Appendix 1 – Memorandum of Understanding

COMMERCIAL IN CONFIDENCE

DRAFT MEMORANDUM OF UNDERSTANDING FOR COLLABORATIVE WORKING AS PART OF CAMBRIDGE AND PETERBOROUGH SYSTEM TRANSFORMATION PROGRAMME

BETWEEN THE "PARTNERS" LISTED BELOW:

HINCHINGBROOKE HEALTH CARE NHS TRUST (HHCT)

PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST (PSHFT)

1. The project

1.1 The partners agree to work collaboratively together to reduce duplication and costs, and support the future delivery of sustainable services for the benefit of patients and taxpayers. The partners agree to the following objectives:

1.1.1 Identification of back office and support function savings opportunities;

1.1.2 Identification of the organisational form changes for the two organisations; and

1.1.3 Agreement on a shared vision for future clinical service provision.

1.2 The key deliverables from this project will be:

1.2.1 Joint CIP programme for 2016/17 and 2017/18;

1.2.2 Outline Business Case for organisational form change (and a Full Business Case should the OBC recommend it).

1.2.3 Input into the clinical service reconfiguration plan for the LHE being undertaken through the System Transformation Programme.

1.3 The project will continue as a minimum until final business case approval and implementation, or until outline business case is presented to the respective boards if there is no decision to proceed. The term of the project will be reviewed at the time of submission of the OBC.

2. Timescales

2.1 The project will commence in November 2015.

2.2 Immediate shared CIP opportunities for 2015/16 will be identified by 14 January 2016. 2016/17 shared CIP opportunities will be presented to the respective Boards in February 2016 in line with national timetables. 2017/18 shared CIP opportunities will be presented to the respective Boards in April 2016 at the same time as submission of the OBC.

2.3 The outline business case will be presented to each board in April 2016.

2.4 Subject to approval of the outline business case, draft heads of terms and a full business case will be presented to each board by:

- Heads of Terms – May 2016
- Full business case – July 2016

2.5 If the full business case is approved, more detailed heads of terms will be presented to each board by August 2016.

2.6 The preferred option from the OBC will be implemented from October 2016.

2.7 A detailed timeline leading to development of the OBC is provided in Appendix 1.

3. Background

3.1 As part of the Cambridge and Peterborough System Transformation Programme it was agreed that the partners listed above will collaboratively work together to reduce duplication and costs, which will also support the future delivery of sustainable services for the benefit of patients and taxpayers. This will include the jointly created CIP programme for 2016/17 and 2017/18, an Outline Business Case for organisational form change and input into the clinical service reconfiguration plan for the LHE.

3.2 The OBC work will encompass both:

3.2.1 the financial case for reducing the duplicate corporate structures including Board functions and corporate support services; and

3.2.2 the clinical vision for closer working to deliver clinically sustainable services and improved outcomes for patients.

4. Purpose and Commitment

4.1 This work will assess the opportunities to reduce duplication and plan for shared CIPs and changes in organisational form across the two organisations in the areas identified above. The partners commit to the identification and delivery of material CIPs in order to reduce the provider deficit as soon as possible.

4.2 By mid January 2016, the partners will have prepared a joint 2015/16 in-year plan for shared CIPs. By February 2016, the partners will have a jointly created 2016/17 CIP programme focussing on shared support functions.

4.3 The partners commit to monitor the delivery of the jointly created CIPs via the project board up until April 2016. Following this, a review will be undertaken to agree how best to monitor shared CIPs going forward.

4.4 By April 2016 an outline business case will be prepared for both boards which explores the future organisational form of the trusts based on a number of options defined below. This will include the jointly created shared CIP programme (to be fed in as a supporting work stream).

4.5 The partners agree to provide management resource and all relevant data connected with the services in scope and for this information to be shared between partners.

5. Project arrangements

5.1 Both CEOs will support this project, the PSHFT deputy CEO will act as Project Director and the HHCT CEO (lead CEO) will chair the project board.

5.2 The project will be supported by relevant expertise from within each trust, the System Transformation Programme and external support from and through Monitor and the TDA.

5.3 The project arrangements can be changed in the event that both parties agree with Monitor and the TDA the new arrangements.

6. General principles

6.1 This project will:

- above all, work to the timescales defined in section 2 above.
- remain compatible with other work streams in the system transformation programme, as far as they are known at the time.
- Remain compatible with national and local initiatives including:
  - New models of care urgent and emergency care vanguard
  - * Work in ENT, orthopaedics, ophthalmology and cardiovascular
  - * Extension of Uniting Care Partners to include PSHFT and HHCT in the future board.
  - LHE led work on Children's services
  - NHS England maternity review

- Urgent and emergency care vanguard
- * Local clinical strategy for HHCT and PSHFT to deliver a long term sustainable vision

6.2 Both parties agree to ensure value for money during the preparation of the outline business case and will limit strategic decision making and avoid incurring short term costs which may need to be reversed depending on the outcome of the business case.

