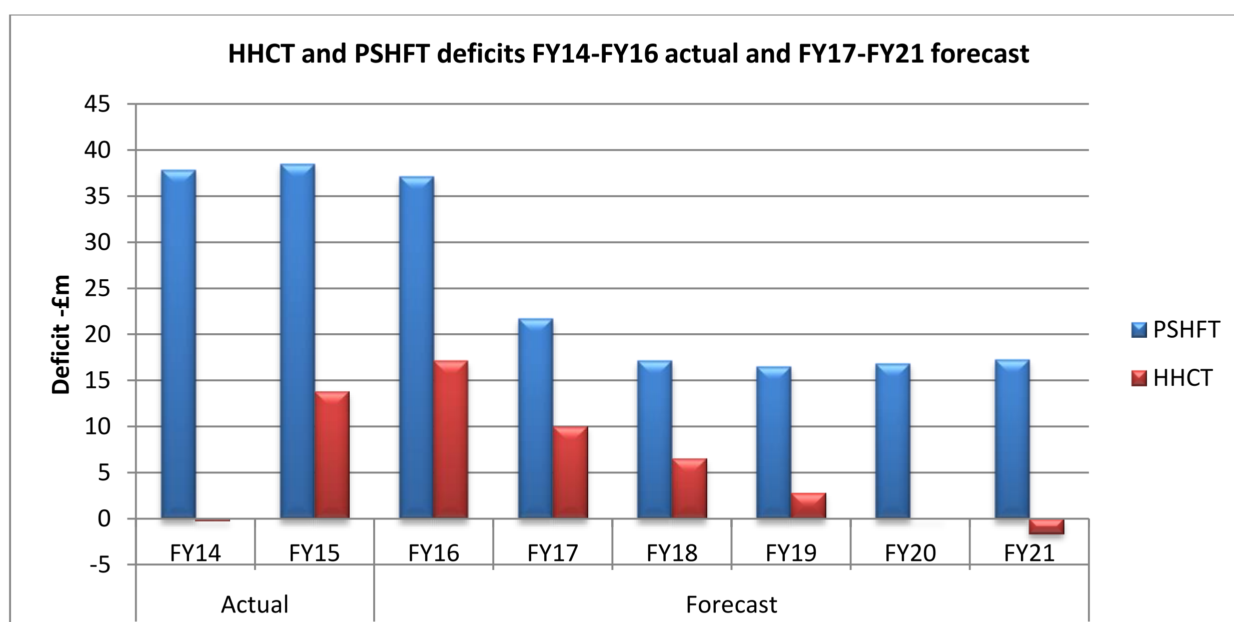
Figure 14 - HHCT performance against national standards March 2015

	Full Year Target	Q1	Q2	Q3	Q4	Full year actual
RTT 18 Weeks -% Incomplete Pathways within 18 weeks	92%	97.7%	97.3%	94.9%	94.2%	96.0%
All Cancers - 2 Week Wait	93%	98.0%	97.3%	96.1%	91.5%	95.7%
All Cancers - 31 day wait from referral to treatment	96%	100.0%	100.0%	99.4%	100.0%	99.9%
All Cancers - 62 day wait from referral to treatment	85%	80.7%	89.6%	80.3%	87.0%	84.4%
All Cancers - 62 day screening	90%	100.0%	91.7%	100.0%	93.3%	91.5%
All Cancers - Subsequent Treatment - Drugs	98%	100.0%	100.0%	100.0%	100.0%	100.0%
All Cancers - Subsequent Treatment - Surgery	94%	100.0%	100.0%	100.0%	97.0%	99.1%
All Cancers - Subsequent Treatment - Radiotherapy	94%					
All Cancers - Subsequent Treatment - All	96%					
Breast Symptomatic	93%	94.5%	94.4%	97.2%	96.1%	95.7%
A&E - Total time in A&E 4 Hours or Less	95%	92.8%	96.8%	94.1%	87.1%	92.7%
C-Diff rates - Inpatients	11	1	3	1	1	6

2.3.9 Financial performance

The experience of both trusts has demonstrated that reliance on traditional cost improvement plans is insufficient to reduce underlying deficits; at best it only delays future deterioration in finances and therefore, potentially impacts on the level of service. The trusts have been operating at a combined financial deficit (Figure 15) for at least two years.

Figure 15 - PSHFT and HHCT financial performance FY14 to FY21



The combined deficit for FY16 is £54.2m, compared with £52.3m in FY15 and £37.6m in FY14.

Since the move to the new Peterborough City hospital site in FY11, PSHFT has been operating at a financial deficit of around £40m. This is due to reliance on locum and agency staff, below tariff payments, penalties associated with the rise in emergency activity, and the national tariff not covering the premium cost of PFI buildings. Achievement of above average cost improvement has failed to deliver a surplus position over the past four years.

The HHCT deficit has arisen in the past two years and is attributed mainly to the size of the organisation with recent significant increases in staff costs associated with both compliance with safe staffing levels and on-going demands of running a small hospital. With the ending of the Circle franchise in 2015 the forecast FY16 deficit is £17.5m and there will be a reliance on HHCT to use external financial support.

PSHFT is anticipating a reduction in its deficit largely through delivery of above average CIP, and sustainability and transformation funding. This will reduce the forecast deficit to £17.2m by FY21. Previous reports including the National Audit Office (2012) have identified that PSHFT also require an additional £15m DH premanent subsidy to meet the recognised gap between the tariff and the cost of the PFI. The benefit of this additional funding is not included in the financial plan shown in Figure 15. Including it would bring the deficit to £2m. The benefits of merger would move the trust into a financial surplus position.

HHCT current plan eliminates its deficit by FY20 through significantly higher than average CIP and delivery of an emerging estate strategy. In addition, elements of the HHCT CIP already include and are dependent on closer collaboration with PSHFT e.g. sharing corporate staff, IT systems and joint cost improvement plans.

2.3.10 Financial risk and governance ratings

As a Foundation Trust, PSHFT is rated quarterly by NHS Improvement for financial and governance risk. As an NHS trust, HHCT is rated by NHS Improvement.

The financial risk of a trust is rated on a scale of 1-4, where higher is better, governance is RAG rated green, amber and red.

Prior to the move to the PCH site, PSHFT had a financial risk rating (FRR) of 4, which deteriorated to a 1 from FY12 after the move (Figure 16). Consequently, the trust was placed in special measures and the governance risk rating fell from amber to red. The most recent FRR improved to 2 in FY16 due to the the score being calculated on the basis of performance against budget rather than surplus/deficit as a percentage of turnover.

Figure 16 - PSHFT Monitor risk ratings

	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16
FRR	4	4	3	1	1	1	1	2
GRR								

The financial performance deteriorated when the trust incurred the cost of the new PFI building and increased use of space in the building is a key contributor to reducing the deficit.

As a non-Foundation Trust, HHCT are not subject to a financial risk rating process although Section 2.3.9 sets out their worsening financial performance over recent years.

2.4 Conclusions

This business case considers whether closer collaboration between HHCT and PSHFT should be explored in more detail, and if so, what form should be considered.

These neighbouring trusts provide district general services to a combined and growing population of around 700,000 people. PSHFT is a financially unsustainable trust, whereas HHCT is both clinically and financially unsustainable.

Quality at PSHFT is rated by the CQC as 'good', whereas HHCT is currently rated 'Requires Improvement' and they are in special measures.

In common with providers in the rest of the NHS, HHCT and PSHFT face significant challenges in meeting rising demand within the available finances. They are operating within a challenged health economy, and there is a recognition that the scale of the financial challenges needs to be met on a system wide basis.

3. The evidence for change

There are three strategic drivers for change described in more detail in this chapter:

1. **Clinical sustainability** – some services are not currently sustainable to be delivered locally for patients now and/or are likely to become unsustainable in the future without collaboration.
2. **Better use of the available NHS capacity to meet demand** – demand for services is increasing regionally and locally, and the current configuration of clinical capacity is not matched to meet this demand.
3. **Financial sustainability** – both organisations are currently financially unsustainable

3.1 Clinical sustainability

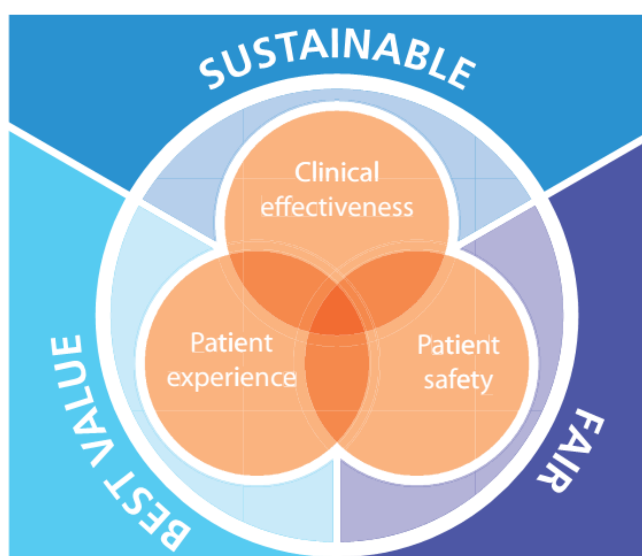
Despite the passion, commitment and hard work of staff, there are some services that HHCT is already struggling to provide sustainably and where working collaboratively will provide real local benefits locally to patients. There are some services at PSHFT which are not sustainable in the medium to longer term, and others where working with another trust will have benefits for Peterborough patients. This OBC focuses on maximising the quality and accessibility of safe services while managing the local and national challenges for both trusts.

3.1.1 Clinical Reference Group

The Clinical Reference Group (CRG) led by the Hinchingbrooke Deputy Chief Executive is a sub group of the Project Management Board and includes clinicians from both trusts. The terms of reference are included in Appendix 2.

The CRG defines sustainable services as those which are located and sized appropriately according to need, and staffed by people with suitable experience and qualifications to provide high quality services that are effective, efficient and represent value for the tax payer (Figure 17).

Figure 17 - Definition of clinically sustainable services



The challenge for both trusts is to:

- Sustain and subsequently improve the quality of care and ensure consistent delivery for people who need it
- Develop our hospitals as a good place to work which will improve recruitment and enable us to keep the staff they have.
- Integrate care and make best use of our expertise and facilities.

Trusts working together are able to make services more sustainable as larger teams can provide the required staffing cover sustainably. Single-handed or small specialties are more susceptible to loss of specialist staff as those individuals move to larger services elsewhere where they are more likely to develop their skills further.

Sustainability example – Hinchingbrooke ED

- third smallest department in the country
- Unable to recruit successfully to substantive ED consultant roles for years
- Only two substantive ED consultants compared with the required six
- Less appealing roles at HHCT due to case mix, smaller teams and fewer trainees
- Cover provided through use of expensive

An example of clinical unsustainability associated with size is the emergency department at HHCT which is the third smallest department in the country. It has been unable to recruit successfully to substantive their ED consultant roles for a number of years due to a general shortage across the country combined with the relatively less appealing role given its size, case mix and associated poorer career opportunities.

Despite all attempts to recruit, only two substantive ED consultants are in post compared with a required establishment of at least six and a 40% vacancy rate in middle grade doctors.

To maintain safe services, the remaining gaps are filled by a combination of long-term locums and short-term locum shifts. This is not a sustainable solution for the ongoing provision of high quality urgent care services through an ED.

In contrast, PSHFT which has been identified by Monitor as operationally and clinically sustainable, has recently appointed four ED consultants which will enable the trust to move from 9.5 WTE to 11 WTE (after people moving on and retirement) later in the year.

3.1.2 Services which are unsustainable in their current form

The Clinical Reference Group defined services as being ‘clinically unsustainable’ if one or more of the following conditions are met:

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

Working with these criteria, medical and nursing directors for both trusts identified four services that are currently unsustainable at HHCT, and eight that will become unsustainable in the medium term. PSHFT identified four services which will become unsustainable in the

medium term. There are more services identified as significant opportunities to improve quality and efficiency through collaboration. The findings are summarised in Figure 18.

Figure 18 – Clinical services sustainability

	Unsustainable		Quality/ efficiency	Affecting	
	Now	Medium term	opportunity	PSHFT	HHCT
Accident & Emergency	□				□
Acute Medicine		□		□	□
Ambulatory Care			□	□	□
Breast Service			□	□	□
Cardiology		□			□
Clinical haematology	□				□
Diabetes			□		
Diagnostic imaging / Interventional radiology		□	□	□	□
Endoscopy			□	□	
ENT			□	□	□
Gastroenterology		□		□	
General Surgery			□		□
Geriatric Medicine			□	□	□
Gynaecology			□		□
Haematology					
Maternity			□	□	□
Neonatology			□		□
Nephrology		□			□
Neurology		□			□
Oncology			□	□	□
Ophthalmology			□	□	□
Oral and max facs			□	□	NA
Ortho-Geriatrics		□		□	□
Trauma and orthopaedics			□	□	□
Paediatrics (provided by CCS)			□		NA
Pain					
Palliative care		□			
Plastics and dermatology			□		□
Radiotherapy - Unsustainable across LHE			□	□	NA
Respiratory			□		□
Rheumatology			□	□	□
Spinal surgery	□			NA	□
Stroke	□				□
Therapy services			□	□	□
Urology			□	□	□

Emerging themes and root causes of unsustainability

A number of repeated themes have emerged, which the Clinical Reference Group has mapped back to three underlying root causes of unsustainability. The root causes and their impact is set out in Figure 19 below.

Figure 19 - Underlying causes of clinical unsustainability

Root Causes	Effect
1. Uncertainty about the future	• Recruitment problems (particularly for HHCT A&E and acute medicine)
2. Catchment area too small to support: • Optimal sized teams • Trainee posts • Sub-specialism	• Fewer clinical posts (several small/single-handed services) • Limited opportunity for cross-cover / resilience • Peer support limited • General/routine case-mix (not varied) • Training posts not supported by Deanery (+impact on recruitment pipeline) • Senior staff required to act-down • Little opportunity for sub-specialist interest • Limited opportunity for personal development • Onerous on-call requirements (also expensive)
3. National shortage of trained staff	• Issues above make it particularly difficult to compete for staff for roles where there is a national shortage of trained staff.
4. Overall impact	• Recruitment & retention difficulties • Greater reliance on agency/locum staff • Quality impact • Cost impact

Greater long term collaboration will directly improve the first three of the root causes and indirectly should place the trusts in a position to address the fourth.

As part of the Outline Business Case development, a change readiness evaluation exercise was undertaken by lead clinicians to identify a short list of services where sustainability is most under threat and the need and motivation for service change was recognised by the clinical teams. Four specialty areas were selected representing medical, surgical and clinical support functions and these were explored in greater detail to understand current service delivery, and explore the opportunities and potential impact of further collaboration. Although these four were chosen for immediate exploration of possible impact, it is clear that there will be many more services that could see similar impacts.

Face to face clinical team meetings were held to discuss the current situation, potential solutions, and the extent to which they could be implemented under each of the organisational form options.

Figure 20 – Specialities for focus

Specialty	Reason for focus
Diagnostic Imaging	High cost area with significant service interdependencies
Stroke	Fragile service at both trusts, but unsustainable at HHCT under current arrangements
Haematology	Unsustainable at HHCT
ENT	ENT on-call rotas under pressure (1 in 4 at both trusts), options for collaboration also include considering the location of short-stay surgery.

A further three services which should be considered in the near future include orthopaedics, cardiology/ respiratory (to be linked to the Papworth move) and seven day gastro-intestinal bleed service.

Discussions with a sample of clinicians in the four specialties demonstrate the current challenges they face and are included in Appendix 3.

The CRG recommendations to improve clinical sustainability include:

- Work a fixed number of clinical sessions across both organisations
- Share out of hours and ‘on-call’ cover
- Join-up of some, or all, clinical teams
- The appraisal process should consider the extent to which each of the options will support this closer working to improve clinical sustainability. Clinicians for all services acknowledged the need for single policies, procedures and IT to make it relevant to deliver care consistently and safely across both trusts.

3.1.3 National initiative sustainability pressures

In addition to the current pressures identified locally, the national drive to improve quality will place additional sustainability pressures on both trusts.

National guidelines

The relationship between increased volume of procedures and the outcome of treatment has long been an area for attention for healthcare professionals and academics. The Royal Colleges, Improving Outcomes Guidance, Clinical Networks and NHS national guidelines are increasingly relating patient outcomes to population size and the need for enough procedures or patients to be treated per annum.

National consolidation of some services has already occurred, including the introduction of major trauma centres in 2013 which significantly improved outcomes for patients involved in serious injury, and the vascular service review concentrated all but the most basic vascular procedures into regional centres. Some surgery and other specialised treatment of cancer (including paediatrics) is another area which has been centralised for some time, as have acute stroke services.

As with services such as stroke, heart attack, major trauma and vascular surgery, further centralisation at specialist centres is being discussed nationally. The national maternity review led by Baroness Cumberledge, and the Urgent and Emergency Care review led by Professor Keith Willett will set new standards of care for providers and impact on every provider in the country including these two trusts.

This business case does not consider any reconfiguration of clinical services which would be led by the commissioner, Cambridgeshire and Peterborough CCG, and would likely be subject to public consultation. Further specialist centralisation will place increased pressure on both trusts from rising clinical thresholds, minimum staffing levels and eventually potential loss of income for some specialties. Failure to collaborate therefore is likely to result in an inability of both or one trust to meet the sufficient numbers of procedures to meet the volume of patients required for accreditation, and hence services will be lost from the local area.

Seven day services

The government committed to make the NHS a 'truly seven day service' as part of their manifesto. Providing on-site cover, seven days a week will be challenging for our trusts, both financially as well as in the ability to recruit, especially for specialties where we already experience shortages.

3.1.4 Recruitment and Retention

Recruitment of suitably qualified staff is an issue for many trusts in the UK for specialties that are less popular for doctors in training to specialise in. Smaller trusts in particular often find it even harder to recruit to services such as stroke where potential candidates have a number of vacancies to choose from across the region. Working in a small team is considered unattractive because of the lack of peer support, junior doctors and career progression prospects, as well as often very onerous on call commitments.

Both HHCT and PSHFT are struggling with recruitment and retention for some clinical roles. For example HHCT are unable to recruit a haematology consultant despite repeated attempts and have no substantive staff member in place for this service. As elsewhere in England, they are highly dependent on temporary staff from agencies. While some level of agency staffing can be positive, giving flexibility to increase or decrease staffing levels according to demand, combined current usage is very high. Both HHCT and PSHFT have gaps in some positions that are currently not filled permanently, for example ED and clinical haematology in HHCT.

Sustainable, high-quality staffing depends upon services being attractive to future applicants and current staff. Making services attractive involves ensuring:

- front-line staff are exposed to the learning opportunities they want and need for professional development;
- an appropriate work-life balance, for example, enough staff on rosters to allow for a sustainable rotation of on-call duties;
- a culture of respect and care for staff.

Working together will make our organisations more attractive to staff, improve morale and recruitment and reduce reliance upon locum and agency staff.

3.2 Matching available capacity to meet demand

The current configuration of healthcare providers will not meet the anticipated demand unless there is a significant change in:

- **Demand** by somehow limiting the demand for hospital care
- **Capacity** through all providers working together

Capacity for in-hospital care is not keeping pace with demand. Demand is forecast to grow faster and it is imperative that hospitals work together to use all the available space. PSHFT operates at an average 98% bed occupancy rate whereas HHCT has empty wards which could be used if there was greater collaboration between the two trusts. High bed occupancy at PSHFT can lead to cancellations and postponement of elective activity[9].

HHCT has an estate which could be better utilised. For example, the trust has decommissioned one ward, but the ability to make better use of existing capacity is constrained because clinical staffing is not flexible enough to match the peaks in demand elsewhere in the region. Moving clinical staff between our trusts is possible, and has been done[10], but this has proved to be complex and time-consuming to arrange due to different policies, procedures and equipment availability at each of the sites. Experience has shown the overall efficiency of doing this via SLA's is reduced and therefore this does not make best use of tax payers money.

Capacity and demand are often misaligned, with a variety of opportunities to better utilise our staff and facilities, so that we can reduce waiting times, avoid cancellations, and reduce the cost to the tax payer. The misalignment of capacity and demand will increase if the forecast population grows is as expected.

3.2.1 Demand

Figures for Cambridgeshire and Peterborough show that the population will grow by 64,000 between 2013 and 2018. The Cambridgeshire and Peterborough CCG total population is forecast to grow by 10% (83,000) between 2016 and 2021, as shown in Figure 7. The highest population growth is in East Cambridgeshire (13%) and Peterborough (11%). In contrast, growth in the over 65 age group is forecast to grow by 14% with the highest increases in Huntingdonshire and East Cambridgeshire (17% for both).

As people age, they are progressively more likely to live with complex co-morbidities, disability and frailty. People over the age of 65 account for 51% of gross local authority spending on adult social care (Health and Social Care Information Centre 2013[11]) and two-thirds of the primary care prescribing budget, while 70% of health and social care spend is on people with long-term conditions (Department of Health 2013[12]). Having reviewed the

---

[9] See the most recent data from NHS England (2015) Cancelled Elective Operations Data available at https://www.england.nhs.uk/statistics/statistical-work-areas/cancelled-elective-operations/cancelled-ops-data/

[10] PSHFT to HHCT elective activity transfers pilot (Orthopaedic Hips and Knees, and General Surgery) which commenced in 2015

[11] Health and Social Care Information Centre (2013) Personal Social Services: Expenditure and Unit Costs, England Published (19 September 2013) Available at https://catalogue.ic.nhs.uk/publications/social-care/expenditure/pss-exp-eng-12-13-prov/pss-exp-eng-12-13-prov-rpt.pdf

[12] Department of Health (2013). Improving quality of life for people with long term conditions. London: Department of Health. Available at: www.gov.uk/government/policies/improvingquality-of-life-for-people-with-long-term-conditions (accessed on 7 January 2014)

growth in population and health needs statistics, both trusts are assuming a growth in activity as part of their capacity and finance plans over the next five years.

3.2.2 Capacity

With a finite number of hospital beds, if our trusts work together we could make better use of the available capacity. The CCG has assessed that the way we provide and deliver care remains the same, then due to the growing and ageing population, 259 additional beds will be required for the population of Hinchingbrooke and Peterborough catchment by FY21. This does not include the impact of population growth in the Lincolnshire area. An assessment of the bed and theatre capacity is included in Appendix 4.

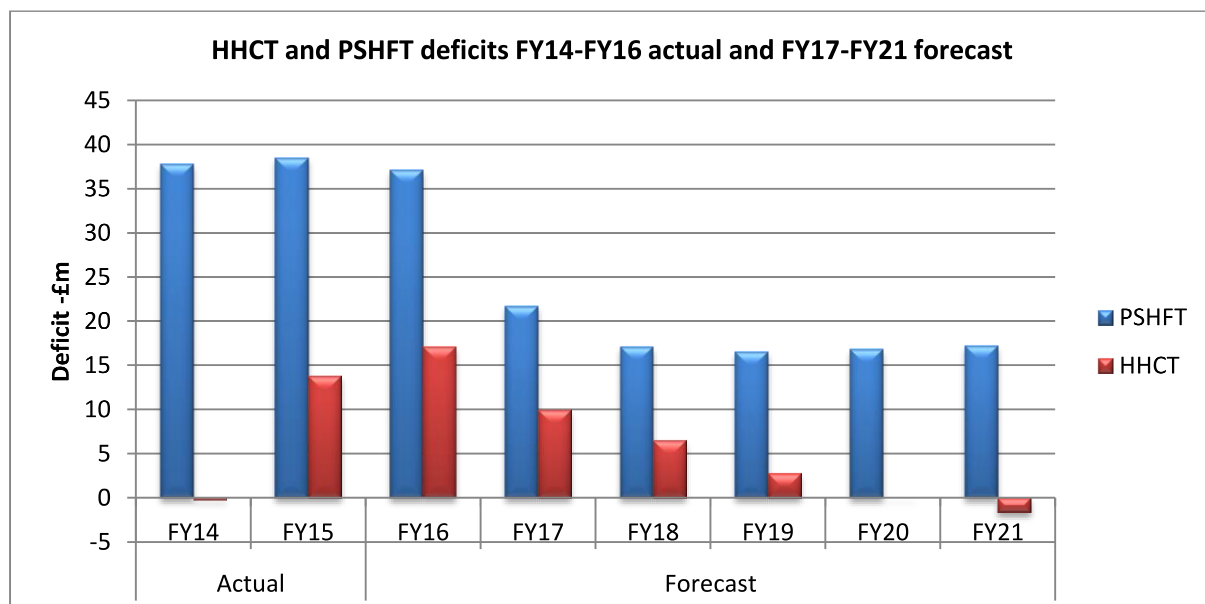
PSHFT is operating at an average of 98% capacity and has a fourth floor which could be converted into two wards (total 60 beds) with the opportunity to build a further 30-40 beds through creating three bed bays from single rooms. In addition, 10 beds could be built at Stamford within the current inpatient unit. HHCT has one 30-bed ward which could be renovated and brought back into use.

The 140 beds described above are just short of half the total anticipated requirement to meet demand. This explains why the LHE plan includes a focus on reducing demand on hospitals through prevention and consolidation of resources within health and social care. The NHS as a whole needs to work better together across primary and acute health, and local authority boundaries, if capacity of all resources will be able to meet demand.

3.3 Financial sustainability

In line with providers nationally, both trusts are in deficit for FY16 and for the foreseeable future (Figure 21). As described previously in section 2.3.9, the PSHFT deficit for FY16 was £37.1m despite average cost improvement and the HHCT deficit was £17.4m.

Figure 21 - PSHFT and HHCT forecast deficits



Without a system wide approach, PSHFT will not deliver a balanced budget for the foreseeable future.

There has been much debate around the size an acute trust needs to be in order to achieve clinical and financial sustainability, but there is a general consensus that economies of scale are a significant factor in a trusts ability to recruit larger and more sustainable teams.

As described previously, both trusts have better than average performance in areas such as length of stay. Opportunities for further efficiency gains are diminishing and structural change across the local health economy is required to meet current and future demand with the required level of operational efficiency.

The forecast shown in the chart above includes the following assumptions:

- Both trusts will receive sustainability and transformation funding recurrently of £4m for HHCT and £10.8m for PSHFT
- HHCT will generate £3m of strategic estate partnership funding from FY18
- PSHFT will deliver £5m above average cost improvements in FY16 and FY17
- HHCT will deliver 6.7% cost improvement in FY17 falling gradually to 2.3% by FY21

3.4 Support for closer collaboration

3.4.1 Commissioner support

The HHCT and PSHFT incremental organisational change work stream is part of the overall system transformation programme, and the commissioner is supportive both in principle and through engagement on the project management board of closer collaboration being explored. Formal written support for the recommended option will be required if the trusts agree to a change in their current organisational form.

3.4.2 Regulator support

Our regulators support greater collaboration to address the underlying issues at both trusts. While recognising that it will not eliminate the financial deficit, the NHS Improvement (formally Monitor) strategic outline case showed that it will significantly improve finances at both trusts and be an enabler to making services sustainable.

3.4.3 Trust support

The boards of both trusts have agreed a joint Memorandum of Understanding setting out how they will work together to assess the options to progress joint working. The first milestone being the completion of an Outline Business Case by May 2016 to allow for a discussion in the public domain outside of any purdah restrictions. If the recommendations of the OBC are accepted, a Full Business Case will be developed within 2-4 months to be transacted by April 2017.

3.5 Constraints and dependencies

The constraints and dependencies relating to any proposed collaboration are identified in Figure 22. Constraints are externally imposed and must be identified and managed from the outset. Dependencies are any actions of development required of others if the ultimate success of the collaboration is dependent on them.

Figure 22 – Collaboration constraints and dependencies

Constraints	Dependencies
Aim to maintain clinical services currently provided on each site	Available resources including expertise and finance to develop and implement the full business case
Sustain wider support of our key stakeholders including commissioners, regulators, staff and the wider public	Commissioner and Regulator support including NHS Improvement
Recognise that some staff will potentially be unable to move between sites to support service sustainability	Competition and Markets Authority approval
Support delivery of the wider sustainability and transformation plan being led by our commissioners	Implementation and integration team, and finances to develop and implement the preferred solution
Support continued delivery of services for populations currently served outside the local health economy, primarily in South Lincolnshire and East Leicestershire	
Meet statutory and regulator requirements placed on NHS organisations	
Meet competition requirements	
Continue to utilise PFI buildings	
Deliver some cost improvement within FY16 and significant savings in FY17 and beyond	
Proposals must be affordable	
Payback on investment must be within five years	

3.5.1 Constraints

The collaboration must ensure that services which are currently provided at both trusts are supported and maintained. Under the NHS Act 2006[13], commissioners have a responsibility to consult with the users of any service where there are proposals to change the way those services are provided. There are no proposals in this business case to change any clinical services, rather the focus is on supporting services across the two trusts and making savings in back office and corporate services which does not require consultation under the Act.

As the hospitals provide a key public service, any changes may generate wide interest, hence any proposals must be understood by and have the support of key stakeholders and regulators. Clinical support is crucial to ensure successful delivery of any option. Therefore, there will be extensive engagement with the public, stakeholders and staff.

With the financial challenges faced by the wider health economy, any collaboration must also support the plans being developed by commissioners to effectively meet the anticipated demand within available resources.

[13] National Health Service Act 2006 Section 242(1B)

Although our trusts are directly involved in the sustainability and transformation plans for Cambridgeshire and Peterborough, any collaboration could also impact upon neighbouring areas, particularly South Lincolnshire which is predominantly served by PSHFT, and to a lesser degree, Bedfordshire and East Leicestershire which are served by either, or both, trusts. Any proposed collaboration must not impact negatively upon the populations in those areas.

3.5.2 Dependencies

The success of the collaboration will be dependent on putting in place teams to develop and implement a Full Business Case. This will require external financial support.

A team will be required to develop the FBC, and then, if the FBC is approved, an implementation and integration team will be required to deliver the preferred option.

Ongoing regulator and commissioner support for the collaboration is required throughout the process.

If the collaboration could affect levels of choice for residents in the Peterborough and Cambridgeshire area (we believe this is limited to maternity services), any collaboration is dependent upon support from the Competition and Markets Authority.

3.6 Project management

The board for this project is chaired by the CEO for HHCT who reports twice monthly to the Health Executive, as shown in Figure 2.

The project board meets every two weeks with representative executive and non-executive directors from both trusts, Cambridgeshire and Peterborough CCG, Monitor and the Trust Development Authority (now NHS Improvement).

3.7 Conclusion

The drivers for this collaboration can be summarised as:

1. Safe access to current services cannot be maintained at HHCT in some clinical areas and at both trusts in the medium term due in part to the lack of sufficient numbers of specialists to run sustainable rotas at smaller DGH's, combined with increasing pressures nationally in safe staffing levels, seven day working and the increasing specialisation of services at fewer trusts.
2. Working separately, both trusts are unable to meet the future predicted demand for beds
3. Both trusts are currently not financially sustainable
4. Regulators and commissioners for both trusts support closer collaboration

Both trusts face existing financial and operational challenges to meet the growing demand for care. Any collaboration between the two trusts must deliver safe and sustainable services through bringing clinical teams together to support each other with less reliance upon temporary and locum staff.

Integrated back office services should facilitate the delivery of joined-up clinical services, and is a pre-requisite for some services such as imaging.

Fully aligned policies and procedures are necessary to facilitate the safe delivery of joined up clinical services where there are significant service interdependencies.

Joining up back office services should also deliver financial savings for reinvestment to meet the growing demand for clinical care and support future integration of clinical services.

4. Options appraisal

4.1 Summary

This section describes the development of a short list of four potential solutions to address the issues identified in the previous chapter. After an appraisal process it identifies option 4, a single merged organisation as the preferred option because it delivers the most sustainable clinical services and over £9m of savings per year to the tax payer.

4.2 Objectives of the Local Health Economy (LHE)

In 2015, Monitor worked with the senior leaders in the local health economy to prepare a *Cambridgeshire and Peterborough strategic option case: potential changes to organisational forms*. It describes the shared objective for all providers and commissioners in the LHE to deliver improved changes while reducing the cost base. The objective of the LHE work is:

> "To enable the successful implementation of the System Transformation Programme [now the Sustainability and Transformation Plan] with a focus on determining the most appropriate organisational tie up to:
>
> - Enable future improved changes in the pattern of care; and
> - Enable the Cambridgeshire and Peterborough local health economy (LHE) to collectively reduce its cost base by driving out back office savings"

4.3 Background – previously considered options

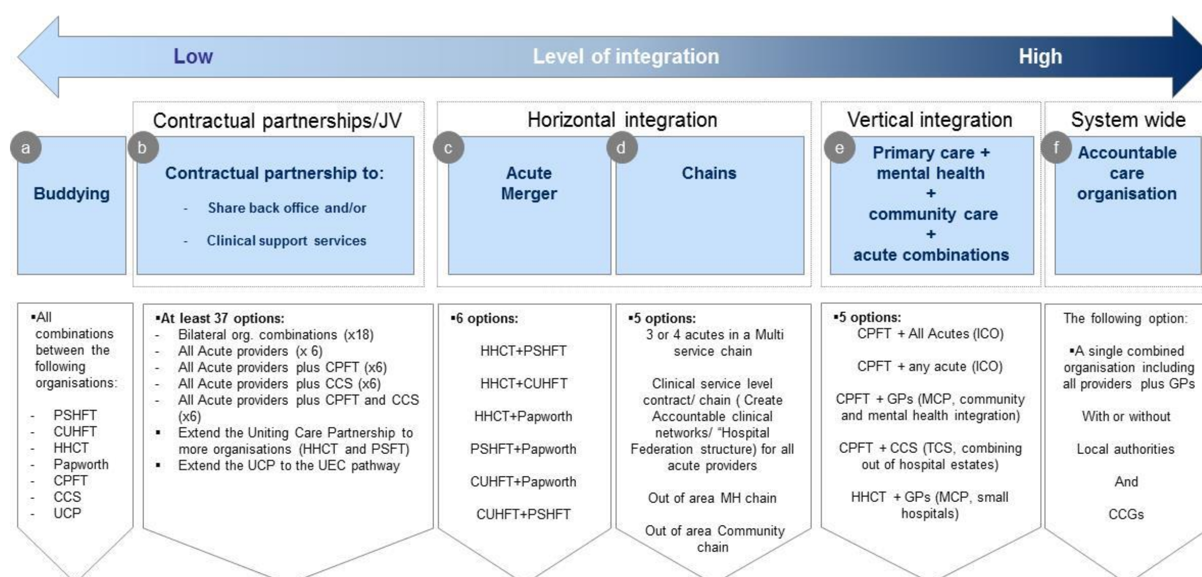
The strategic options case was developed with all providers and commissioners in Cambridgeshire and Peterborough from September 2015. The work built upon extensive previous reviews within the local health economy, and new stakeholder engagement exercises including interviews, workshops and system meetings during September and October 2015. The key findings from the work informed the next steps on exploring changes to organisational form and functional change within the local health economy.

4.3.1 Long term aspiration of the local health economy (beyond 2020)

During development of the strategic option case, a long list of options (Figure 23) were identified by stakeholders in September 2015 as a possible means to addressing the objectives and challenges of the local health economy referred to in section 4.1 and 4.2. The Dalton review also informed the possible range of options for organisational form changes across the local health economy.

Each of these options was evaluated via a series of prioritisation, engagement and appraisal exercises against set criteria (see Appendix 5).

Figure 23 - Long list of organisational form options across the LHE



Given the scale of the clinical and financial challenges in our local health economy, it was agreed by all that significant transformational change was required, to close the system wide financial challenges and improve the pattern and provision of care for the population of Cambridgeshire and Peterborough, with no single organisation acting in isolation.

Through an options appraisal process, an accountable care type solution was identified as the long term aspiration for the Cambridgeshire and Peterborough system at some stage beyond 2020. Further consideration was given to the preferred approach to achieve such long term change which is currently not supported by national policy.

The SOC supported an incremental stepping stone approach to changing both function and form across Cambridgeshire and Peterborough, via the development of a short to medium term (0 to 5 years) programme of work involving the Cambridgeshire and Peterborough system focusing on deliverable benefits of integration and alignment (Figure 24 below).