6.3 Both parties agree to explore all opportunities to fast track any potential back office savings in advance of the April 2016 outline business case decision. These will be set out in a Joint 2016/17 CIP.

6.4 Both partners agree to avoid entering into any additional long term strategic or financial commitments without the prior approval of both CEOs and regulators, including:

- appointment of substantive executive and senior management posts;
- approval of new major capital projects; and
- strategic partnerships.

7. Confidentiality

7.1 Until the existence of this Memorandum of Understanding is declared as part of public engagement, this agreement will be commercial in confidence and not subject to disclosure where a request is made under the Freedom of Information Act (2000).This is considered as being exempt from disclosure under section22 (information intended for future publication) of the Act. Whilst work is ongoing on the subject matter of this agreement this is considered exempt under section 43 (prejudice to commercial interests) of the Act.

7.2 If either party to this Memorandum of Understanding is approached or is considering disclosure of the existence or content of the agreement, then the other party will be informed, and formal legal advice sought as consideration of the public interest test under the Freedom of Information Act 2000 at the time of the request will apply.

7.3 Commercially Sensitive Information provided by each provider as part of this project is provided in confidence and is not to be disclosed beyond the project team or to whom it is essential. All individuals in receipt of commercially sensitive or confidential information will be required to sign a separate non-disclosure agreement. If either party suspects that this is breached they are to inform the other party as soon as is practically possible.

7.4 Any information already available in the public domain is not exempt from disclosure under the Freedom of Information Act 2000

8. Competition law

8.1 The partners agree that for the purposes of this Memorandum, “Commercially sensitive information” means any and all trade secrets, confidential financial information and confidential commercial information including without limitation, information relating to the terms of actual or proposed sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by either partner, the publication of which a corporate entity in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions, providing that this shall not apply where the exchange of such information is permitted in accordance with this Memorandum.

8.2 The partners acknowledge that competition law will apply to their conduct before any possible transaction and that competition approval is likely to be necessary in relation to any transaction.

8.3 In particular, the partners acknowledge that competition law imposes obligations in

relation to dealings with each other during this stage and in relation to the preparation of the Outline Business Case and that the partners are required to take special care to ensure compliance with the obligations. In particular, the partners acknowledge that the sharing of Commercially Sensitive Information is an area that might cause competition law concerns unless these communications are properly managed.

8.4 The partners acknowledge that, at this early stage, in practice, the information that is likely to be shared will predominantly be already in the public domain.

8.5 To the extent such information is not already in the public domain, the partners have, in Appendix 2 set out the principles which will govern the conduct relating to information sharing in order to comply with competition law.

8.6 Any commercially sensitive information must be shared in accordance with the protocol set out in Appendix 2 and in line with Competition Guidance. Any information related to areas of work where the organisations may be considered to be in competition, should not be shared with staff involved in contractual arrangements.

9. Governance

9.1 The project board will form part of the governance arrangements for the system wide transformation programme show in diagram 1.

9.2 The project board will report to the Shadow Health Executive.

9.3 The lead CEO will report every two weeks, updating system leaders, Monitor and NHS England on project progress, including any risks or issues requiring clarification or support from partners.

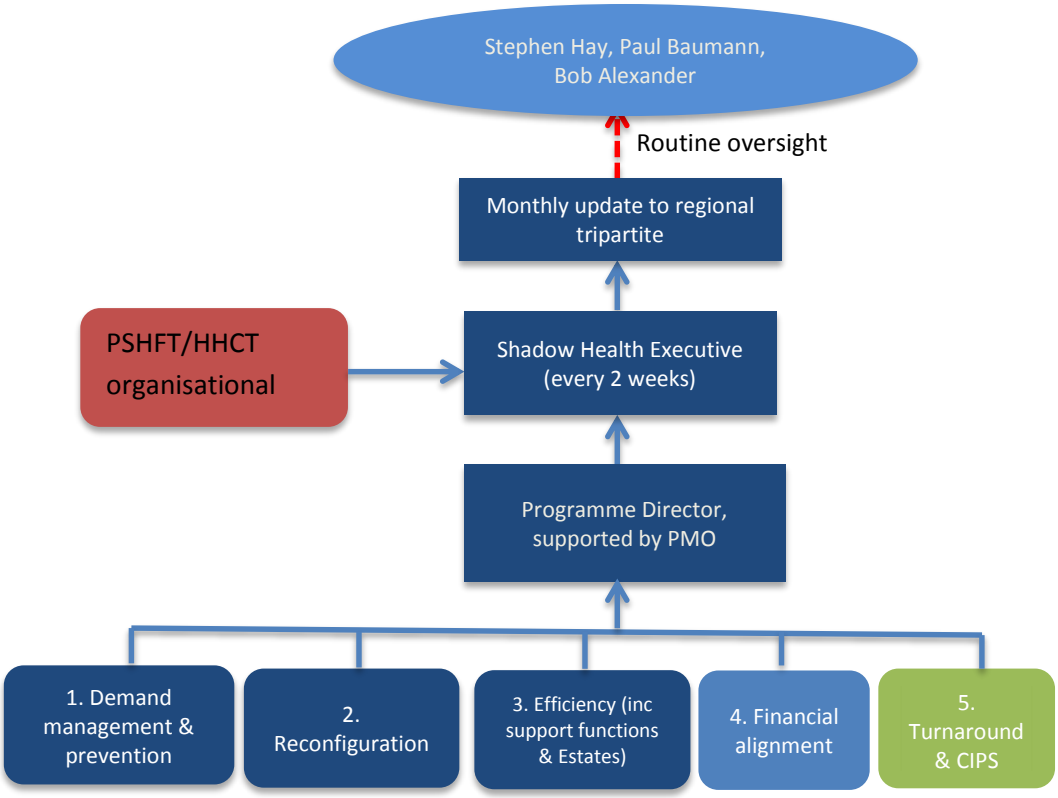
9.4 Each CEO will report to their individual Boards and Governors as applicable