Figure 24 – LHE key outcomes for organisation form changes

Outcomes	Organisation form solutions
Long term (5 to 10 year plan) preferred solution for system wide organisational form changes:	Explore system-wide Accountable Care Organisation (ACO) type solutions for beyond 2020. This requires a change in national policy
Immediate to medium term (0 to 5 year plan) preferred solutions for system wide organisational form changes:	Explore an incremental stepping stone approach to incremental integration starting with exploring: - Horizontal integration (form and function) - Financial alignment options - Vertical integration (function only)

Source: 2015 Cambridgeshire and Peterborough strategic option case: potential changes to organisational forms

4.3.2 Short to medium term aspiration of the local health economy (pre 2020)

In 2016, the Cambridge and Peterborough providers and commissioners, continued to progress a system wide programme[14], including the SOC recommendations below:

- Accelerating the CCG-led system wide clinical reconfiguration programme to address the clinical challenges; and
- Exploring an incremental stepping stone approach towards further system integration in the short to medium term (0 to 5 years), starting with horizontal integration, including closer working between HHCT and PSHFT.

Organisational form options which were excluded as part of an appraisal process, are outlined in Appendix 6.

The short list options for the local health economy, including the recommendation to explore further collaboration between HHCT and PSHFT, are outlined in Figure 25.

Figure 25 – Short listed stepping stones for organisation form changes in the LHE

Option	Category
HHCT and PSHFT merger	Horizontal integration – merger
Papworth and Cambridge University Hospitals Foundation Trust (CUHFT) merger (post the move to Cambridge)	Horizontal integration – merger
Extending Uniting Care Partnership (UCP now decommissioned) to HHCT and PSHFT	Financial alignment/contractual options
Extending UCP to additional services	Financial alignment/contractual options
Acute hospital chain (elective service pathways)	Horizontal integration – Chain/Federation
Acute hospital chain (all services)	Horizontal integration – Chain
ACO (including CCG and Acute chain plus Cambridgeshire and Peterborough Foundation Trust (CPFT)	Partial ACO type solution
Multi community provider (GPs and HHCT or CPFT)	Vertical integration
In hospital and Out of hospital review of Children's services	Vertical integration

This short list of options was evaluated (See Appendix 7), and it was recommended that horizontal integration options to maximise system efficiency benefits first, in particular those that did not impact on front line services first i.e. back office costs, including:

- Closer collaboration working options between PSHFT and HHCT, and
- Closer collaboration working options between CUHFT and PFT

[14] Now referred to as the 5 year Sustainability and Transformation plan (STP) programme of work

This recommendation was made alongside a broader five year programme of work for local health economy, including accelerating the CCG led system wide clinical reconfiguration programme to address the clinical challenges.

4.4 Options for collaboration between PSHFT and HHCT

Following the Cambridgeshire and Peterborough system work, in December 2015, the Boards of PSHFT and HHCT agreed in a signed Memorandum of Understanding (MoU) (Appendix 1) to explore options for collaboration between the two organisations and the timescales by when decisions would be made. As part of the development of the Strategic Outline Case, varying levels of integration between the trusts had been explored (see Figure 26).

Figure 26 - Options for collaboration between PSHFT and HHCT

Functional change	Possible organisation form	Short listed
Do nothing for now	• 2 standalone legal entities - PSHFT and HHCT	Yes, this is a pre requisite for all business cases
Shared clinical services	• Collaboration via non contractual agreement i.e. Federation via a memorandum of understanding between the two standalone legal entities - PSHFT and HHCT	No, this was excluded during the strategic outline case criteria on the basis of time to implement and cost
	• Collaboration via creation of a new additional legal entity i.e. Joint venture between PSHFT and HHCT	No this was excluded as part of the C&P system strategic outline case criteria
	• Contractual service level chain, for some services, where one provider provides service on the behalf of the other (either PSHFT or HHCT, become a service provider for the other entity)	No this was excluded as part of the C&P system strategic outline case criteria. Delivery of previous HHCT/PSHFT surgical service pilots demonstrated high set up and running costs
Shared back office services	• Collaboration via non contractual agreement i.e. Federation via a memorandum of understanding between the two standalone legal entities - PSHFT and HHCT	No, this was excluded as part of the C&P system strategic outline case criteria
	• Collaboration via creation of a new additional legal entity i.e. Joint venture between PSHFT and HHCT	No, this was excluded as part of the C&P system strategic outline case criteria
	• Collaboration in one or two back office functions only	No, the scale of the benefits was considered insufficient[15]
	• Contractual service level chain/agreement, for some services (more than one or two), where one provider provides service on the behalf of the other (either PSHFT or HHCT, become a service provider for other entity)	Yes, this is one form of consolidation under the Dalton reforms which the strategic outline case considered feasible
One operational	• PSHFT and HHCT remain as two standalone	Yes, part of the Dalton reforms,

[15] Based on estimates from existing collaborations between the trusts on HR/IT/procurement and governance

Functional change	Possible organisation form	Short listed
organisation Two boards, one executive team	legal entities, with one executive team and one operational organisation plus service level agreements integrating back office and operational services to deliver reduced costs and sustainable services	adopted in some local authorities and identified as potential solution in the strategic outline case
One organisation	• Full consolidation between PSHFT and HHCT to create a single organisation via merger or acquisition process	Yes, identified in the strategic options case as a potential solution
	• Integrated care organisation between PSHFT and HHCT, and some or all of primary care, community, and mental health services in the area, in the next 5 years	No, this was excluded as part of the C&P system strategic outline case criteria
	• Accountable care organisation between PSHFT, HHCT, with other parts of the C&P system (including the CCG and other providers) in the next 5 years	No, this was excluded as part of the C&P system strategic outline case criteria

Source for organisational form descriptions: Dalton review page 18

Sharing clinical services was excluded under the ‘chain’ SOC options, because it was part of the wider STP work.

Integration of all back offices was included.

An accountable care organisation or integrated care organisation was not considered as this model is being developed more widely within the local health economy. However, we did consider a single executive team working across two organisations as a further option.

A complete merger, as proposed in the SOC, was also considered as a viable option. This left four available options for further evaluation in this outline business case.

4.5 Assessment of short list options for collaboration

The four available options agreed by both trust boards in the MoU on the 18 December 2015 for further evaluation in this outline business case are included in Figure 27:

Figure 27 - Short list of options for collaboration between PSHFT and HHCT

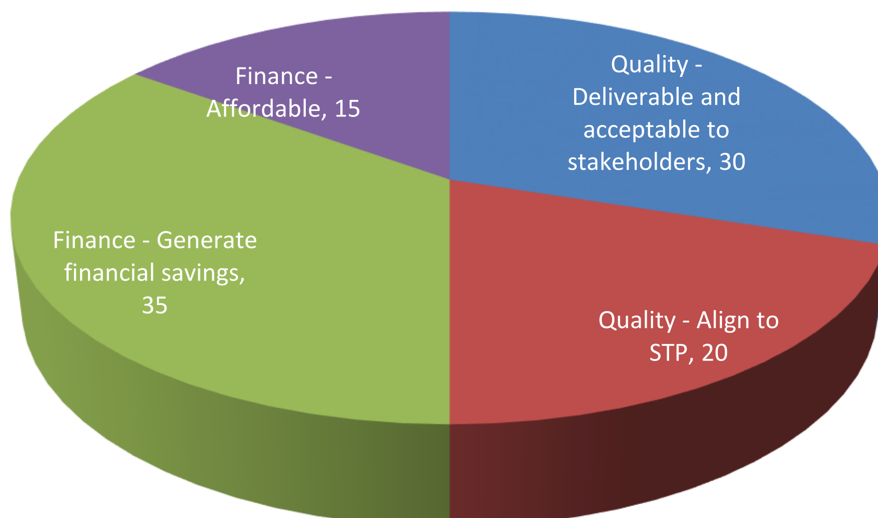
Short list of available options	
Option 1	Do nothing for now
Option 2	Shared back office only – leading and integrating back office and operational services to deliver reduced costs and sustainable services
Option 3	Two boards, one executive team and one operational organisation plus option 2 (leading and integrating back office and operational services to deliver reduced costs and sustainable services)
Option 4	One organisation - Full consolidation between PSHFT and HHCT to create a single organisation (via merger or acquisition process)

The four options were assessed using the criteria listed in the MoU (Figure 28), using a process agreed by both boards. A detailed report on the process is included in Appendix 8.

Figure 28 - Option appraisal criteria

Options were appraised by an equal number of executives and included both Medical and Nursing Directors from both trusts in a session which was independently facilitated and monitored by an external assurer. The boards agreed weightings for the assessment criteria (Figure 29) with quality and finance equally weighted.

Figure 29 - Option appraisal criteria weightings



Appraisers allocated 100 points across the four options based upon how well each met the criteria. Scores were collected and any significant variation between scorers was discussed.

There was open discussion around the different scores which led to more detailed exploration of how well each option met the criteria.

4.6 Appraisal of options

The following section outlines the appraisal of the short listed option, with the recommendation that Option 4 is progressed: One organisation - Full merger of PSHFT and HHCT to create a single organisation.

The process to identify the back office savings opportunities in each of the options is explained in Appendix 9.

An explanation for each of the back office saving assumptions as agreed by the responsible Executive Directors and checked by both CEO's, is available in Appendix 10.

A summary of the option appraisal is shown in Figure 30 and a detailed description of the option appraisal is included in Appendix 11.

Figure 30 – Summary of option appraisal

	Option 1 – Do nothing	Option 2 – Shared services	Option 3 – Two boards, one executive team	Option 4 – One organisation
Must be deliverable and acceptable to patients and other stakeholders including staff	4.27	6.29	8.48	10.96
Aligns to STP plans that aim to secure sustainable and safe services for patients	1.25	3.63	6.09	9.03
Must generate financial savings to ensure safe and sustainable services for patients	0.22	6.34	8.53	19.91
Must be affordable, making the best use of public funds	0.53	3.61	4.46	6.4
TOTAL SCORES	6.27	19.88	27.56	46.3
RANK	4	3	2	1

4.7 Summary of savings

Lord Carter is currently undertaking a benchmarking review of back office costs within the NHS and suggests that the total back office costs should not exceed 7% of the income revenue. At present the combined back office costs of both organisations when compared to their combined income is 9%. Once the back office savings of £9.1m as set out in this case are realised (see Appendix 9 for more detail) then the combined back office costs as a percentage of combined income will reduce to 6%. The SOC suggested £11.5m savings could be achieved through back office collaboration between the two organisations (see Appendix 7), so further savings may be available and this will be explored in the FBC.

A summary of the costs of each option are shown in Figure 31. The financial assumptions used in calculating these savings are included in Appendix 13.

Figure 31 - Summary of back office costs and savings of each option

Departments	TOTAL £'000			
	Agreed baseline	Opt 2	Opt3	Opt4
CEO	£3,702	£3,702	£2,000	£1,833
Finance	£5,864	£5,555	£5,555	£4,882
HR	£4,562	£4,218	£4,424	£3,632
Nursing	£4,826	£5,044	£5,044	£4,739
Facilities	£34,698	£33,831	£34,010	£33,744
Ops	£2,058	£2,004	£1,556	£1,556
IT/IS	£6,531	£6,531	£6,531	£5,686
Clinical Support	£63,800	£63,537	£63,483	£63,483
CEO Challenge site leadership reductions			-£74	-£18
Additional 4% CIP reduction on pay in yr 2			-£797	-£797
Non-pay				-£1,763
TOTAL	£126,040	£124,422	£121,732	£116,976
Savings				
Savings against previous option		£1,618	£2,691	£4,756
Saving against baseline		**£1,618**	**£4,309**	**£9,064**
Agency spend on corporate and back office	£811	£545	£545	£0
WTE reduction		-18	-20	-70
Implementation costs				
	Redundancy	-£633	-£703	-£2,455
	Project costs	-£100	-£100	-£1,900
	Due diligence	-£400	-£800	-£3,300
	IT/IS			-£4,000

Delivery of the savings will incur implementation costs and this case describes them at high level, including redundancy, project support costs, due diligence and the £4m cost of integrating IT systems between the two organisations. The IT costs may off-set future costs that both organisations may incur in any case without merger, and this will become clearer during development of the Full Business Case.

4.7.1 Net present value

It is good practice to assess the value today of future savings minus the investment required by calculating the net present value (NPV). A summary of the NPV calculations of the three options over 10 years, discounted at the Treasury recommended value of 3.5% is presented in Figure 32. This shows that option 4 provides the highest return over a period of 10 years.

In calculating the net present value of each option, we have assumed:

- NPV over 10 years (standard assumption for strategic cases)

- Redundancy is not included in the calculation of costs as per the Green Book; and
- Full benefits are realised from year 2 under options 2 and 3.

Figure 32 - Option appraisal scores and NPV

	Option			
	1	2	3	4
Net present value (£m)	0	12,167	30,801	53,452

A sensitivity analysis of each option is considered in chapter 5.

4.8 Conclusion and recommendation

Following the consideration of a wide range of options, the creation of a single organisation through merger or acquisition is the preferred option as it delivers notable clinical and service benefits for patients and saves the taxpayer more than £9m per annum. There is a difference of almost 20 points between the scores for this option and the next ranked option, a single executive team with two boards.

The information in the option appraisal will be scrutinised in more detail if the boards agree to progress to Full Business Case, but at this stage it is very clear that a single organisation will deliver significantly more clinical and financial benefits for both organisations than the alternatives. These benefits will positively impact on our local population groups and give them more assurance that they will have sustainable local services at their local hospital site in the longer term.

It is recommended that the trusts move forward to undertake the more detailed analysis of a merger of the two organisations in an FBC and this would include an implementation plan setting out the practical and regulatory steps to merger.

5. Benefits

This chapter sets out the benefits that the recommended option will bring to patients, staff, and the wider NHS; particularly through making services more sustainable and hence safer whilst being delivered locally.

5.1 Benefits summary

The key clinical benefits were identified by doctors on the clinical reference group and are summarised in Figure 33. The clinical benefits are described in more detail in Chapter 7 – Clinical Vision.

Figure 33 - Benefits of merger

Benefit	Effect
Increased certainty about the future through joint clinical vision and clear plan for clinical services	• Improved recruitment particularly for HHCT ED and acute medicine • Reduced reliance upon agency locum staff, and reduced cost • Better training, education and professional development
Increased catchment area to support optimally sized teams, trainee posts and sub-specialism	Greater opportunity for: • Multidisciplinary clinical teams • Improved resilience and cross-cover, and reduced on-call commitment and cost • Sub-specialism and provision of more local sub-specialty services • More varied case-mix and greater opportunity for training roles, and professional development • Reduced overhead costs • Repatriation of some more specialist activity • Recruitment and retention of staff: • Better training, education and professional development
Reduced back office costs	• Reduced barriers to joint working for clinical teams • Greater integration of IT systems • Improved efficiency and savings for tax payers
Overall impact	• Improved access - more timely and more locations for some services • Some new services / specialist clinics and procedures • Improved quality and governance • More efficient use of taxpayers' money.

5.1.1 Deliverable and acceptable to patients and stakeholders

Contrary to concerns about the loss of key services through collaboration, this will in fact ensure the ongoing provision of some unsustainable services locally that would otherwise be lost from the Hinchingbrooke site.

However, the awareness of members of the public and other key stakeholders about the vulnerability of some services, particularly those at HHCT, will be explained in more detail in the next phase of this work. A communication and engagement plan will be developed at an early stage to explain how this option will support the future sustainable delivery of services for both sites.

5.1.2 Generate financial savings to ensure safe and sustainable services for patients

The robustness of the quality of care delivered to patients will improve as all clinical teams are joined under a single operational management structure and as a result will benefit from being part of larger teams with medical staff working across locations, sharing workload, rotas and out of hours cover.

Merged, larger services that offer greater opportunities for training and sub-specialism will help enhance staff recruitment and retention, which, in turn, will have a positive impact on the care our patients receive.

Patients and taxpayers will also benefit from £9m reduction in the cost of back office services which can be reinvested in clinical services to support the growing demand for patient care. Although this option does not completely resolve neither the financial nor clinical sustainability issues, work with the clinical groups suggests there are further opportunities for greater efficiencies, such as reducing reliance upon agency clinical staff, and taking advantage of savings that can be made by bulk buying from suppliers.

5.1.3 Affordability, making the best use of public funds

Creating a single organisation will reduce overall expenditure on corporate and back office services, without impacting upon front line services.

Figure 34 - Merger savings

	Total costs £'000	
Department	Agreed baseline	Post merger cost
CEO department	£3,702	£1,833
Finance	£5,864	£4,882
HR	£4,562	£3,632
Nursing	£4,826	£4,739
Facilities	£34,698	£33,744
Ops	£2,058	£1,556
IT/IS	£6,531	£5,686
Clinical Support	£63,800	£63,483
CEO Challenge site leadership reductions		-£18
Additional 4% CIP reduction on pay in yr 2		-£797
Non-pay		-£1,763
TOTAL COSTS	£126,040	£116,976
Saving against baseline		£9,064
WTE reduction		-70

Figure 34 shows the provisional savings of £9m from merger when compared with the current cost. The small reduction in nursing cost relates to corporate nursing positions, not front line nursing.

The departmental savings are not the full opportunities, and the boards have agreed that a further 4% (£800k) cost improvement should be deliverable throughout the organisation in year 2.

5.1.4 Benefits for commissioners and the health economy

Commissioners support greater collaboration between the two trusts as part of the proposals for the Sustainability and Transformation Plan. Of the four options, option 4 provides the greatest level of collaboration through creating a single organisation which has been supported by the commissioner representatives at the project board.

A merged organisation will be better placed to respond to any changes proposed by commissioners to better meet the needs of the population as part of the Sustainability and Transformation Plan. Merger will allow time for senior management to focus on driving through changes to deliver savings and efficiencies to support delivery of the STP. In future, commissioners will work with a single provider which will bring greater efficiencies in contract and negotiation work which is currently duplicated between both trusts.

5.2 Phasing of costs, savings and CIPS

The estimated phasing of costs and savings are shown in Figure 35 and have been developed with an assessment of time taken to implement the necessary joint systems and processes, with a view that the faster new departmental structures can be delivered, the sooner staff can have assurance and stability and the benefits to patients can begin to be realised.

Figure 35 – Phased costs and savings

		Savings			**Costs**
	Yr1 £'000	Yr2 £'000	Yr3 £'000	Recurrent £'000	One off £'000
Costs					
Redundancy	-246	-1,228	-982		-2,455
Project transition costs	-1,000	-900			-1,900
Legal and due diligence costs	-1,800	-1,500			-3,300
IT integration costs	-1,000	-1,500	-1,500		-4,000
Savings					
CEO department	1,869			1,869	
Finance	308	337	337	982	
HR		465	465	930	
Nursing	87			87	
Facilities	477	477		954	
IT/IS			845	845	
Ops		503		503	
Clinical Support		317		317	
CEO site leadership		18		18	
Additional 4%			797	797	
Non-pay			1,763	1,763	
Total	**-1,305**	**-3,011**	**1,724**	**9,064**	**-11,655**

The £9m savings are recurrent, whilst the costs are one-off, and some of the IT costs may have been incurred if the organisations remained independent. Therefore, the payback period is just over one year.

The transition costs of £11.6m; comprise £2.4m redundancy; £1.9m project transition costs; £4m IT integration costs; and, £3.3m legal, financial and corporate due diligence costs.

Redundancy costs have been assumed as 50% of WTE reduction receiving no redundancy as they will be lost via the normal turnover of staff or alternative employment being found. Of the remainder we have assumed 25% would receive the maximum redundancy of £80k and the remaining 25% will be eligible for a reduced amount of £60k. This has been spread across the three years post FBC agreement and tracks the delivery of new structures in the various departments. Both existing trusts and the merged trust will ensure value for money in any decision it makes.

IT integration costs have been estimated at £4m which excludes any costs that would be required for IT upgrades and new systems as part of a 'do nothing' scenario. As described in Chapter 4 however, the cost of integrating IT systems between the two organisations may off-set future costs that both organisations may incur in any case without merger. There is recognition that there may be an optimism bias of up to 25%. IT integration costs will be explored in more detail at FBC stage.

5.2.1 Cost improvement plans (CIP)

The back office savings identified are planned to be on top of the CIP plans already developed within each organisation and which are included within the base case financial scenario's.

If we presume a transaction date of April 2017 then the combined CIP plan for the new organisation looks like:

Figure 36 – Combined cost improvement programme

	16/17	17/18	18/19	19/20	20/21
Base-cases	19.7	16.8	11.4	10.3	9.8
Back office	2.7	2.1	4.2	9.06	9.06
Total	22.4m	18.9m	15.6m	19.4m	18.9m

Note - In FY17 and FY18 the base case scenario's presume above average CIP delivery at PSHFT.

5.3 Risks

Although there have been successful mergers in the NHS, most recently at Frimley Park and Heatherwood and Wexham Trusts, there are risks associated with this scale of organisational change. These have been identified by the Kings Fund which highlighted challenges associated with merging, in particular, conflicting cultures and business models.

The merger approval process can be complex and time-consuming with as many as 10 separate organisations responsible for approving some recent mergers, although the efficacy of these organisations in assessing business cases has been questioned.

The delivery of savings in line with the phasing assumptions brings both risk and benefits associated with delay or delivery before the dates in Figure 35.

5.4 Conclusions

There are significant clinical benefits from increased collaboration between the two trusts, which impact positively on patients and staff alike. Increased size of clinical teams will increase resilience, and the enlarged organisation will be better placed to meet the current and expected demand as a result of recruitment and retention of clinical staff.

The financial benefits identified in chapter 4 have been tested and show a higher net present value for this option. The change in assumptions required to make the net present value for options 2 and 3 equal to option 4 are unrealistic.

Option 4 offers significantly greater benefits than the other options in all the scenarios.

6. The Financial Case

6.1 The merged trust

From FY20 onwards, the deficit of the merged trust is forecast to be around £6.7m yearly, a significant improvement over the current forecast yearly deficit of £31.7m for both trusts in FY17.

This is expected to reduce even further if agreement is reached with the Department of Health on PSHFT's residual PFI subsidy of £15m. It is therefore expected that the combined trust would be able to achieve a break even position within 3 to 4 years.

The forecast income and expenditure (I&E) summary is shown in Figure 37. It has been prepared by combining the forecast I&E of both trusts and adjusting for any consolidation adjustments such as transaction synergies and associated transaction costs. It is based on the following key assumptions:

- the plan forecast is derived by extrapolating the FY17 Annual Plan Review (APR) submission
- the inflation assumptions applied for both trusts are based on the same assumptions used in the Sustainability and Transformation Plan (STP) which we understand the CCG will prepare shortly
- the Sustainability and Transformation (S&T) funding continues recurrently for both trusts

6.1.1 Transaction synergies

The estimated savings identified to date total £9.1m pa, including £6.9m pay and £2.2m non-pay. These figures mainly relate to expected savings from back office collaboration from the CEO, Finance, HR, Nursing, Facilities, Operations, IT/IS and Clinical Support departments. The expected savings have been phased as £2.7m (Yr1); £2.1m (Yr2); £4.2m (Yr3); £9.1m recurrently from Yr4.

6.1.2 Transaction costs

Transition costs of £11.7m; comprising £2.5m redundancy, £1.9m project transition costs, £4m IT integration costs and £3.3m legal and due diligence. These costs are expected to be incurred over three years and have been phased as £4m (Yr1), £5.1m (Yr2) and £2.5m (Yr3). Further work on the detail of the implementation will be undertaken should we proceed to FBC and that will improve the accuracy of these initial assumptions.

The assumption built into the case is that these costs, although self-financing in the medium term as a result of the savings, will require Sustainability and Transformation funding from the Department of Health in the interim. This funding has been modelled as Public Dividend Capital (PDC). This is in line with other recent mergers.

6.1.3 Additional capital requirement

Incremental activity growth in the combined trust due to the growing and ageing population will require additional capacity. It is assumed that PSHFT's 4th floor will be converted to create an additional 60 beds, and other capital works will be required to create more three bedded bays and additional beds at Stamford. Works to bring the decommissioned ward at Hinchingbrooke back into use will also require supporting capital. The fourth floor works are

estimated to cost £8.8m over two years, starting FY18 and completed in FY19, to be depreciated over an estimated period of 60 years in line with the current depreciation policy and is assumed that this would be funded via PDC. Bed expansion at Stamford is included in the base case, but funding for the three bedded bays and Hinchingbrooke is not yet identified.

In addition, a review of both trusts' IT capital requirements suggest that there is likely to be a combined spend of around £21m over 5 years in a 'Do Nothing' scenario. However, this would be reduced by about £4m in a merged organisation as duplicate spends, such as on a new Patient Administration System (PAS), would be avoided. This is a further benefit of the merger which has not been included as a benefit in the OBC but will be considered in the FBC. This should not to be confused with the £4m IT integration cost.

These estimates do not include other non-IT capital needs and the impact of depreciation has not been factored into the financial calculations. Also the estimated IT costs have not been benchmarked against implementation costs in other merger situations but this will be fully assessed during the production of the Full Business Case.

6.1.4 CIPs

The combined trust forecasts to deliver CIPs totalling £86.2m over the five years. This is an average CIP delivery of about £17.2m pa.

6.1.5 Cash

The forecast cash position has been estimated based on the trusts delivery of its external finance limit, which on current terms is estimated at around £2.4m for the merged trust.

6.1.6 Financial Risk Rating

The financial sustainability risk rating which ranges from 1 (the most serious risk) to 4 (the lowest risk), is NHS Improvement's view of the level of financial risk a trust faces to the ongoing delivery of key NHS services and its overall financial efficiency.

The FRR of a merged trust shows improvement from "1" to "2" and is expected to gradually improve to at least a "3" in subsequent years in line with projected financial performance.

6.1.7 Risks rating

There are inherent risks in the calculations regarding the savings and implementation costs that would exist in any financial forecast. The most significant of these are:

i. Non-pay - a general assumption of 30% reduction in costs associated with total combined spend on computer software licences and maintenance contracts. Both the total combined spend and the 30% cost reduction will need significant further work in the FBC
ii. Agency – an assumption has been taken that no back office department will require agency staff in the combined trust, as the merging of two departments will have enough substantive staff with the required skills to fill all vacant substantive posts and meet future demands on the departments. This assumption has been checked with each executive director but remains a future risk as £3.2m was spent on agency costs in FY16 back office departments for both organisations.

iii. Future Structures – all back office areas have attempted to consider future demands on their departments and have submitted structures to manage that demand adequately.

iv. Implementation Costs – Where possible benchmarked information on integration costs have been used, although with the knowledge that every separate trust is entirely different, the circumstance for merger is different and local and national NHS environments are always changing, the assumption that costs may be similar is a risk. IT integration costs in particular are the most significant risk. A more detailed analysis will need to be done as part of the FBC and this will differentiate between necessary IT investment and the extra IT investment to facilitate merger.

v. Risk of double count – HHCT has made assumptions around income repatriation from outsourced work in the region of £1.5m yearly. This is not a risk to the potential savings, but rather the accuracy of the assumptions made in the HHCT base case as PSHFT already has plans to reduce outsourced work through its CIP schemes. Similarly, there is a potential risk with HHCT's income forecast with respect to clinical collaboration plans with PSHFT of c.£0.4m yearly, which have not been discussed in any detail.

vi. Strategic Estates Partnership (SEP) – HHCT's forecast assumes around £2-3m share of net profit from the joint venture. There is a risk that the forecast profit may not materialise to the expected level due to start-up risks or deals once concluded are not as beneficial.

vii. HHCT has already included clinical collaborations in its base case although it has no agreements with another organisation as to what those are. As with (v.) above, this is not a risk to the potential savings, but rather the accuracy of the assumptions made in the HHCT base case.

Figure 37 – Combined trust income and expenditure summary

Combined Trust - Option 4

	units	Out-turn 2015-16	Plan 2016-17	Forecast 2017-18	Forecast 2018-19	Forecast 2019-20	Forecast 2020-21
Summary Income and Expenditure Account							
Operating income (inc. in EBITDA)							
Clinical income	£m	327.1	347.2	354.9	362.7	370.3	381.3
Non-Clinical income	£m	45.0	57.7	58.1	58.4	58.6	58.9
Total operating income, inc. in EBITDA	£m	**372.1**	**404.9**	**413.0**	**421.1**	**428.9**	**440.2**
Operating expenses (inc in EBITDA)							
Employee expense	£m	(247.3)	(248.4)	(244.7)	(245.1)	(245.6)	(249.8)
Non-Pay expense	£m	(119.9)	(125.6)	(129.3)	(132.5)	(136.3)	(140.7)
Transaction Synergies	£m		2.7	2.1	4.2	9.1	9.1
PFI / LIFT expense	£m	(21.2)	(22.6)	(22.6)	(23.4)	(23.9)	(24.5)
Total operating expense, inc. in EBITDA	£m	**(388.4)**	**(393.9)**	**(394.5)**	**(396.9)**	**(396.8)**	**(405.9)**
EBITDA	£m	**(16.3)**	**11.1**	**18.5**	**24.2**	**32.1**	**34.3**
EBITDA margin %	%	*-4.4%*	*2.7%*	*4.5%*	*5.7%*	*7.5%*	*7.8%*
Transaction costs	£m		(4.0)	(5.1)	(2.5)	0.0	0.0
Other Operating expenses	£m	(22.5)	(20.3)	(20.1)	(20.5)	(20.9)	(21.4)
Non- Operating income	£m	2.1	0.0	0.0	0.0	0.0	0.0
Non-Operating expenses	£m	(18.1)	(18.8)	(18.8)	(18.9)	(19.1)	(19.7)
Surplus / (Deficit) after tax	£m	**(54.8)**	**(32.0)**	**(25.6)**	**(17.7)**	**(7.8)**	**(6.7)**
Summary Statement of Financial Position							
Non-current assets	£m	525.8	532.1	527.1	517.5	503.0	492.5
Current assets (excl Cash)	£m	32.9	32.4	34.0	34.5	35.1	27.4
Cash and cash equivalents	£m	3.0	5.6	2.4	2.4	2.4	2.4
Current liabilities	£m	(54.0)	(53.3)	(53.8)	(54.1)	(54.6)	(55.4)
Non- Current liabilities	£m	(417.9)	(447.4)	(472.7)	(495.2)	(514.8)	(524.9)
Reserves	£m	89.7	69.4	36.7	5.2	(28.7)	(57.9)
		-	-	-	-	-	-
Financial Sustainability Risk Rating							
Financial Sustainability Risk Rating	Score	1	2	2	2	2	2
Capital Service Cover		1	1	1	1	2	2
Liquidity rating	Score	1	1	1	1	1	1
I&E Margin rating	Score	1	1	1	1	1	1
I&E Margin Variance From Plan rating	Score	3	4	4	4	4	4
Summary of assumptions applied in plan							
CIPs as a percentage of opex within EBITDA less PFI expenses	%	3.7%	5.0%	4.3%	3.0%	2.7%	2.5%
CIPs	£m	14.0	19.7	16.8	11.4	10.3	9.8

Key Assumptions

1 OBC does not include financial evaluation of potential clinical reconfigurations
2 Pay Savings based on 15/16 costs; Exclude the effect of inflation and CIPs that would arise in later years
3 Funding of the implementation and integration costs via Public Dividend Capital (PDC)
4 Consolidation adjustments include PSHFT's £1.0m Project orange costs in FY 16 and FY17
5 Depreciation does not include impact of additions outside the Trusts normal capital programme
6 7 Day working - assumed it will be self-financing
7 S&T Funding ongoing

6.2 PSHFT

This section reviews the financial position of the trust in a 'Do nothing' scenario and provides useful information on the historical and forecast position.

6.2.1 Historical trading

Figure 38 shows a summary of PSHFT's historical trading for the last three years including the forecast outturn position for FY16.

Figure 38 – PSHFT historical I&E

Summary Income and Expenditure		Actual 2013-14	Actual 2014-15	Out-turn 2015-16
Operating income (inc. in EBITDA)				
Clinical income	£m	217.4	219.5	230.1
Non-Clinical income	£m	15.7	30.6	30.6
Total operating income, inc. in EBITDA	£m	**233.1**	**250.1**	**260.8**
Operating expenses (inc in EBITDA)				
Employee expense	£m	(152.5)	(167.0)	(171.0)
Non-Pay expense	£m	(71.8)	(75.9)	(79.4)
PFI / LIFT expense	£m	(19.3)	(19.6)	(19.4)
Total operating expense, inc. in EBITDA	£m	**(243.7)**	**(262.6)**	**(269.8)**
EBITDA	£m	**(10.5)**	**(12.4)**	**(9.0)**
EBITDA margin %	%	*(4.5%)*	*(5.0%)*	*(3.5%)*
Other Operating expenses	£m	(14.7)	(14.0)	(14.2)
Non- Operating income	£m	0.0	0.8	(0.0)
Non-Operating expenses	£m	(12.5)	(12.9)	(13.8)
Surplus / (Deficit) after tax	£m	**(37.8)**	**(38.5)**	**(37.1)**

The trust has been in a financially challenging position for at least three years, largely attributable to the cost of financing its PFI building. It has been constantly challenging itself and has found new ways to reduce cost and transform how it delivers services.

6.2.2 Annual plan forecasts

The forecast plan (Figure 39) is derived by extrapolating the FY17 draft APR submission to reflect the economic assumptions of the STP group plus an additional internal CIP stretch target of £5m in FY18 and adjusting for a control total of £21.7m.

The inflation assumptions applied for both trusts are based upon NHS Improvement published assumptions.

To reduce the deficit further, the collaboration work suggests more savings can be achieved and this is demonstrated in the combined trust position.

Figure 39 – PSHFT forecast baseline I&E

Summary Income and Expenditure

		Plan 2016-17	Forecast 2017-18	Forecast 2018-19	Forecast 2019-20	Forecast 2020-21
Operating income (inc. in EBITDA)						
Clinical income	£m	244.1	249.5	254.5	259.7	267.6
Non-Clinical income	£m	40.3	40.6	40.9	41.2	41.5
Total operating income, inc. in EBITDA	£m	**284.4**	**290.1**	**295.3**	**300.9**	**309.0**
Operating expenses (inc in EBITDA)						
Employee expense	£m	(174.6)	(171.4)	(172.5)	(173.5)	(176.7)
Non-Pay expense	£m	(81.2)	(85.5)	(87.7)	(91.6)	(95.6)
PFI / LIFT expense	£m	(20.7)	(20.7)	(21.4)	(21.9)	(22.4)
Total operating expense, inc. in EBITDA	£m	**(276.5)**	**(277.5)**	**(281.6)**	**(286.9)**	**(294.7)**
EBITDA	£m	**7.9**	**12.5**	**13.7**	**14.0**	**14.3**
EBITDA margin %	%	*2.8%*	*4.3%*	*4.6%*	*4.6%*	*4.6%*
Other Operating expenses	£m	(15.0)	(14.7)	(15.0)	(15.3)	(15.6)
Non- Operating income	£m	0.0	0.0	0.0	0.0	0.0
Non-Operating expenses	£m	(14.6)	(14.9)	(15.2)	(15.5)	(15.9)
Surplus / (Deficit) after tax	£m	**(21.7)**	**(17.1)**	**(16.5)**	**(16.8)**	**(17.2)**

6.2.3 Forecast cash and capital

The forecast cash position has been estimated based on the minimum cash balance required to be held under the terms of the loan with Department of Health.

Forecast capital is based on the trust's annual rolling capital programme of £5m pa.

6.2.4 Historical and Forecast Cost Improvement Plans

The trust has consistently met its CIP targets, and expects this to continue. The CIP forecast is based on the 2% assumption in NHSI's planning guidance. In addition, for 2016/17 and 2017/18, the trust has set an internal stretch target of £5m for each of the two years.

6.3 HHCT

6.3.1 Historical trading

HHCT's historical trading for the last 3 years and the forecast outturn position for FY16 is shown in Figure 40.