9.5 The project will be established and operated on PRINCE principles.

9.6 A project board will be established which will comprise both CEOs, with individual work stream leads from within each trust and representation from Monitor and TDA

9.7 The Project Board will include a nominated Non-Executive Director from each Trust.

Diagram 1



9.8 The outline business case will be structured so as to enable assessment and appraisal of the content to be carried out in accordance with the Five Case Model (HM Treasury 2007) for business case development, as described in the table 1

Table 1

Five case model OBC	Proposed HHCT/PSHFT OBC
Strategic case – to demonstrate that the proposals are supported by a robust case for change.	The case for change*: - National context - LHE - CCG commissioning intentions - Drivers for change
Economic case – to demonstrate the options appraisal of potential benefits compared to costs, and that value for money has been optimised for society as a whole	Options appraisal* - Previously considered options - Available options - Assessment of options Benefits* - Benefits for commissioners and the local economy - Clinical case
Commercial case – to demonstrate that the proposals are commercially viable	Not included
Financial case – to demonstrate that the proposals are financially affordable	Financial case - Assessment of each trust's financial position - Assessment of the finances of the proposed new organisational form
Management case – to demonstrate that the proposals can be delivered successfully	Vision and organisational design - Vision for the proposed organisational form - Areas the new organisation will serve - Organisational structure - Board structure(s) - Governance of the enlarged structure - Performance management Programme timeline, Governance and management - Programme timeline - Transactional workstream - Organisational workstream - Legal and regulatory approvals - Communications and engagement - Programme management and governance arrangements

** Note - the Monitor strategic outline case will form the core of these sections*

9.9 Business case development

The trusts will explore the following options for organisational form in an outline business case:

- 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

9.10 The outline business case will be presented to the two Trust boards in April 2016. If one of the options 2-4 is approved to proceed, the full business case will be presented to the August 2016 boards, following each Board undertaking its own due diligence, for implementation from October 2016.

Criteria for ranking possible remaining options

Order of application

	Criteria	Summary
1	Aligns to STP plans that aim to secure sustainable and safe services for patients	• Must be compatible with the clinical workstreams currently under way, e.g. UEC and ACC vanguard proposals • Enabler to address the capacity mismatch across the patch • Ability to build on local clinical collaborations and work already done by Uniting Care • Aligns with the principles of the five year forward view
2	Must generate financial savings to ensure safe and sustainable services for patients	• To continue to deliver high quality services to the people of Cambridgeshire and Peterborough the system needs to be able to operate within the available financial envelope in a sustainable way • The new organisational form needs to demonstrate that significant financial savings can be made through synergies and better use of the physical capacity existing in the system • Ensure long term financial viability of any new provider forms
3	Must be deliverable and acceptable to patients and stakeholders	• Ability to align culture and other values between organisations in a relatively short period of time • Maintain safe staffing levels • Maintain commissioner requested services • Maintain patient access • Minimise the extent to which patient choice is reduced (competition considerations) • Acceptable to the public and key stakeholders
4	Must be affordable, making the best use of public funds	• The cost of investment must not be excessive relative to the financial benefits • The payback period should be reasonable • Must consider what / whether central funding will be available, and whether alternative funding is available within the Local Health Economy

10. Resources

10.1 As far as possible, both organisations will utilise in-house resources with external support as required. The costs will be shared 50:50.

10.2 PSHFT resource will include:

- Deputy Chief Executive (Project Director)
- Assistant Director of Strategy
- Assistant Director System Transformation and Stamford Redevelopment
- Deputy Director of Finance - Planning
- Deputy Director System Transformation
- Other individuals to support the programme of work will be identified to lead workstreams as required

10.3 HHCT resource will include

- Individuals to support the programme of work will be identified to lead workstreams as required

10.4 The System Transformation Programme team will provide activity analytic support where available.

10.5 In agreement with Monitor, procure financial analytic and competition analysis support where required.

10.6 Separate to the above arrangement each Organisation will procure and incur the costs of its own due diligence which will cover at least, legal, commercial and financial matters.