The trust reported a deficit in each of the last two years (FY15 and FY16) having largely delivered financial balance before that time. The emerging deficit is attributed mainly to the size of the organisation with recent significant increases in staff costs attributable to the required compliance with safe staffing levels, and the on-going demands of running a small hospital has contributed to the trust not achieving its planned cost improvements.

Figure 40 - HHCT historical I&E

	units	Actual 2013-14	Actual 2014-15	Out-turn 2015-16
Summary Income and Expenditure Account				
Operating income (inc. in EBITDA)				
Clinical income	£m	97.395	97.930	97.272
Non-Clinical income	£m	14.244	13.122	15.008
Total operating income, inc. in EBITDA	£m	**111.639**	**111.052**	**112.280**
Operating expenses (inc in EBITDA)				
Employee expense	£m	(65.598)	(71.943)	(76.978)
Non-Pay expense	£m	(36.317)	(41.985)	(39.985)
PFI / LIFT expense	£m	(1.412)	(1.839)	(1.876)
Total operating expense, inc. in EBITDA	£m	**(103.327)**	**(115.767)**	**(118.839)**
EBITDA	£m	**8.312**	**(4.715)**	**(6.559)**
EBITDA margin %	%	*7.4%*	*-4.2%*	*-5.8%*
Other Operating expenses	£m	(4.390)	(5.181)	(7.871)
Non- Operating income	£m	0.017	(0.014)	0.012
Non-Operating expenses	£m	(4.274)	(4.473)	(4.362)
Surplus / (Deficit) after tax	£m	**(0.335)**	**(14.383)**	**(18.780)**
One off income/costs	£m	(0.502)	(0.597)	(1.710)
Normalised Surplus / (Deficit)	£m	**0.167**	**(13.786)**	**(17.070)**

6.3.2 Annual plan forecasts

The plan forecast in Figure 41 is derived by extrapolating the FY16 forecast position, adjusting for ordinary cost improvement expectations and reflecting the trust's strategic aspiration as an elective hub along with the development of the Health Campus. The need to collaborate on these schemes with others in the health economy is key, and brings the trust broadly into financial balance over the planning period.

The trust is focusing during FY17 on ways of both improving overall efficiency along with opportunities for growth. The trust has significant bed and theatre capacity on which to base its expectation of becoming an elective hub. In addition, it has a significant ambition to develop a health campus in Huntingdon bringing together primary care, community and mental health services along with social care services onto the Hinchingbrooke site. A Strategic Estates Partnership (SEP) is being sought via a procurement process, as a vehicle to fund the significant capital investment that will be needed.

Figure 41 - HHCT forecast I&E

	units	Plan 2016-17	Forecast 2017-18	Forecast 2018-19	Forecast 2019-20	Forecast 2020-21
Summary Income and Expenditure Account						
Operating income (inc. in EBITDA)						
Clinical income	£m	103.109	105.355	108.248	110.522	113.747
Non-Clinical income	£m	17.425	17.559	17.524	17.489	17.451
Total operating income, inc. in EBITDA	£m	**120.534**	**122.914**	**125.773**	**128.011**	**131.198**
Operating expenses (inc in EBITDA)						
Employee expense	£m	(73.777)	(73.286)	(72.667)	(72.097)	(73.034)
Non-Pay expense	£m	(45.402)	(44.814)	(44.664)	(44.638)	(44.946)
PFI / LIFT expense	£m	(1.928)	(1.963)	(1.999)	(2.040)	(2.082)
Total operating expense, inc. in EBITDA	£m	**(121.107)**	**(120.063)**	**(119.331)**	**(118.774)**	**(120.062)**
EBITDA	£m	**(0.573)**	**2.851**	**6.442**	**9.237**	**11.135**
EBITDA margin %	%	*-0.5%*	*2.3%*	*5.1%*	*7.2%*	*8.5%*
Other Operating expenses	£m	(5.316)	(5.412)	(5.513)	(5.624)	(5.741)
Non- Operating income	£m	0.012	0.000	0.000	0.000	0.000
Non-Operating expenses	£m	(4.151)	(3.913)	(3.727)	(3.589)	(3.789)
Surplus / (Deficit) after tax	£m	**(10.028)**	**(6.474)**	**(2.798)**	**0.024**	**1.605**
One off income/costs	£m	0.000	0.000	0.000	0.000	0.000
Normalised Surplus / (Deficit)	£m	**(10.028)**	**(6.474)**	**(2.798)**	**0.024**	**1.605**

6.3.3 Forecast cash and capital

The forecast cash position has been estimated based on the trust's delivery of its external finance limit. No assumptions have been made on available capital for the development of an Electronic Patient Record, for example, and it is expected that any IT requirement of this sort would be funded through the need for integration around the health campus and afforded through the strategic estate partnership.

In this plan, the trust expects to spend all of its internally generated funds on its general capital requirement.

6.3.4 Historical and forecast CIPs

The trust has not delivered all of its expected cost improvements in either FY15 or FY16 although this has improved in FY16. For FY17 the trust has an expectation that it will deliver cost improvement of 2% above the economic assumption along with additional productivity through population growth and the repatriation of activity to Hinchingbrooke, a plan that has some traction with commissioners.

The trust is actively using information from the review by Lord Carter of Coles in assessing the opportunities available, and is already working collaboratively with PSHFT in procurement and IT as one vehicle to achieve these improvements

6.4 Sensitivity analysis

Given the uncertainties around assumptions, we have introduced sensitivity analysis to test the robustness of the estimates. This looks at the identified risks for example, that the project

implementation does not run according to plan, or that the costs have not been properly estimated. In addition, it captures the potential upsides relating to savings not fully costed or captured.

In calculating the downside sensitivity, we have assumed that there will be 20% less back office savings than estimated and that transaction costs are 25% higher. Similarly we have calculated the potential upsides by assuming we have not captured 10% of the estimated savings. We have applied these assumptions to the estimated savings and costs over a 10 year period at a discounted rate of 3.5% to produce the Net Present Values (NPV) shown in the below table (Figure 36).

The results of the analysis show that Option 4 produces the highest net benefit, with a NPV in the range of £35.9m - £55.6m; the range being estimates in a best case, likely case and worst case scenario.

The best case looks at only the upsides and the worst case considers only the identified risks. In the middle is the likely case which combines the identified risks and the potential upsides.

Figure 42 – Sensitivity analysis NPV

		Option 2	Option 3	Option 4
Likely case	£'m	10.8	27.4	41.7
Best case	£'m	13.4	34.0	55.6
Worst case	£'m	9.5	24.2	35.9

6.4.1 Sensitivities of other options to Option 4

To test the sensitivities further, we considered how the other options compare to Option 4, and by how much the assumptions would need to be flexed to produce the same net benefits as Option 4.

Option 3 requires a 40% upside in potential savings (from 10%) and implementation risks would have to be reduced to 5% (from 20%) to make it equal to the preferred option.

A 40% upside for option 3 represents an increase in savings from £4.3m (Figure 31) to £6m.

The only possible additional savings available under option 3 would arise from a single Facilities, HR team and corporate nursing. The trusts agreed that this would not be possible with two separate boards, and even if they were, they only account for an additional £1.25m saving, which is only 29% improvement in savings compared with the required 40% to make option 3 preferable to option 4.

Option 2 requires a 240% upside in potential savings (from 10%) and implementation risks would have to be reduced to 5% (from 20%) to make it equal to the preferred option. It is not feasible that an upside of this magnitude could be achieved.

The calculations for the transaction savings have been worked up using a methodical approach which have also been validated by external assurers, therefore we would expect

the probability of a 40% - 240% upside to be fairly remote. In addition the probability of the implementation risks being 5% is unlikely to be realistic.

Using a set of realistic assumptions therefore, merger is the most beneficial financial option.

7. Clinical vision and organisational design

7.1 Our joint clinical vision

The strategic directions of both trusts are aligned, and the current visions for each organisation fit well with each other.

"Both our organisations have the same strategic direction; to be the best possible DGH for their local population – that seems like a good place to start." Consultant HHCT

Clinicians across both sites agree that the overall aim of this work can be summarised as: **"Better, Safer, Local'.** Any collaboration should make patient services better; they should be safer, for example through providing faster access to key clinical decision makers; and they should be delivered locally by default, provided elsewhere only if this is the right and safer option.

The vision and strategy for a combined organisation will be a matter for the board and governors, but this combined draft version (Figure 43) put together by clinicians is a starting point for discussion.

It will be crucial for the transition and implementation phase that we have a clearly articulated vision and set of values that our staff subscribe to and feel they can 'get behind'. They will also be a point of reference for, how we go about implementing changes.

Figure 43 - First draft of a joint vision

7.2 Areas the collaborating trusts will serve

The merged organisation will continue to serve the communities served by the current trusts, namely Huntingdonshire, Peterborough and South Lincolnshire. The combined population will be around 700,000 with the main commissioners continuing to be Cambridgeshire and Peterborough CCG and South Lincolnshire CCG.

7.3 Benefits for patients

The creation of larger teams will improve recruitment and retention leading to significant benefits to patient experience and quality of service.

Quality of patient care will improve across both sites as services which have been rated as

Patient benefit – Hinchingbrooke ED

- Patients needing emergency treatment at Hinchingbrooke Hospital's A&E department will have greater access to a larger number of experienced consultants, nurse practitioners and junior doctors who will rotate shifts between Peterborough City Hospital's busy Emergency Department and Hinchingbrooke's A&E. This will provide a safer service that ensures staffing levels meet patient demand – especially at busy times.
- Hinchingbrooke patients will have access to a larger team of consultants under a merged organisation. Junior medical cover will also be available to support and treat minor ailments.
- By rotating between the two hospitals' emergency departments, consultants will also be able to fulfil training and teaching sessions, to ensure ED staff can further develop their skills.
- A merged team will also be a far more attractive prospect for all grades of ED staff in the future.

'Good' in either organisation and areas of good clinical practice, can be shared across the

Patient benefit – Peterborough gastrointestinal bleed service

- The Gastroenterology service at Hinchingbrooke is good, thanks to strong leadership within the team and a high commitment to providing an out of hours on call service for patients with emergency gastro-intestinal bleeding.
- The service at Peterborough is, by comparison, not as strong.
- Under a merged organisation, both patients and staff at PSHFT would hugely benefit from the quality leadership and good working practices developed at Hinchingbrooke.
- Adding more staff from both organisations to the out of hours GI bleed rota, would provide sustainable cover across both hospital sites for the longer term and ensure that all patients are provided with care which meets, and exceeds, the national standards.

new merged organisation to the benefit of all patients.

7.3.1 Making services sustainable

Urgent and emergency care provision will improve across both sites as a result of the expanded teams and there will be opportunities to use capacity across both sites in a more coordinated way.

Services which have been identified by the CQC as requiring review, or are otherwise unsustainable in HHCT, could continue to be provided in future as a result of the closer collaboration. Small services such as pain management which has had to close recently at HHCT could in future be provided at local outpatient clinics through the team at PSHFT.

Using the clinical sustainability assessment in the evidence for change (Figure 18), the clinical reference group has assessed the impact of option 4 on the sustainability challenge faced by some services and the opportunities for quality improvement in others. These are summarised in Figure 44 below.

Further detail on how these improvements will be developed and implemented will be included if there is a decision to proceed to Full Business Case.

A summary of clinical services which will benefit from merger is shown in Figure 44 below. More detail is provided in Appendix 12.

Figure 44 – Clinicians view of the impact of merger on clinical sustainability

Service	Does merger address the issues/risks identified for this service?
Accident & Emergency	Yes - Merger facilitates a more sustainable service, but the future is influenced by national policy on A&E designation which is being led by the CCG through the System Transformation work.
Acute Medicine and geriatric medicine	Partially – through a single team working in a joined up way to cover service gaps in delivery on both sites. This is also linked to System Transformation work.
Ambulatory Care	Yes – opportunities linked to economies of scale and increased use of outpatient IV antibiotic
Breast Service	Yes - opportunities for efficiency/collaboration – but no sustainability risks.
Cardiology	Yes - opportunities for sub-specialism with greater catchment, e.g. repatriation of specialist procedures (PCI) which will ensure they can be provided locally
Clinical haematology	Yes – opportunity to support HHCT service with PSHFT team
Diabetes	Yes – Opportunities for efficiency/collaboration
Diagnostic imaging / Interventional radiology	Yes – opportunities for HHCT and PSHFT to reduce outsourcing reporting and use of locums through single team, but single IT system is essential
Endoscopy/ gastroenterology	Yes – HHCT has a fully accredited, high quality, 7-day bleed rota which could be used to improve services for Peterborough patients
ENT	Yes – larger team would result in sustainable on call commitments and improve recruitment
General Surgery	Yes – improved recruitment and retention due to the improved case mix

Service	Does merger address the issues/risks identified for this service?
	for a single team
Geriatric Medicine	Partial – see *acute med.*
Gynaecology	Yes –joint team could lead to inpatient gynaecology service for HHCT
Maternity	No as no current problems, This area is being considered by the System Transformation work stream
Neonatology	No as no current problems This area is being considered by the System Transformation work stream
Nephrology	Yes – service and advice for inpatients could be provided by Peterborough team
Neurology	Yes – Opportunities to support HHCT
Oncology	Yes – Opportunities for efficiency/collaboration
Ophthalmology	Yes – Opportunities for efficiency/collaboration
Oral and max facs	Yes – Opportunities for efficiency/collaboration
Ortho-Geriatrics	Yes – will provide more robustness to single handed services on both sites and allow cross cover during periods of annual leave so there is no service interruption for patients.
Trauma and orthopaedics	Yes – Opportunities for efficiency/collaboration
Paediatrics service in Hinchingbrooke is provided by CCS	Partially – this area is being considered by the System Transformation work stream
Pain	Yes – would provide an opportunity for services to be delivered locally for Hunts patients as previously.
Palliative care	Yes – will provide more sustainability to a single handed medical service. Other benefits of a single service across the patch will be for staff to get experience in other settings and a more seamless service for patients moving between acute and community and home at this vulnerable time.
Plastics and dermatology	Yes – Opportunities for efficiency/collaboration
Radiotherapy	Opportunity for HHCT catchment patients to access additional LINAC capacity @ PSHFT closer to home. Supported by Cancer Network
Respiratory	Yes - Opportunity for both teams to work together, particularly important after the Papworth relocation
Rheumatology	Yes – Opportunities for efficiency/collaboration
Spinal surgery	Yes – Opportunities for collaboration will make recruitment more likely for both trusts
Stroke	Yes – PSHFT could provide support to the rehab element of care currently unsupported at HHCT
Therapy services	Yes – HHCT opportunities for efficiency through scale and improve weekend cover
Urology	Yes – Opportunities for efficiency through scale

Patient benefit – Diagnostic imaging

- A single radiology department, based at both sites and using the same reporting system, would reduce treatment times and improve clinical outcomes.
- Results would be available faster as patient images could be viewed by a consultant at either hospital site, seven days a week.
- Waiting lists for MRI scans could be potentially shortened as patients can be offered a scan at Peterborough, Hinchingbrooke or Stamford Hospitals.
- A combined, more robust radiology team would give trainees the opportunity to work across all sites as, at present there is no support available for trainees to work at Hinchingbrooke.
- Developing trainees is the key to a more sustainable future in radiology services. By giving them greater opportunities to gain experience across all hospital sites, we can be a more attractive prospect for other radiology students in the future.

7.3.2 Patient records

Patients who transfer between the two hospitals will have one set of patient records and one entry on an integrated Patient Administration System (PAS) and other clinical systems. This will improve communication between treating clinicians and improve the speed and accuracy with which clinical decisions can be made at either site regardless of where a patient might be inadvertently admitted. This means that patients will be able to access services at any of the three sites and be able to expect seamless high quality care and decision making. It will also reduce cost, for example from those incurred by duplication of tests or imaging. Access to pathology tests will also be required as part of the shared patient record and PAS. PSHFT has already commenced the procurement of a PAS and HHCT would be included in the roll out when it is procured and implemented.

A merged Picture Archive and Communication System (PACS) is essential to delivering joined up care for patients, with clinicians on both sites being able to access radiology images captured on all three sites, resulting in patients being able to access the same care regardless of location. This already works well between Stamford and Peterborough and will be rolled out to Hinchingbrooke during the implementation phase.

Where types/makes of clinical systems differ in the organisations, a review of both will determine which gets rolled out across all three sites based on effectiveness of the system, ability to be easily rolled out further, ability to integrate with other clinical systems and cost.

7.3.3 Integrated pathways

Patient pathways will be streamlined following merger. Patients will be referred to one team but could be seen at both sites by the same clinicians as part of their overall care, improving access for patients. Integrated pathways will be delivered through merged clinical teams with a single set of clinical systems and an ability to view test results at any of the three sites.

Patients will be registered once, even where they would ordinarily be transferred to the other site during their care, improving efficiencies. On a practical level, this will reduce patients being asked for the same information multiple times, and the same test being requested by both organisations. Information will be shared between the sites more freely improving communication between clinicians and boosting the continuity and quality of care.

Patient benefit – Clinical haematology

- Patients using the Clinical Haematology service will see improved quality and far greater continuity in their care.
- Hinchingbrooke patients will benefit from more, if not all, of their outpatient treatment being delivered at Hinchingbrooke rather than Peterborough.
- The larger team of consultants at Peterborough would fulfil rotas at both hospitals, giving Hinchingbrooke patients access to a larger team of experts across the whole range of blood diseases much closer to home.
- Patients who require regular ongoing hospital visits will receive seamless, high quality care from dedicated consultants whom they come to know, rather than seeing a locum, which is beneficial to their mental and physical health.
- A merged team will be a more attractive prospect for new doctors in this field, eliminating the recruitment issues faced by Hinchingbrooke

As specialists at either site will be supported by colleagues at the other, this will improve resilience, reduce use of agency staff and avoid cancellation of appointments or procedures associated with the current lack of resilience in the individual small teams.

The new staffing model will allow senior decision-makers to be at key points in the patient pathway.

7.3.4 Increased specialisation

Increasing the catchment area will support a move towards sub-specialisation where individual clinicians focus upon developing specialist areas of expertise, conducting higher numbers of similar procedures. For example, under the current pathway a patient might be seen by a general orthopaedic surgeon, and then referred to a colleague. With a larger combined orthopaedic team, patients will be referred to the appropriate sub-specialist in foot and ankle, hip and knee, upper limb or hand depending upon the referral.

Specialist non-acute stroke support at HHCT, which is currently supported by non-specialist physicians, will become available as the teams combine. This will provide opportunities for configuration of beds to provide the most appropriate care in the right setting with ongoing support to patients from a single team. Patients will have a clear pathway using both sites with management of the immediate aftermath of a stroke managed at Peterborough City Hospital, but with rehabilitation of Huntingdonshire patients under the same team focussed on the HHCT site.

7.3.5 Improved governance systems

Governance systems will merge across the combined organisation. A single governance arrangement, with merged clinical policies, management arrangements and operational procedures, will give greater flexibility for staffing and service provision across sites.

7.4 Benefits for staff

Staff can more easily move across sites to further develop their skills and experience and see the widest set of clinical conditions possible. This will assist in improving the morale and retaining clinical staff, as well as those in corporate teams, which should in turn improve the trusts' recruitment capabilities. As we move towards a permanent rather than agency workforce, this will improve the morale of current staff members.

Merger will facilitate the integration of cultures, with levels of joint working across sites not seen before as clinicians work to deliver a shared vision of excellent patient outcomes delivered safely, efficiently and locally for patients.

There are significant demands on staff time to support joint clinical collaborations included in the STP work and any future collaboration with other providers and commissioners. A merged organisation will be better placed to support this work as the number of clinicians involved in designing the new pathways will be halved between the two organisations. This will increase patient facing clinical time available.

The current arrangement of SLAs for orthopaedics and general surgery are reliant on doctors working to two sets of clinical and operational policies. With this option, there will be only one set of policies and ways of working for clinical staff who are working in multiple locations, making things easier and safer for them.

Capacity and demand can be managed more easily across sites to reduce patient waiting times and maximise their choice of where to be treated.

7.5 Organisational structure

It has been suggested that the current clinical and clinical support services are organised into divisions which are managed on a cross site basis.

Each division will be clinically led, usually through an experienced medically trained consultant, but supported by a divisional manager and a divisional lead nurse in a tri-partite model of management. This arrangement will provide robust clinical, nursing and operational leadership for each division and will underpin the delivery of excellent care. Each major division will operate along a business partnering framework and be supported by a dedicated individual in Finance and HR.

All post holders will be accountable for delivering within quality, performance and budgetary expectations. They will also all have a key role in leading their merged teams through a period of change, providing welfare support and embedding new ways of working at pace while continuing to drive improvements in quality standards.

Maintaining momentum to drive the implementation of new pathways of care will require a transformation team to support the leadership with change management, allowing managers time to maintain operational performance.

Cross site management and delivery will have the benefits of ensuring:

- Faster and more successful integration of cultures, working across sites to deliver a shared vision of excellent patient outcomes delivered safely and efficiently.

- Improved ability to support the joint clinical collaborations as highlighted in section 5.
- Implementation of merged clinical and operational policies to improve safety across the sites where clinical staff are working in multiple locations.
- Staff move easily across sites to further develop skills and experience, cover on-call responsibilities and manpower gaps to reduce risk.
- Capacity and demand is managed across sites to reduce patient waiting times and maximise their choice of where to be treated.

It is proposed that each of the two main acute sites will be managed on day to day basis by two Senior Associate Director of Operations. The purpose of these roles it to support day to day management and resolve problems at each of the sites; provide senior site management to staff and patients, driving site efficiency and high quality standards. This will provide the Chief Operating Officer an opportunity to work with external partners to deliver the strategic operational change required for a successful health economy.

7.6 Future board arrangements and structure

Trust Boards have a number of duties both statutory and voluntary, they include:

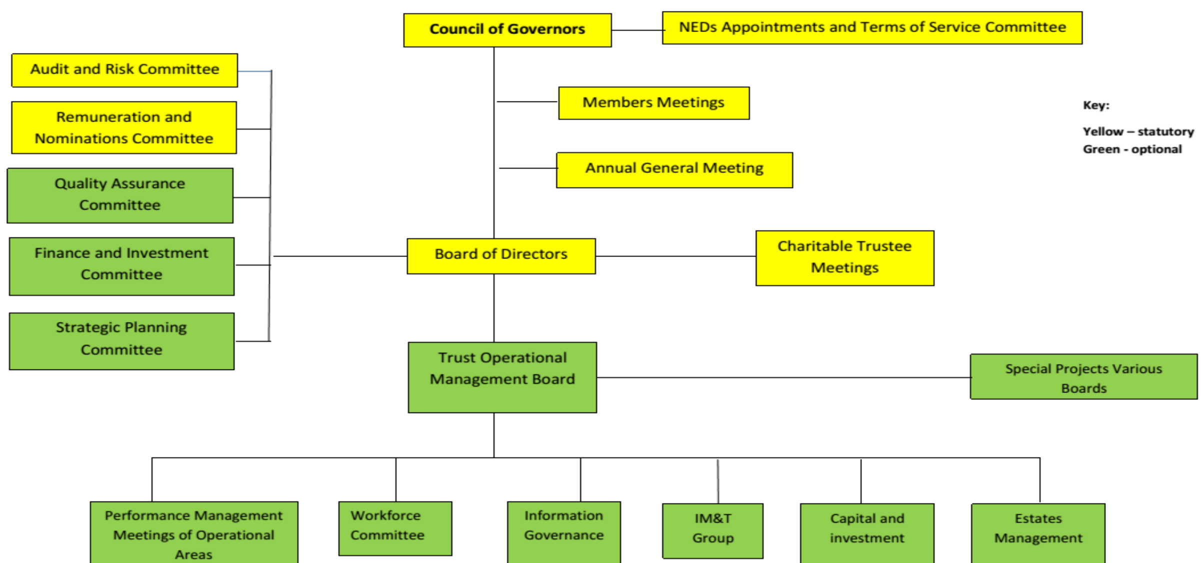
- Setting the strategic direction of the trust
- Ensuring the care delivered to patients is safe and of high quality
- Ensuring value for money for the tax payer and that all public money is spent wisely and effectively to improve care for patients
- Ensuring services are accessible and responsive
- Managing significant risks to the organisation, its staff and the patients and public who visit it

The Board will receive assurances on these responsibilities through a variety of board sub-committees and reports, and through proactive and direct engagement with the operational divisions, the services they provide and the patients they treat.

Figure 45 shows the proposed governance with both statutory and non-statutory meetings of a Foundation Trust board that will enable it to achieve the duties as set out above. Final arrangements however would be confirmed by the newly appointed Board members.

The wider governance system will provide assurance that the standards and obligations set for the trust are met as a minimum, and that organisational, clinical and financial control systems are in place and operating effectively. The output from the governance systems and reporting will provide a valuable and independent quality assurance for the performance management systems and reporting.

Figure 45 – Proposed governance meeting structure



7.7 Performance management

The merged trust will, in the first years of operation, face significant challenges in maintaining and improving quality, whilst delivering day to day operational services, aligning processes and procedures and most importantly the cultures. Consequently, a robust and comprehensive performance management framework with a single set of associated performance reporting systems are essential. At the heart of this is the need to ensure that there is clear visibility and accountability for performance at all levels of the organisation.

Non-achievement of performance will be managed in accordance with trust policies to ensure staff and patients receive the highest standards of care and welfare delivery.

8. Programme timeline, governance and management

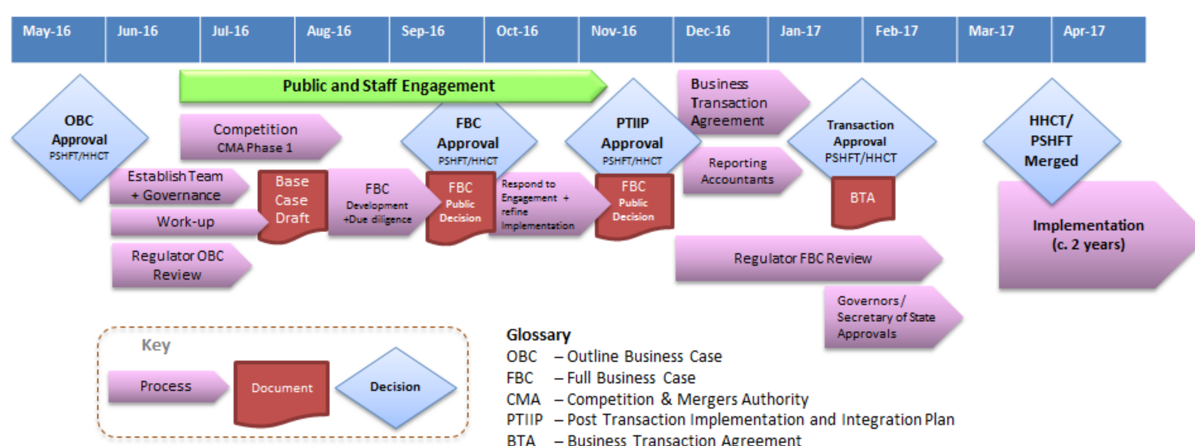
8.1 Programme overview

Subject to OBC approval and agreement to proceed to FBC, public engagement would commence, subject to EU referendum purdah rules, at the end of June and continue to September.

The Full Business Case will be discussed in public at the end of September 2016, which, if approved, would be followed by a period of further engagement to inform and develop the Post Transaction Integration and Implementation Plan (PTIIP) by November 2016. In total the public engagement period would be over four months.

Subject to agreement and approval at each stage, our two organisations would then merge on 1 April 2017 see Figure 46.

Figure 46 - Indicative Timeline to implementation of Option 4



8.1.1 Legal route to transaction

Of the three possible legal routes to which the new combined trust could be established we have identified that only an acquisition of HHCT by PSHFT is viable and this chapter describes how this could be achieved by April 2017.

The three possible routes considered were:

1. Merger (dissolution of both trusts, and the formation of a new NHS Trust)
2. Acquisition of PSHFT by HHCT (organisation is an NHS Trust)
3. Acquisition of HHCT by PSHFT (organisation is an NHS Foundation Trust)

All three scenarios have been considered for relative advantages and disadvantages taking into consideration examples of previous NHS transactions nationally. Specialist advice from regulators and legal advisors has also been sought. It is concluded that; in terms of process and management, the two organisations will merge taking the best of both organisations. Legally this will be achieved through PSHFT acquiring HHCT, however this would only relate to the transaction and transfer of assets and liabilities.

8.1.2 Overview of transaction

An overview of the programme from OBC, to FBC, to Statutory Transaction is set out in Figure 47 below.

There are two overlapping stages to the implementation plan:

1.) **Plan to Approval** - regulatory review and assurance, through to transaction approval
2.) **Plan for Implementation**

8.2 Plan to Full Business Case approval

NHS Improvement's framework for significant mergers and acquisitions is as follows:

- Stage 1 - Strategic Options Case
- Stage 2 - Outline Business Case
- Stage 3 – Full Business Case
- Stage 4 – Decision and execution

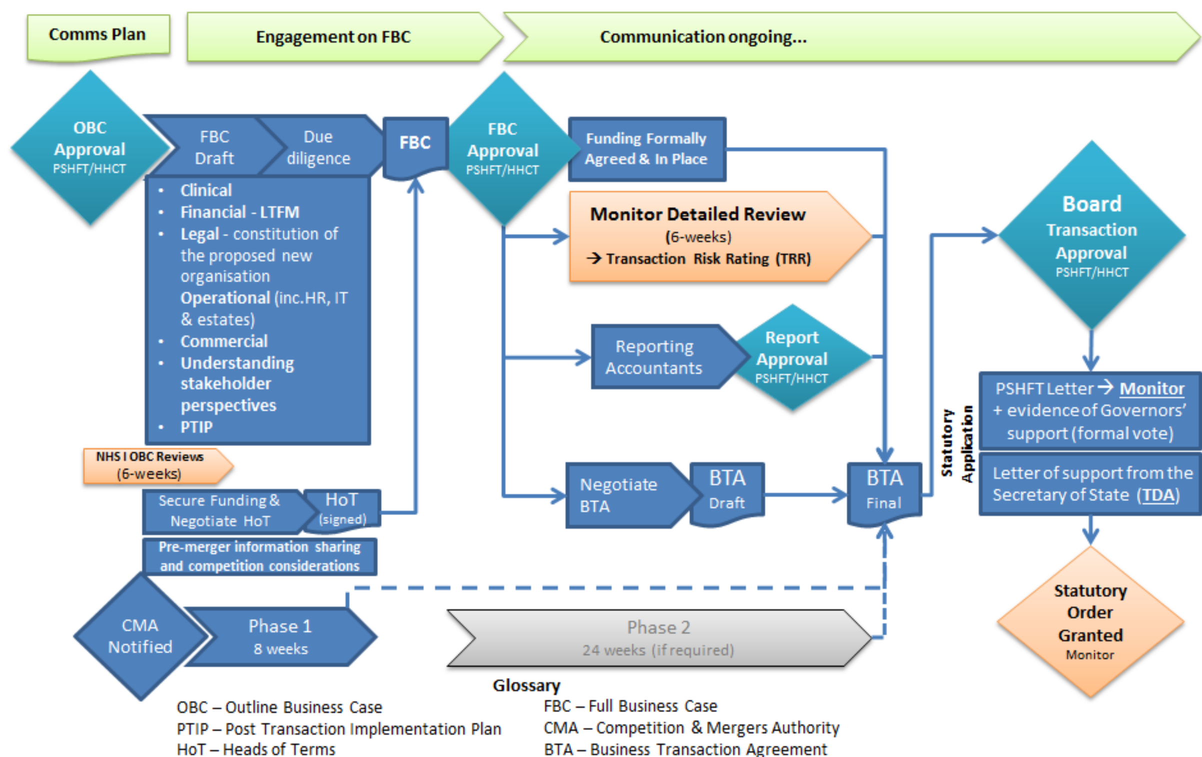
Approving this OBC and taking the decision to develop an FBC will initiate Stage 3 of this framework. The next steps will be for our regulators to formally review our OBC and advise of particular issues or risk areas that will need to be addressed in the FBC.

Following OBC approval and decision to proceed to an FBC, the project board, with support from NHS Improvement, will formally notify the Competition and Markets Authority (CMA). This will initiate a formal review of the potential impact on competition. As part of this review, NHSI will provide expert advice to the CMA on the patient benefits of a merger.

In parallel, we will agree Heads of Terms for the development of a Business Transfer Agreement (BTA) which will set out the nature of the transaction, the new organisation and details of assets liabilities and staff to transfer.

Once we have developed the FBC in draft, we will need to undertake a due diligence exercise to assure our boards, and subsequently our regulators, that the FBC is comprehensive and robust.

Figure 47 - Programme Overview - from OBC to FBC to Statutory Transaction



The steps to from OBC to FBC approval and transaction taken from guidance provided by Monitor 2015, are illustrated in Figure 47.

Further Trust Board decision points are:

- FBC Approval
- Accountants' Report Approval
- Board Transaction Approval

The final stage is to provide evidence of governors' support (for PSHFT) and a letter of support from the Secretary of State for Health (for HHCT) before a 'Statutory Order' is granted by NHS Improvement.

8.3 Legal and regulatory approvals

8.3.1 Competition

Mergers can benefit patients by helping providers improve the efficiency and quality of their services. At the same time, choice and competition also have an important role in encouraging providers to deliver better services. The merger review process allows for both the competition effects and the benefits of mergers to be taken into account in order to determine what is in the overall best interests of patients.

"Monitor and the CMA work together to ensure that the interests of patients are always at the heart of the merger review process. We want to ensure that the merger review process is well understood and operates as quickly and predictably as possible, both to serve the patient interest and to preserve public resources."[16]

8.3.2 NHS Improvement's role with regard to Competition

In summary NHS Improvement's role is to:

- Provide expert advice and guidance on the regulatory framework governing transactions in the NHS;
- Assess merger benefits and provide expert advice on benefits to the CMA;
- NHS Improvement would be the regulator of any merged HHCT-PSHFT organisation.

8.3.3 Competition and Markets Authority (CMA)

The Competition and Markets Authority is the UK's primary competition and consumer authority. It is an "independent non-ministerial government department with responsibility for carrying out investigations into mergers, markets and the regulated industries and enforcing competition and consumer law."

The Process

There are three phases to the CMA evaluation:

i) Pre-notification
ii) Phase 1
iii) Phase 2 (only needed if the evidence supplied at phase 1 is not sufficient to eliminate any competition concerns)

Pre-notification has no time limit but is an opportunity to liaise informally with regulators and the CMA to provide data analysis, mitigating factors and patient benefits that are considered sufficient to give CMA all the information they need to fully understand the local picture to

---

[16] Competition review of NHS mergers: A short guide for managers of NHS providers

what their data analysis may suggest is an area of concern. It is a two way dialogue that is an opportunity to prepare sufficiently well that a phase 2 referral is not required.

Once a merger has been formally notified to the CMA by Monitor, the review process is as follows:

Phase 1: (Lasts up to 40 working days). As part of a phase 1 review, the CMA must decide whether there is a realistic prospect that the merger will result in a substantial lessening of competition and have an adverse effect on patients and/or commissioners by significantly reducing their choice of provider, and consider Monitor's expert advice on the benefits of the merger.

If the CMA believes that the merger will not result in a realistic prospect of a substantial lessening of competition, or if the benefits of the merger outweigh any lessening of competition, it will not refer the merger for a Phase 2 review and that would conclude the CMA's review of the merger.

If a merger is not cleared at Phase 1, the review progresses to Phase 2.

Phase 2: (Limited to 24 weeks). In Phase 2, the CMA conducts a detailed assessment and must decide whether the merger is reviewable and whether it is expected to result in a substantial lessening of competition.

As part of their process to understand if competition issues exist with collaborative working, the CMA will undertake a service by service analysis of emergency and elective work and where GP's refer patients to.

Data Analysis

We have already engaged with NHS Improvement's Competition and Co-operation Department, which has been acting as an advisor to the collaboration project to help us understand the likely level of interest from CMA in the proposed merger.

The CMA will consider as part of pre-notification and phase 1, whether the impact of reducing competition in the above services, is likely to significantly affect patients.