11. Work streams

11.1 The project board will oversee six work streams to develop the outline business case. These are described in more detail in Appendix 2.

11.2 The outline business case will be developed from the Strategic Outline Case.

11.3 Responsibility for writing the business case rests with both organisations with the lead author being the Project Director.

11.4 The work streams to develop the OBC include:

- Strategic drivers for change
- Activity analysis
- Financial analysis
- Competition
- The clinical vision and organisational design
- Programme design
- CIP

11.5 Depending on the outcome of the outline business case a process of due diligence may be required. This will run consecutive to the development of the full business case.

12. Communication

The Trusts will jointly develop and manage a single and consistent communications plan through the Project Board.

13. Agreement

Signed by:

HHCT Chief Executive: _____

(L.McCarthy)

PSHFT Chief Executive: _____

(S.Graves)

November 2015

MoU Appendix 1 – Detailed timeline for development of the outline business case

Milestones	Dates
A formal Memorandum of Understanding between PSHFT and HHCT agreed	11 December 2015
Programme Arrangements and Governance agreed	11 December 2015
PID agreed for presentation to Programme Board	11 December 2015
First Programme Board	24 December 2015
Work stream programmes of work commenced	24 December 2015
Agreed 2015/16 shared CIP	14 January 2016
Agreed 2016/17 shared CIP	February 2016
Agreed 2017/18 shared CIP	April 2016
Outline Business Case completed	April 2016
PSHFT/HHCT formal approval to proceed to Full Business Case	April 2016
FBC commences (should the decision to proceed be taken)	May 2016
CMA Phase 1* (if required)	June 2016
Full Business Case completed	July 2016
PSHFT/HHCT formal approval of Full Business Case	July 2016
Monitor assessment process concludes* (if required)	September 2016
Formal Board/Governor approvals by both PSHFT and HHCT to conclude transaction* (if required)	September 2016
Transaction go-live*	1 October 2016

*As the outcome of the OBC decision is uncertain, this timetable sets out an indicative process which is the most complex, i.e. it requires competition and regulatory approval. In the event that these are not required, the FBC and Transaction go-live date could be earlier.

MoU Appendix 2 Conduct and Information Sharing Protocol

Commercially sensitive or other confidential information that relates to the work being undertaken in accordance with this Memorandum of Understanding will only be shared with identified members of the project teams.

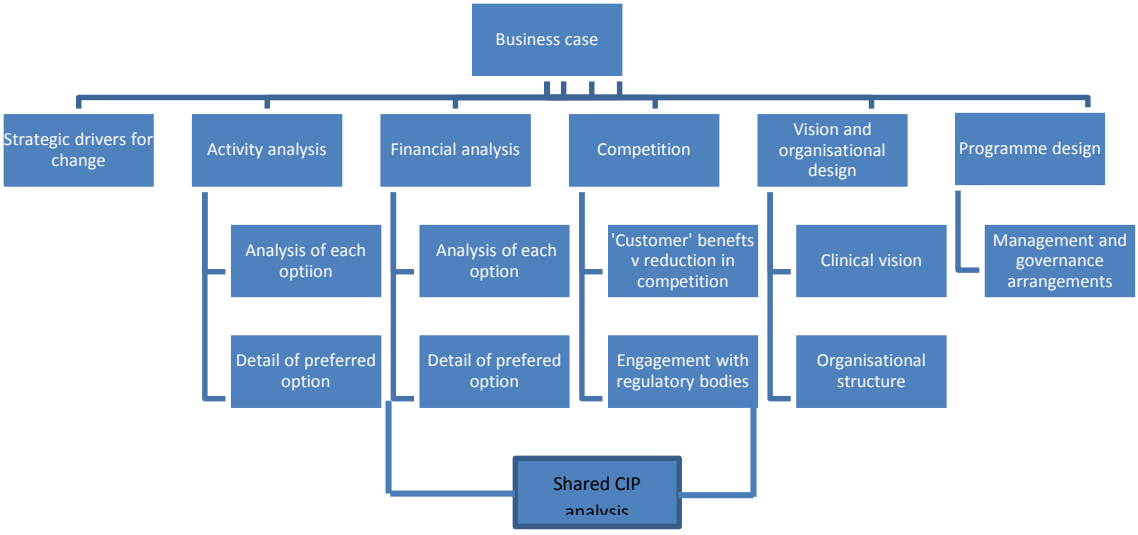
All project team members will be required to sign a non-disclosure agreement.

Any other individuals requesting access to such data who are outside the project teams will need to be approved on an exception basis by the Project Director or the Chief Executive of the party to whom the information relates.

Information shared between the project teams can be done:

- electronically over NHS.net or otherwise encrypted and/or
- to a dedicated e-mail box accessible to project team members only and/or
- to a shared secure document location

MoU Appendix 3 Work streams to develop the outline business case



Strategic drivers work stream

The project board will review the strategic drivers in the Monitor strategic outline case.