We will also have an opportunity to provide evidence to the CMA to support the case in terms of patient benefits of the proposed merger, and measures that we might put in place to ensure that patients would not be disadvantaged by a reduction in choice.

Competition - next steps

PSHFT and HHCT are working to identify the possible impact for individual services. This is being done in collaboration with NHS Improvement's Competition and Co-operation Department and this, in turn, will inform pre-notification discussions with CMA.

If this OBC is approved by our Boards, the next step will be to commence further detailed work to develop an FBC. As part of the FBC development, we would formally notify the CMA and commence a Phase 1 CMA review.

Note: If a Phase 2 review should be required, this will have a significant impact on the transaction and implementation timeline. An FBC decision cannot be ratified without CMA approval.

8.3.4 Due diligence – prior to board FBC approval and regulator review

The areas of due diligence (assurance that the FBC is comprehensive and robust) required as assurance for FBC board approval and regulator review, are listed below:

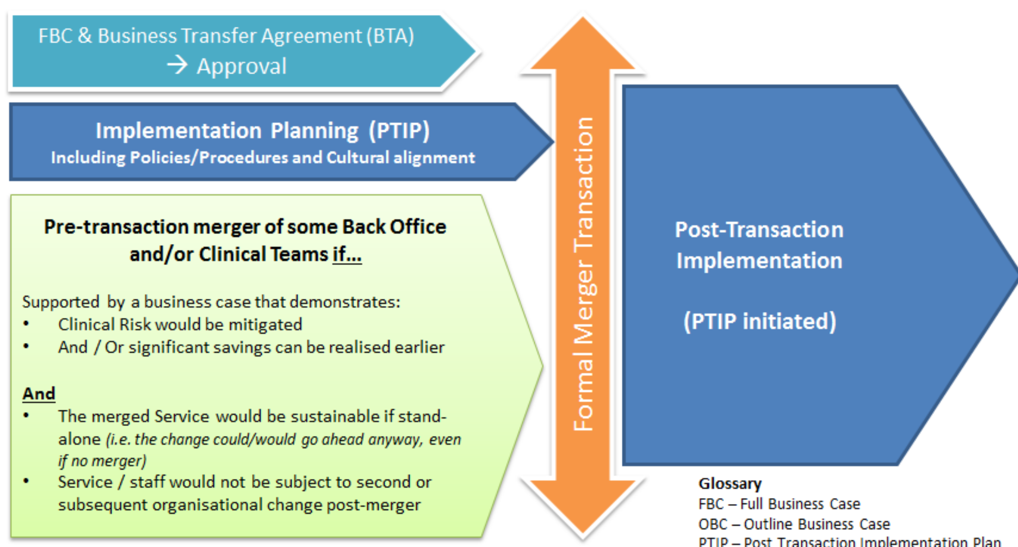
- Clinical
- Financial
- Legal
- Workforce
- Infrastructure, including IT and estates
- Governance processes including quality
- Commercial
- Understanding stakeholder perspectives

This due diligence forms part of the FBC process as set out in section 2.2.

8.4 Implementation planning - principles and approach

Figure 48 below illustrates the key areas of work to be undertaken, pre and post transaction.

Figure 48 - Overview of approach - Transaction Approval & Implementation Planning



There are some services where it may be sensible to merge clinical or back-office teams ahead of the full organisational merger transaction. However, unless there is a compelling need to consolidate early, the focus will to on developing detailed plans to be implemented following merger.

Any service or function merging early would require staff to transfer to one organisation, and the service to be provided back to the other under a service level agreement (SLA). This TUPE transfer of staff, and SLA development would mean significant additional work.

It is suggested that this course of action is only pursued where there is a compelling clinical need or service benefit to merge early.

8.4.1 Possible Implementation Timeline

The nature of the transition and process between approval and incorporation will be set out in the FBC and is a decision for the Trust Boards for ratification by regulators. However, it is recognised that the length of the transition period needs to be limited in order to minimise

uncertainty for staff and direct resources, enthusiasm and focus towards continued delivery of high standards of care.

High level timelines have been developed to illustrate a number of options and consider the correct balance between pace and pragmatism and project timelines.

Risks of merging too quickly include:

- Losing focus on the implementation, resulting in having to work through issues in a reactive way post-transaction.
- Too little time for detailed implementation planning.
- Not having enough senior staff capacity to both merge and run the existing services

To achieve a very fast merger would also require considerable expenditure on external consultancy support.

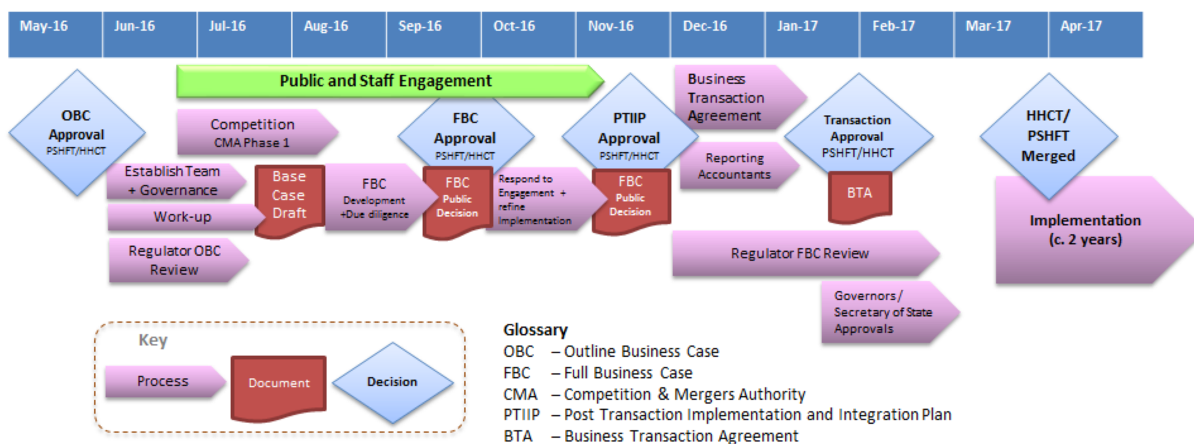
Risks of merging too slowly include:

- An extended period of uncertainty for our staff
- Staff who are more mobile, in demand or anxious about what the future may hold, may choose to leave for roles elsewhere.
- Others, who are not as mobile, may become overly worried, demotivated, or disenfranchised and resistant to change.

There are four key factors that affect the overall potential timeline to transaction:

1) Legal route to transaction (see Sec 8.1.1)
2) Public and staff engagement (see Sec 8.5)
3) CMA approval (see Sec 8.3.3) and other Regulatory approvals
4) Resourcing of FBC & integration and implementation team(s)

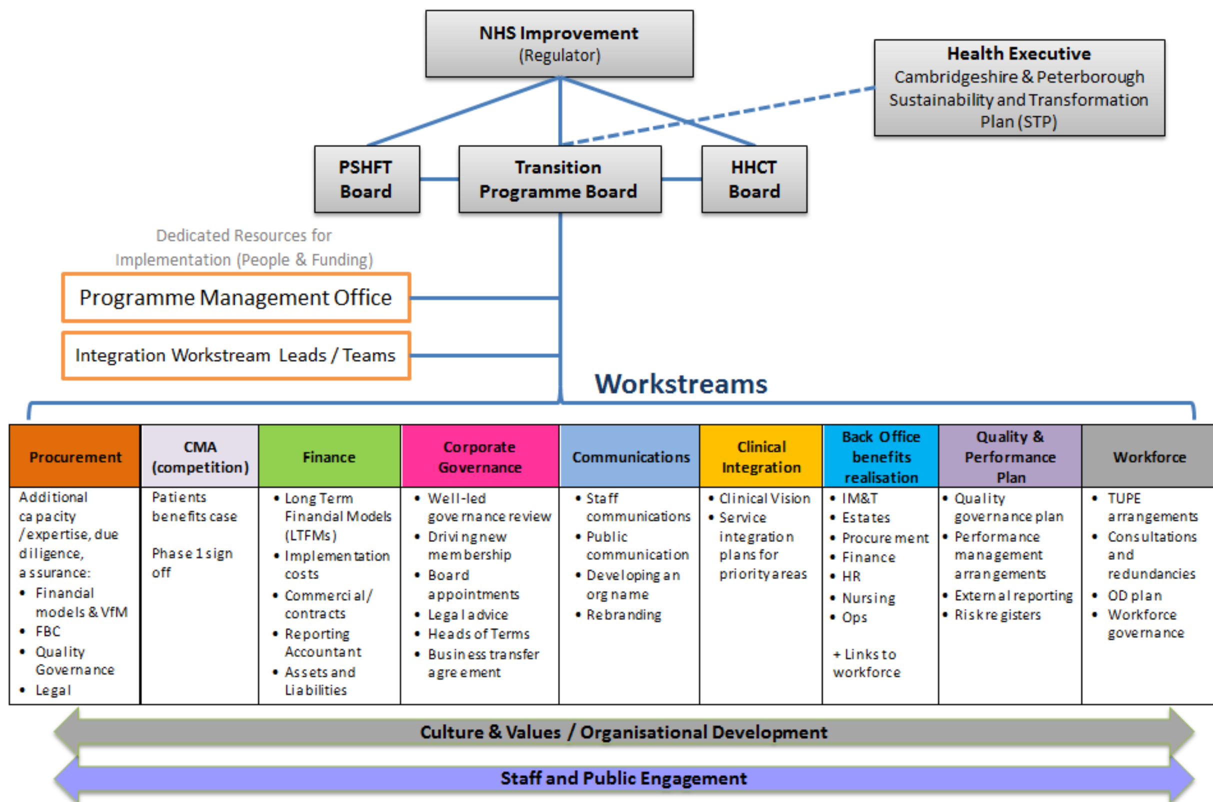
Figure 49: Indicative Timeline to implementation of Option 4



8.4.2 Programme Governance Structure

The proposed programme will be delivered through a number of work streams that will operate to drive activities within specialist areas. The oversight of the development of the FBC and detailed implementation plans will be through a Transition Programme Board (Figure 50) which will replace the existing Collaboration Project Board.

Figure 50 – Transition programme board governance and work stream structure



Section 8.7 outlines the implementation blueprint, which will be delivered through this programme structure.

Programme Management and Governance arrangements

A project team will be required to develop the FBC, but this team will need to be supplemented with additional dedicated resource to deliver the more detailed outputs required.

For example, there will need to be significant focus on staff and public engagement, and an implementation plan developed to cover each and every back-office and clinical service across both organisations, as well as ensuring that the necessary assurance is in place to support regulatory review and approval at each stage. Feedback from other similar NHS transactions is that it is imperative that there is dedicated programme management and implementation planning resource to support this work.

Project Management methodology

It is proposed that at Programme Management Office (PMO) is established, accountable to the Transition Programme Board to coordinate and track each work stream's progress. Prince 2[17] methodology will primarily be used.

---

[17] PRINCE2 (an acronym for Projects In Controlled Environments, version 2) is an industry standard project management methodology which encompasses quality management, control and organisation of a project with consistency and review to align with project objectives.

8.5 Communication and engagement

A draft communication and engagement strategy is attached at Appendix 13. The purpose and proposed arrangements are summarised below:

8.5.1 Purpose of the Strategy

- Develop stakeholder understanding of the reasons why closer working and why service change is necessary
- Ensure robust and effective communication and engagement systems are in place to ensure joined-up, consistent, credible, timely and well-coordinated messages to stakeholders
- Ensure robust systems for communicating and engaging with staff during a period of change, enabling them to shape and become advocates of the new organisation
- Build confidence among stakeholders in plans for working more closely together
- Ensure best practice in terms of communication and engagement; for example, integrity, openness, inclusivity and involvement is followed
- Ensure Healthwatch, the relevant Overview and Scrutiny committees and other stakeholders are engaged with.
- Ensure formal consultation with staff on any changes that may affect them is undertaken as required
- Support the development of a common vision, values and culture for closer working
- Start sharing a profile of closer working between the two organisations with their communities
- Ensure communication on potential future organisational forms (including internal stakeholders) and the commissioner-led 'Sustainability and Transformation Plan' external stakeholder process are aligned
- Ensure communication is sufficiently resourced to be deliverable, using existing channels whenever possible; ensuring value for money and appropriate use of public funds at all times

8.5.2 Communications and engagement – governance arrangements

A Communications and Engagement work stream will be established to oversee the development of the strategy set out above and that it delivers against the timelines and key milestones. This group will also oversee coordination of plans with the wider health economy and will include leads from the following organisations:

- Cambridgeshire and Peterborough CCG
- NHS Improvement
- Hinchingbrooke Health Care NHS Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust

8.6 Post-Merger Integration and Implementation Plan (PMIIP)

This section sets out the early approach to implementation planning for the merger and describes the key things that must be in place for Day 1.

Achieving a successful merger and a stable financial and operational future requires early and detailed planning. The actions required to achieve a smooth transition to the new organisation on Day 1 must be clear, in order to have effective control of the combined organisation, and become a fully integrated organisation as quickly as possible.

The detailed planning for the successful merger must also ensure clear accountability for the delivery of the business as usual activity in the interim.

Planning for the new organisation must also build on the existing work underway at both our trusts, and the development of an organisational design strategy will be an example of this.

The date upon which the new merged organisation is expected to come into being is dependent on the factors outlined in section 8.4.1), however, regardless of these factors, a new organisation being constituted would be subject to approval of the FBC by the two Trust Boards, Foundation Trust Governors, Regulators, and the Secretary of State for Health.

Section 8.8.2 sets out the approach to developing the benefits realisation strategy, which is how the benefits that will be delivered by the merger will be measured and tracked.

8.7 Integration and Implementation Blueprint

Underpinning all implementation plans will be an emphasis on developing a single, consolidated, centralised structure; and a single set of systems, processes and policies.

Activities will be focussed on the development of the Post Transaction Integration and Implementation Plan (PTIIP). This will be done in an inclusive manner that ensures that all work stream leads own and deliver these plans as part of their day-to-day activities.

Performance during the merger activities must be sustained so there needs to be an early focus upon developing a shared understanding of the performance and activity at service line level.

A proposed organisational structure has been developed and more detailed work now needs to take place with the corporate, functional and clinical work streams to plan for Day 1 and beyond.

All specialty work stream leads will be asked to structure their plans in a common way using the change readiness evaluation process piloted with four specialty areas as part of the development of this OBC.

The output of this process will be a set of clear action plans covering each of the following categories:

- People and culture
- Processes and policies
- Systems
- Facilities
- Contracts
- Financial

The outputs of this work will be used to determine the scale and scope of the change programme that will be initiated and implemented both pre and post-merger. This section contains an initial summary of the key deliverables planned for Day 1.

We will need to take account of the priorities and interdependencies between the work streams. These plans will be completed for the FBC and tested with relevant advisers including the legal team before FBC submission.

For the FBC, the PTIP will be developed and integrated into each work stream's detailed project plans with interdependencies clearly identified.

These plans will highlight the actions to be completed in the run up to Day 1, and forward to the end of the second year post implementation.

In practice, detailed project plans will cover a rolling 12-month period and address service redesign and transformation, CIP delivery, skills and capacity development, workforce engagement and involvement and leadership development for board and clinical staff.

8.7.1 Operational and clinical leadership

Operational and clinical leads and executive sponsors will be established to focus between now and September 2016 on developing a detailed plan to include the following key areas:

- Culture alignment
- Strategy formulation
- Policy development
- Information systems and reporting alignment/integration
- Identification of service and financial merger synergies
- Future organisational structures
- Partnership and stakeholder engagement

In addition, they will work with the merger team, as well as operational and clinical leaders across our three hospitals, to help develop the requirements for the FBC.

The management of the transition, from the current operational management arrangements to the new structures, is to be worked through as part of the FBC.

In transition:

Accountability for delivery of clinical, operational and financial performance during the transition period remains with the existing management structures and governance arrangements across our three hospitals.

Accountability for the development of the operational plans, including service standards and financial and targets, including CIPs, remain with the existing management arrangements. The merger work streams will contribute to this process, with effective collaboration between the current management teams and the merger work streams.

Planning for Day 1:

On Day 1, any changes in management and control arrangements below Board level will be limited to those areas which are essential for day to day running of the trust. For other areas, the merged trust‘s management structure will evolve over the following year by merging the best of both organisations.

Accountability for the delivery of operational plans will sit with existing operational structures and management arrangements until new arrangements are ready to be put in place. Further consideration is being given by the Project Management Board to the management of that transition and the assessment and management of the risks associated with it.

8.7.2 Communications and engagement

A coordinated corporate communications team will be in place. A communication and engagement strategy (see Sec 8.5) will be ready to guide and support the positioning of the merger within the community and the workforce.

Planning for Day 1: There will be a single corporate identity, including; publications, reports and stationery. Efforts will be made to achieve a single website, basic intranet and standard email addresses in advance of Day 1 as a channel to engage and communicate with staff.

8.7.3 Governance Systems (Corporate)

Governance Systems have been defined as integrated governance of the following:

- Policy and procedure development
- Risk governance
- Regulatory compliance
- Board and membership

In each of these four areas detailed plans will be developed that will enable the successful transition from two organisations into one. This section summarises some of the key actions and milestones for Day 1 in each area.

Planning for Day 1:

- A vision, objectives and set of values will be in place for the new organisation.
- A Day 1 executive team will also have been appointed and there will be agreement on policies, procedures and guidance and those critical to operational and risk management will be identified.
- Integrated governance - the trust will have board members and terms of reference for the Board will be documented and approved.
- The trust will be registered with the CQC and NHS Litigation Authority and a single set of key operational and clinical policies will be in place e.g. health and safety, fire, clinical guidelines, clinical audits, and procedures for clinical untoward incidents and safeguarding children and adults etc.
- The trust will have a major incident plan and procedures for complaints, legal services, and coroner‘s inquest arrangements.
- The trust will also have clear arrangements in place for organisation membership, governor appointments, and patient involvement.

8.7.4 Functional level - Implementation

The functional areas cover HR, Information Management and Technology (IM&T), Finance, Procurement and Estates. In each of these five areas detailed plans are being developed for the transition from two organisations into one.

Planning for Day 1:

Again, the emphasis will be upon having a single, consolidated, centralised structure and single systems, processes and policies.