Activity work stream

- Led by xxx.
- Supported by the strategic transformation programme.
- Analysis of the impact on activity will be for each option.
- Detailed analysis for the preferred option.
- Resource will include xxx from PSHFT, xxx from HHCT, support from the STP.

Financial work stream

- Led by the PSHFT Deputy Chief Executive.
- Assess the financial savings of each option.
- Assess the long term financial viability of the preferred option.
- Both trusts will operate on an open book basis and share all relevant financial information with each other and with the additional external support.
- Resource will include xxx from PSHFT, xxx from HHCT, Monitor/Partners procured independent scrutiny of the finances.

Competition work stream

- Led by xxxx.
- Support by the Monitor team.
- Monitor/Partners procured independent scrutiny of the competition issues.
- Based on the previous work in this area.
- Identify the benefits to ‘customers’ (commissioners and the public) of each proposed option.
- Propose an approach to regulators to implement the preferred option.
- Resource will include xxx from PSHFT, xxx from HHCT, Monitor/Partners procured independent scrutiny of the finances.

Vision and organisational design work stream

- Led by xxxx.
- Develop a high level clinical vision and site strategy.
- Supported by a clinical senate sub group.

- Propose the governance arrangements for the preferred option.
- Facilitation will be through hospital and PSD teams.

Shared CIP analysis

- Led by xxxx
- Identify and deliver 2015/16 shared CIPs from support functions.
- Jointly Identify and create a shared CIP programme for 2016/17 and 2017/18.

Appendix 2 – Clinical Reference Group terms of reference

Role and purpose

The Purpose of this group is to lead on the clinical design and evaluation of sustainable clinical service models, and provide support an advice to the Collaboration project team giving Clinical Oversight to the content and implications of options set out in the OB

The Aim of the group is to:

- Agreeing the 'counterfactual' (Opt 1)
- Assess the range of options / opportunities to provide services under more sustainable* models (Opt 2-4)

This will be achieved through:

- Agree existing risk areas and assess impact under each option
- Ensure Clinical Oversight to the content and implications of options set out in the OBC (as this is developed)
- Identifying opportunities to fast-track areas of work to deliver improved performance / capacity / efficiency
- Ensure clinical involvement in the design / evaluation of potential Operational structures and Clinical Governance arrangements

Critical success factors

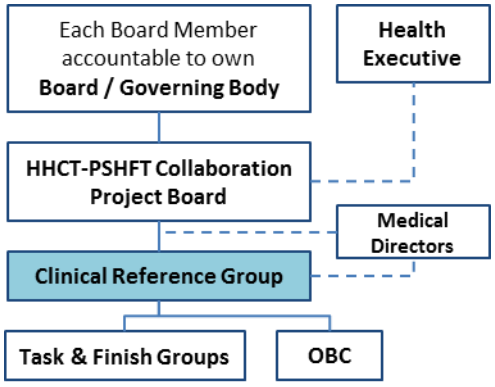
- OBC document draft to Boards in March correctly reflects underpinning clinical perspectives
- Patient experience and outcomes are maintained or improved
- The overall combined unit costs of delivery are reduced
- Existing risks for clinical services are relieved / mitigated
- Workforce is sustainable (recruitment, retention & training arrangements)

Meeting arrangements

- Meetings will be held fortnightly at HHCT or PSHFT
- Papers will be circulated at least two working days in advance
- Non-members may be invited with the prior agreement of the Chair / Exec Lead
- Project team will provide notes / meeting records.

Accountability

- The Group reports to the HHCT-PSHFT Collaboration Project Board
- The Group is accountable via individual members and the respective Boards within their individual organisations



Membership

Chair & Workstream Executive Lead:

- Cara Charles-Barks COO HHCT Hinchingbrooke Health Care NHS Trust

- Filippo DiFranco
- Anitha Mathews
- Hagen Schumacher
- Suzanne Hamilton
- Chris Walsh (NED)

Peterborough & Stamford Hospitals NHS Foundation Trust

- Alfred Choy
- Jon Naylor
- Fiona Miller
- Sateesh Nagumantry
- Madhu Davies (NED)
- Sarah Dunnett (NED)

Collaboration Project Team

- Cara Charles-Barks COO HHCT
- Mark Avery – Deputy Director
- Obi Onyiah – Workstream Project Manager

Appendix 3 – Clinical service discussions

A detailed service by service sustainability analysis by the medical and nursing directors for HHCT and PSHFT is shown below.

	Unsustainable		Quality/ efficiency opportunity	Affecting		Description HHCT/ PSHFT
	Immediate	Medium term	Medium term	PSHFT	HHCT	
Accident & Emergency	☐				☐	Current inability to recruit and retain medical and nursing staff due to size and case mix & career opportunities PSHFT has just appointed 4 A&E consultants. Urgent care redesign across the region to provide long term robustness forms one of the key streams of work of the STP.
Acute Medicine		☐		☐	☐	Roles and service delivery models are moving and changing, requiring nursing & AHP staff to develop to match changing models. Challenge for a smaller workforce. Nursing risks (recruitment and retention) 2 consultant vacancies (currently covered by locums) PSHFT – has appointed 2 new consultants but still has 3 additional vacancies
Ambulatory Care			☐	☐	☐	Opportunities (linked to economies of scale) – Outpatient Parenteral Antimicrobial therapy (OPAT)
Breast Service			☐	☐	☐	1 vacancy (covered by locum) 2 breast radiologists due to start May/June (joint posts with CUH) Opportunities for efficiency/collaboration – but no sustainability risks. PSHFT – has appointed one new consultant breast surgeon
Cardiology		☐			☐	HHCT one substantive consultant, with budget for 2.4 WTE to meet training needs. Opportunities for sub-specialism with greater catchment, e.g. repatriation of specialist procedures (PCI) when Papworth moves to Cambridge

	Unsustainable		Quality/ efficiency opportunity	Affecting		Description HHCT/ PSHFT
	Immediate	Medium term	Medium term	PSHFT	HHCT	
Respiratory						See Thoracic med
Clinical haematology	☐				☐	Unsustainable. No substantive HHCT consultants. Locum cover only. Unable to recruit. 5 consultants in post and a further one commencing in October 2016.
Diabetes			☐			Opportunities for efficiency/collaboration but no sustainability risks. Multidisciplinary / SpNs / Podiatry
Diagnostic imaging / Interventional radiology		☐	☐	☐	☐	HHCT & PSHFT outsourcing reporting/ use of locums as both unable to fill all consultant posts. Joined up IT essential.
Endoscopy			☐	☐		Full JAG accreditation. High Quality, 7-day bleed rota. Nurse endoscopist – national society chair – high profile. Sustainable & resilient Full JAG accreditation with spare room capacity.
ENT			☐	☐	☐	1 in 4 on-call cover at both trusts unsustainable
Gastroenterology		☐		☐		No seven day bleed service at PSHFT PHSFT likely to benefit from linking with HHCT Endoscopy – See endoscopy above
General Surgery			☐		☐	Lack of variety leading to impact on recruitment and retention
Geriatric Medicine			☐	☐	☐	***See*** - ***Acute medicine*** - ***Orthogeriatrics (single consultant)*** - ***Stroke*** Dementia services development (key to the Health Campus Strategy) good quality service. Opportunities come with scale.
Gynaecology			☐		☐	No IP gynae service (elective or non-elective.) Most work is daycase in the treatment centre.
Haematology						See Clinical Haematology
Maternity			☐	☐	☐	Options for providing future capacity under different service

	Unsustainable		Quality/ efficiency opportunity	Affecting		Description HHCT/ PSHFT
	Immediate	Medium term	Medium term	PSHFT	HHCT	
						models. Linked to STP work. HHCT No recruitment issues. Quality & Patient experience scores high.
Neonatology			☐		☐	Level One unit provided by CCS. Opportunity being explored via STP work.
Nephrology		☐			☐	HHCT advice and support provided by Addenbrookes on an honorary contract
Neurology		☐			☐	HHCT single handed consultant
Oncology			☐	☐	☐	***See…*** - ***McMillan Centre*** - ***Radiotherapy***
Ophthalmology			☐	☐	☐	
Oral and max facs			☐	☐	NA	Opportunity to undertake more activity at PSHFT – dedicated theatre/proc room not used.
Ortho-Geriatrics		☐		☐	☐	HHCT single consultant PSHFT – has sessions from a care of the elderly consultant. Opportunity to merge cover to provide more reliable service all year round including cover in periods of one being absent.
Trauma and orthopaedics			☐	☐	☐	Location for elective surgery and possible development of spinal service within larger service. R&R for trauma nurses – not possible @ HHCT
Paediatrics			☐		NA	Options being developed under STP work.
Pain						HHCT not commissioned for a pain service. When spinal back pain service ceased the impact on PSHFT chronic pain referrals increased creating a capacity and demand challenge.
Palliative care		☐				HHCT. Fragile. One WTE consultant cover HHCT 16 nurses. Rotate through community. PSHFT has two consultants working with the local hospice and the joint hospital and

	Unsustainable		Quality/ efficiency opportunity	Affecting		Description HHCT/ PSHFT
	Immediate	Medium term	Medium term	PSHFT	HHCT	
						community MacMillan service. Opportunities for all staff to increase learning and development.,
Pathology						TPP
Plastics and dermatology			☐		☐	Sustainable but opportunities for >efficiency through >scale
Radiotherapy	**Unsustainable across the C&P LHE**		☐	☐	NA	CUH unable to cope with demand. 3rd LINAC @ PSHFT operational Autumn '16 Opportunity for HHCT catchment patients to access additional LINAC capacity @ PSHFT closer to home. Supported by Cancer Network
Respiratory			☐		☐	Papworth move to Addenbrookes may impact on HHCT residents and PSHFT flows. Combined service may allow for development of a more local service
Rheumatology			☐	☐	☐	Stable service with good reputation at HHCT and PSHFT
Spinal surgery	☐			NA	☐	HHCT unsustainable in its current form. Single handed Consultant leaving imminently. – see correlated impact under pain services No service at PSHFT
Stroke	☐				☐	HHCT unsustainable under current arrangements (issues = mix of financial/contractual & clinical– no stroke physicians)
Therapy services			☐	☐	☐	HHCT opportunities for efficiency through scale. Poor weekend cover
Urology			☐	☐	☐	New service at HHCT 2-3 years ago. Now established locally, 4 consultants, service doing well. Opportunities for efficiency through scale