Functions will be responsible for the line management of those areas that are likely to be devolved and adopt a business partner approach.

Further work will be undertaken as part of the development of the FBC to assess workforce capabilities, decisions on which functions will remain in-house etc.

Some of the key planning actions are as follows:

Human Resources

Planning – for Day 1

- Following appropriate consultation as required by legislation and trust change management policies, existing NHS employees will be transferred into the merged trust.
- Key employment and employee relations policies will be in place.
- Contracts, terms and conditions for staff will be standardised in line with the national contracts.
- An initial gap analysis identifying any differences between both organisations' broader suite of HR policies will be complete and a plan and timetable for their harmonisation will be agreed.

Organisational Development (OD)

- Work to establish an agreed vision for the new organisation along with an agreed set of new strategic objectives will be complete
- An initial exercise, through engagement of employees of both trusts, to establish both the prevailing organisational cultures, along with a clear and agreed description of the desired cultural state for the new organisation for the future will be complete.

Planning for Day 1:

- An evaluation of each organisation's current OD programmes and provision will be complete and a roadmap to integrate such programmes will have been developed and agreed.

Finance

Planning for day 1:

- Transfer of all assets and liabilities into the merged trust
- A coordinated finance function, with consistent Standing Financial Instructions and management accounting structures in place
- A single financial IT system
- Contracts and SLAs for service provision will be agreed with commissioners

Procurement

Work has already commenced to develop coordinated procurement functions in order to increase purchasing power and increase efficiency. A Head of Procurement is already leading the procurement teams in both organisations.

Estates

Planning in transition:

- An Estates investment and divestment plan will be established.

Planning for Day 1:

- A single estates and facilities risk register and reporting arrangements will be in place.

IM&T

This work stream is currently assessing the clinical requirements of the merger and further engagement will be required with the clinical work streams as they are established. Systems to enable single management reporting are being assessed.

Planning for Day 1:

- Network integration, single email service and diaries will be created.
- An information governance structure, policies and procedures will be established.
- Principle patient database systems will be aligned.
- All policies will aligned with the new 'Policy for Policies'.

Post implementation planning

- IM&T Systems for Patient Administration System (PAS) will need to be fully integrated.

8.7.5 Operational and clinical - Implementation

High level clinical integration

The steps below set out the intended high-level approach to clinical integration which will be applied to each clinical service separately. The overall aim is to ensure a smooth transition and the delivery of sustainable services.

A change readiness evaluation process has been designed to help:

- Assess change readiness and prioritise service integration
- Identify and define specific interventions to address readiness needs
- Identify opportunities for clinical standardisation to improve efficiencies and patient outcomes

This will then facilitate:

- Development of integration plans , applying a consistent approach and templates, supported by workshops with clinical teams
- Tracking of benefits, evidence capture and lessons learned
- Ongoing communication and engagement

These specialty implementation plans will need further detailed work-up as part of a Full Business Case, and will be a key feature of the overall implementation plan.

Developing the culture

"Cultural differences are increasingly thought to be a major cause of post-merger dysfunction." (Carroll, 2006) but **"Both our organisations have the same strategic direction; to be the best possible DGH for their local population – that seems like a good place to start." Consultant HHCT.**

Differences in culture have not been raised as a concern throughout the clinical collaboration workshops, but the importance of ***how*** transition to merged services is managed has been raised repeatedly:

> "It is not just about implementing what looks to be the right thing to do on paper. We must go about it the right way"
>
> "There are risks to losing staff, or destabilising services in any transition. Mishandled change will result in unintended consequences, and a failure to fully realise the benefits we are setting out to achieve.
>
> "Staffing is fragile. Mishandled change will represent a significant risk to retention and recruitment."

The Clinical Reference Group recommendations include:

- Respect for job plans
- Protection of specialist sessions
- Rotas and OOH cover must be workable
- Opportunities for flexibility should be maximised

Key stakeholders, including staff, will be engaged in the implementation plan as it is developed and refined to provide opportunities to maximise buy-in, but we must avoid a prolonged period of uncertainty by failing to make timely changes.

"Proper planning and resourcing the transition is critical." Consultant PSHFT.

Operational Management

Maintaining and improving patient safety, operational and financial performance in the new organisation depends on clarity of responsibility and accountability for each service line through the transition period.

A clinical operational model be agreed with the medical directors, chief nurses and chief operating officers.

The model will define the management team at clinical directorate and service line level, and further work will develop the wider teams and workforce within and establish their performance management and operational and professional governance arrangements.

The operational management work stream will develop an integration programme around the following areas, within the governance arrangements outlined above.

Each clinical directorate will consider services across the new organisation under the four headings below:

i. Management of clinical risks

Aligned to the work of the governance work stream, plans will be developed that will maintain the standards of clinical governance and identify improvement opportunities. Clinical risk policies will be in place and current risks to clinical services (such as pressurised rotas and use of locums, bank and agency staff) will be reviewed to determine how to configure the extensive resources and capacity that becomes available through the merger and address these where possible.

ii. Leadership and care pathways

- There will be one management team responsible for each clinical service across all sites.
- A detailed organisation design will be completed with professional accountability clearly articulated.
- These roles will be consulted on and then filled with a relevant training programme of support provided.
- Care pathways will be consistent across sites with a view to implementing many of the required changes ready for day 1.

iii. Financial control

Financial management and control capabilities will remain aligned with the structures of the existing organisations until consultation and appointments are complete.

iv. Performance Management

Performance management arrangements will continue in line with the arrangements in place at the existing organisations. In anticipation of the creation of a unified structure, a single performance management process will be developed and implemented at the point at which staff are appointed to the new organisation.

8.8 Benefits realisation strategy

Further to the benefits set out earlier in this document, a benefits realisation strategy will be developed through the FBC phase to form a central part of the overall integration plan. The costs of realising the benefits will be assessed as part of the implementation planning process and built into the FBC submission. As implementation proceeds, the forecast benefits will be cross-referenced with work stream project plans, risk management plans and the corporate vision and objectives to which each benefit relates.

The potential benefits will be identified using the following processes:

- Development of benefits captured in the OBC and FBC
- Discussion through the work streams, with programme board oversight
- Work with members of the programme management team and external advisers
- Identification of relevant items arising in other working papers
- Benefit and metric identification
- The prime benefits expected from the combined trust may be summarised as follows:

    - Providing a sustainable and viable platform for services
    - Providing a strengthened workforce with improved flexibility, recruitment and retention
    - Establishing one environment which takes the **'best from both'** organisations
    - Achieves economies of scale in corporate services, facilities, functional and clinical areas.

Further work will be undertaken to develop benefit profiles for the items identified and standardised template developed. The completion of a benefit profile template ensures that the following issues are considered:

- Details of measurability
- Details of interdependencies with other benefits and projects
- Allocation of responsibilities for the realisation of the benefits
- Fitness for purpose checklist
- Are the dates by which the benefits should accrue clearly understood and realistic?
- Are the dates by which the benefits should accrue in line with the programme milestones and relevant project deliverables?
- Are the actual benefits accruing compared to the projected benefits?

8.8.1 Content of the benefits realisation plan

- A schedule detailing when each benefit or group of benefits will be realised.
- The identification of appropriate milestones when a programme benefit review could be undertaken
- The details of any handover activities, beyond the mere implementation of a deliverable or output, to sustain the process of benefits realisation after the programme is closed.

8.8.2 Benefits realisation (delivery) plan

The benefits realisation plan will be used to track the delivery of benefits across the programme. It will be owned initially by the Programme Management Office (PMO) but over time it is intended to integrate this into the routine business management processes of the combined trust.

Once developed, the plan will include the dates by which the key benefits will be delivered and ensure that these are in line with the programme milestones and project deliverables. It provides clarity about where and when the benefits will occur and who will be responsible for their delivery. The plan will show that it will be necessary to identify clear processes to sustain the process of benefits realisation after the initial integration programme is finished.

The plan will include evidence of how action plans will be written to identify the activities, timelines, responsibilities, interdependencies and resources required to achieve the benefits at an operational level. The plan will give details of the key performance indicators and tracking mechanism that will be used to monitor achievement of benefits against expectations and targets.

9. Risks

The risks to achieving a preferred option for collaboration that is jointly agreed by both Trust Boards have been identified, documented, and tracked throughout the development of the OBC. These risks and mitigations have been reviewed fortnightly by the HHCT/PSFHT collaboration Project Board.

This section discusses the key risks to delivering the preferred option; focussing upon how the identified risks will be managed as the organisations progress from OBC to FBC, and from FBC to implementation of the preferred option, including risks to delivering its stated benefits. This includes:

- Impact on performance targets for both pre and post-merger
- Achievement of the merger benefits
- Potential blockages to change from staff or other stakeholders
- Impact on transition and financial position, particularly if transitional costs are not externally financed

9.1 Risk Assessment and management

Risk assessment is a fundamental management tool and forms part of the governance and decision making process at all levels of an organisation. The risk register is a risk management tool whereby identified risks are described, scored, controls identified, mitigating actions planned and a narrative review is recorded.

Risk management is a key item covered in trust reports, including the financial and operational management reports. The principles of risk management are also embedded in the trust's approach to business continuity planning, the internal and external audit reviews, local counter fraud services and security management. It should be used as a tool to drive decision making at all decision making levels in organisations, and therefore the identification and accurate reporting of risks needs to be embedded into staff culture at all levels, along with an understanding that risks reported will be acted upon appropriately by those in more senior positions. This will be vital throughout any collaborative work, in order to ensure day to day performance on quality, finance and operational performance does not slip, and in order to support the integration processes of merging the two organisations.

Following approval, the project will continue to adopt sound and tested risk management processes based on both trust's risk management policies to allow the project (or shadow) board to understand the project risks and put in place mitigation measures to manage those risks.

The most significant risks to the project for either or both trusts, are those which score 12 and above. These should be reviewed at each separate organisation's board or appropriately identified sub-committee to ensure the risks are adequately scrutinised, managed according to known mitigating factors and implications on the individual trusts are known.

The risk register matrix of how all identified risks are scored is included in Appendix 16. Risks that are rated high or significant are deemed as unacceptable to trust boards and actions should be taken to ensure the risk becomes reduced over time.

9.2 Current project risks

The full risk register of current project risks is included in the risk register in Appendix 17. These are reviewed and managed fortnightly at the project board.

9.3 Risks of not proceeding

The risks of not proceeding with option 4 have been set out in chapter 5's option appraisal descriptions of the alternative options. In summary however they include:

- Short, medium and long term clinical unsustainability of various services at one or both trusts, due to issues with recruitment of specialist staff and an inability to fill rota's and provide seven day services for patients.
- Lack of ability to improve quality by reducing variability in patient outcomes and experience.
- Inability to deliver CIP targets and a continuation of a deteriorating financial position, not making best use of tax-payers money.
- Lack of ability to find another suitable partner to collaborate with due to worsening clinical and financial position and reputation of willingness to partner.
- Inability to contribute to the STP both through the points above and senior staff within the organisations will need to spend increasing amounts of time managing the worsening internal pressures.

9.4 Risks of moving to a single organisation

With more than 20 NHS hospital mergers in the previous five years, it is essential to review the problems and issues those mergers faced, in order that we can learn lessons and put in place robust mitigations to ensure this project does not suffer from them. Recent reviews by the Kings Fund[18] and others have led to a variety of published papers detailing the mistakes other mergers made and things the trusts will need to ensure they are adequately prepared for such a transaction.

For example, although there are advantages for patients and staff in creating larger organisations as cited in Chapter 6, in practice it is evidenced that there are often disadvantages that need to be considered in order that they can be avoided, for example:

- The organisation becomes unresponsive and slow to make decisions, leading to lack of service developments
- Senior management are removed from the front line, leading to deterioration in quality of care
- Managers feeling removed from services and deterioration in morale
- Increased travel time of staff and reduced communication at all levels

In almost all cases senior management had underestimated the timescale and effort involved in the mergers and the restructuring of teams and staff can easily become distracted by the merger process itself and the uncertainty of employment. In a review of mergers that occurred in the 1990's Fulup et al (2002)[19] found that 'the loss of managerial focus on services during the merger had some detrimental effects on patient care.' Also although

---

[18] The Kings Fund: Foundation trust and NHS trust mergers 2010 to 2015 (September 2015)
[19] Fulup (2002) Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis British Medical Journal 2002 Aug 3; 325(7358):246

open, fair recruitment into merged posts is necessary, if it is viewed by junior staff that more staff from one of the original organisations seem to be appointed, then there are often feelings of disassociation with the new organisation and feelings that they have been 'taken over'.

A further issue highlighted as an unintended difficulty post-merger was understanding and addressing the cultural differences between organisations. In this business case, both trusts are local district general hospitals delivering a similar range and complexity of services and therefore many staff should feel familiar and have similar behaviours, values and ways of working. However, there will inherently be differences in some aspects of culture.

If it is decided to proceed to FBC, then an implementation plan that addresses all of the above issues and provides assurance that a new organisation can avoid and mitigate against them occurring will need to be created.

9.5 Risks of proceeding

9.5.1 The CMA rule against the decision to become a single organisation.

Lessons learnt from the proposed merger between Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust[20] include a lack of clear understanding by the trusts of the process and requirements of the CMA approval process. This led to documents that did not clearly articulate the reasons behind the merger and did not show that the proposed form was the only one that could deliver the patient benefits that were being claimed. It also led to delays and miss-communications at board level of the two trusts and between them, Monitor and the CMA which led to the trusts being 'on the back foot from the beginning'. As set out in chapter 8, this project has already been engaging with Monitor's Cooperation and Competition Department to understand the area's where the CMA may find that a combined trust would lead to a lessening of competition, and to begin to provide further detailed information on the contracting landscape and relationships for those services. Continuing with this ongoing dialogue and having regular updates to the project board (and subsequently to trust boards) where it is a standard agenda item will ensure the project remains on the 'front-foot' and any concerns the CMA may have can be addressed and answered with appropriate evidence in a timely manner.

9.5.2 External stakeholders

This risk arises if the local public, patients and political figures do not agree with the case for change and reasons for the transaction. The project needs to ensure the current situation of clinical unsustainability is made clear in the public communications campaign so stakeholders can fully understand the case for change, as well as how an organisational form change can deliver the improvements more sustainably for the longer term.

---

[20] The Heath Foundation: Mergers in the NHS Lessons learnt from the decision to clock the proposed merger of hospitals in Bournemouth and Poole *(December 2014)*

9.5.3 Impact on operational, quality of financial performance

Delay

Delay on making the decision could lead to; distraction of staff from day to day operational tasks; a deterioration in performance standards; a deterioration in quality; lack of progress on service development; loss of key talent; increased cost; decreased reputation of both trusts.

Tight robustly managed operational and quality performance agenda's in both trusts, plus a clear communication strategy is essential to ensure the consequences above are mitigated. The project team however need to work to ensure that significant delays to the programme of work do not occur, by having:

- a realistic implementation plan including times for external transaction and approvals
- continued close liaison with external regulators and approval bodies
- tightly managed plan by the project board
- clear, regular communications to all staff including down to individual meetings where individuals are directly affected.

Leadership and management capacity

Failure to invest the required leadership and management capacity to deliver the transaction, integration and day to day running of the organisation is a key risk in both organisations. Mitigation against this being a concern include a well resourced project and implementation team that can adequately support both the transaction and implementation in order that other managers can continue to focus on delivering the day to day operational running of the organisations.

9.5.4 Staff Resistance

Loss/lack of support from clinical colleagues

This will result in poor and/or slow clinical integration of teams and a reduction of the pace at which patients can begin to see the benefits. Involving clinical colleagues in describing the clinical vision of the combined trust and ensuring they are engaged with colleagues from their service in the opposite trust in designing how a merged service will look, the benefits it will bring and how it will be achieved is vital to ensure clinical teams are engaged from the outset. Supporting them to deliver that vision through good management and leadership is then essential to continue their support throughout the implementation.

Culture differences and lack of support

Differences could lead to slow and difficult integration of teams, and lower morale of some staff. An assessment of the culture of both organisations will be undertaken as part of FBC with a robust organisational development plan put in place. Continued open and honest communication with all staff and strong leadership from the senior team to focus upon shared values and beliefs will help to mitigate this. The communications and engagement plan will need to continue some years following transaction and should engage with every member of staff across the three sites, even where they are not directly involved in working at other sites. A new organisational identity borne out of staff and public engagement will assist in creating a shared unity for staff.

9.5.5 Financial assumptions are incorrect

Incorrect assumptions used in the original base case and savings opportunities will result in an unachievable financial forecast and a loss of reputation of the combined trust. The

implementation costs are also at risk of being inadequate. Further due diligence at FBC stage will be needed to provide the required internal and external assurances.

9.5.6 Financial position of the merged organisation if transition costs are not externally financed

This would lead to a significant pressure on the merged organisation from day 1 and would result in a continued financially unsustainable organisation into the future. Sustained engagement with regulators to agree the financing of the transitional costs, as well as detailed analysis in FBC to ensure the expected costs are accurate is essential. This will be managed through the programme board and reviewed directly with regulators on a regular basis.

9.5.7 Intended benefits are not realised/delivered

The process of identifying the benefits to be derived from a merger is set out in the approach to developing the Benefits realisation strategy (see section 8.8 on page 89.) This includes defining what is to be achieved by when, by whom, the measures to be used, and arrangements for tracking their delivery.

10. Appendices

Appendix 1 – Memorandum of Understanding

Appendix 2 – Clinical Reference Group ToR

Appendix 3 – Clinical service discussions

Appendix 4 – Capacity analysis

Appendix 5 – Strategic outline case assessment criteria

Appendix 6 – Strategic outline case long list reasons for exclusion from the short list

Appendix 7 – Strategic outline case short list of options

Appendix 8 – Detailed report in the option appraisal process

Appendix 9 – The process for identifying back office savings opportunities

Appendix 10 – Back office savings assumptions

Appendix 11 – Detailed description of option appraisal

Appendix 12 – Clinical services which will benefit from merger

Appendix 13 – Financial assumptions

Appendix 14 - Indicative Timeline to Transaction Approval (by 1 April 2017)

Appendix 15 – Communications and Engagement Plan (DRAFT)

Appendix 16 – Risk register matrix

Appendix 17 – Full risk register