Haematology

Hinchingbrooke has no substantive consultants in post, and has been unable to recruit locums. Previously, PSHFT provided consultants to HHCT, but following the departure of two consultants were unable to continue this support. HHCT staff are supportive of a single team across both trusts if this results in providing a better, more sustainable service to patients.

> *"Most important is a viable, sustainable service at HHCT"*
>
> HHCT haematology specialist nurse

The shared view is that only providing consultant cover at HHCT will not work because without on-site junior cover, the posts will not be attractive or sustainable as demonstrated by the lack of locum applicants.

Successful consultant recruitment is the key to delivering a sustainable service. This requires a 500,000 catchment population, about the same as the PSHFT core and wider catchment, as well as an opportunity for sub-specialism. A single team would meet these requirements making recruitment more likely.

ENT

Out of hours and on call cover can be difficult at both trusts with frequent on call shifts. Middle grade sharing could work, but only if there is only one site open at weekends for acute admissions. To date the two trusts have worked collaboratively to manage demand at Peterborough which has included transferring all care for some patients to HHCT. Long term arrangements are essential for these patients to ensure there is effective planning, resourcing and recruitment.

Stroke

In London where 31 hospitals used to provide stroke care, services are now concentrated in eight hospitals - and outcomes have improved from one of the worst to one of the best in Europe.

There are no specialist stroke consultants or Specialist Registrars at HHCT. The service is provided by a locum consultant (1.4 wte) and two SpR's, who are all general medicine physicians or geriatricians without specialist skills in the care of patients with a stroke. Consequently, the backlog on the Stroke National Audit Programme (SNAP) is around 12 months and the CQC have recommended that there is a service review. This contributes to a payment and contracting risk with rehabilitation patients who receive treatment in the Trust from days 13 to 44 of the stroke pathway not being paid for under tariff. There is support for the creation of a single stroke team to create a sustainable, safe service.

> "Joined up IT is absolutely essential!"
>
> Consultant physician HHCT

Diagnostic imaging

Both Trusts have vacant consultant posts, with three at Peterborough and four at HHCT. Hinchingbrooke completely outsources the out of hours reporting, whereas PSHFT uses this as a back up to local reporting. Peterborough has full Imaging Services Accreditation Scheme (ISAS) accreditation but HHCT does not. Equipment is managed in house at HHCT which includes an MRI machine which is 14 years old and beyond the end of its agreed life cycle. Peterborough has a fully managed equipment service as part of the PFI contract.

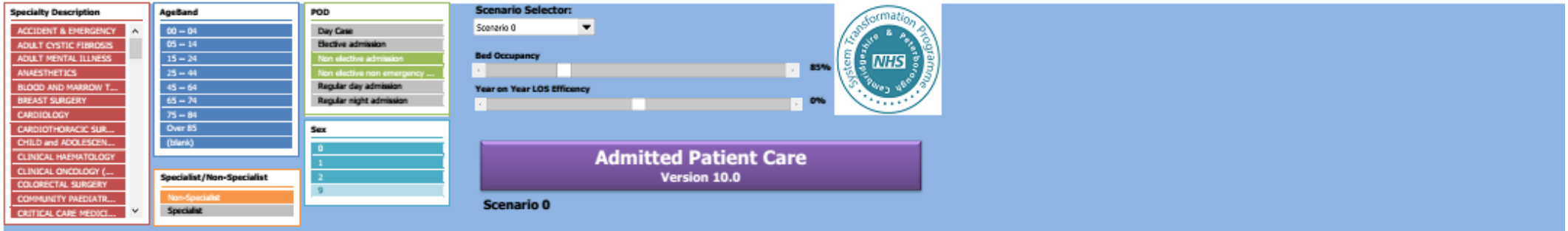
> "For Hinchingbrooke and Peterborough, and regionally, it is really important to talk and keep talking."
>
> PSHFT radiologist

The groups said that collaboration will help to address some of the staffing and equipment issues, but are contingent on joined up IT and PACs which is only possible where a combined set of patient data exists

across the two Trusts. Collaboration could help in delivering workable rotas and out of hours cover, but will need to address the lack of investment in the infrastructure.

Appendix 4 – Capacity analysis

CPCCG assessment of required additional non-elective beds – additional requirement of 111 HHCT and 148 PSHFT



Activity

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2026/27	2031/32
Bedford	144	146	149	151	155	159	163	167	170	188	207
CUHFT	25,546	26,001	26,443	26,933	27,669	28,413	29,098	29,824	30,499	33,914	37,082
E & N Herts	355	361	366	372	379	387	394	401	409	443	480
Hinchingbrooke	10,976	11,201	11,428	11,651	11,954	12,302	12,657	13,025	13,372	15,203	16,910
Kettering	153	156	159	160	164	168	172	176	181	203	224
Northampton General	50	51	51	52	53	54	56	57	58	63	67
PSHFT	23,687	24,052	24,528	25,028	25,532	26,143	26,748	27,352	27,883	30,091	31,954
QEHKL	4,665	4,740	4,819	4,894	4,972	5,066	5,157	5,257	5,351	5,868	6,365
United Lincs	72	73	73	74	76	77	79	80	82	87	89
West Suffolk	380	384	389	395	407	420	433	444	454	509	559
Others	7,314	7,381	7,444	7,519	7,637	7,791	7,931	8,067	8,182	8,545	8,720
TOTAL	73,342	74,547	75,850	77,230	78,998	80,982	82,887	84,851	86,643	95,113	102,658

15-16 to 20-21	2,824
	1,597
	14.0%
	2,824
	11.5%
	53
	13.7%
	96

Obesity Adjusted Activity

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2026/27	2031/32
144	150	155	161	169	177	185	193	202	248	302
25,546	26,567	27,603	28,714	30,124	31,593	33,042	34,597	36,132	44,685	54,068
355	368	380	393	409	426	441	457	475	565	672
10,976	11,455	11,951	12,457	13,069	13,755	14,475	15,241	16,007	20,420	25,286
153	160	166	170	178	186	194	204	214	267	325
50	52	54	55	58	60	63	66	68	83	98
23,687	24,475	25,395	26,358	27,352	28,490	29,655	30,855	32,005	37,827	44,019
4,665	4,836	5,015	5,195	5,383	5,596	5,811	6,044	6,277	7,629	9,134
72	74	76	79	81	85	88	91	95	109	122
380	392	405	421	441	465	489	513	536	666	808
7,314	7,460	7,604	7,762	7,970	8,219	8,457	8,696	8,918	9,873	10,711
73,342	75,989	78,804	81,767	85,234	89,051	92,899	96,957	100,928	122,372	145,544

Bed Days

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2026/27	2031/32
Bedford	724	745	766	787	812	839	866	894	922	1,073	1,253
CUHFT	133,937	137,077	140,229	143,512	147,847	152,601	157,102	162,210	167,014	193,559	220,932
E & N Herts	1,357	1,394	1,422	1,460	1,505	1,552	1,587	1,632	1,678	1,895	2,142
Hinchingbrooke	64,596	66,681	68,747	70,819	73,252	76,004	78,873	81,943	84,902	101,700	118,249
Kettering	780	808	830	842	870	898	926	963	999	1,172	1,363
Northampton General	292	303	313	319	331	344	356	372	389	462	567
PSHFT	115,304	117,832	120,716	123,434	126,428	130,033	133,532	137,241	140,732	158,759	176,780
QEHKL	23,704	24,274	24,837	25,379	25,962	26,635	27,294	28,043	28,729	32,900	37,139
United Lincs	207	210	214	218	224	230	236	242	248	273	296
West Suffolk	2,703	2,746	2,798	2,859	2,950	3,067	3,183	3,299	3,398	4,018	4,609
Others	59,288	59,935	60,615	61,436	62,752	64,139	65,407	66,643	67,690	72,300	76,633
TOTAL	402,892	412,005	421,487	431,065	442,933	456,343	469,362	483,482	496,702	568,112	638,962

Obesity Adjusted Bed Days

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2026/27	2031/32
724	765	808	853	904	958	1,016	1,077	1,140	1,512	1,982
133,937	140,761	147,816	155,220	164,036	173,678	183,383	194,235	205,056	268,868	343,870
1,357	1,421	1,476	1,544	1,623	1,706	1,777	1,863	1,954	2,430	3,027
64,596	68,475	72,480	76,638	81,352	86,633	92,264	98,383	104,597	142,168	185,538
780	825	865	896	945	995	1,047	1,112	1,177	1,530	1,941
292	312	333	351	375	401	428	461	496	677	934
115,304	120,672	126,570	132,447	138,800	146,067	153,453	161,360	169,264	213,894	265,164
23,704	24,924	26,175	27,438	28,788	30,295	31,838	33,552	35,243	45,676	57,707
207	214	221	229	239	250	260	271	282	336	392
2,703	2,828	2,965	3,115	3,305	3,532	3,768	4,014	4,247	5,735	7,374
59,288	61,048	62,873	64,874	67,452	70,184	72,862	75,590	78,163	91,444	104,336
402,892	422,244	442,582	463,605	487,817	514,699	542,096	571,919	601,619	774,269	972,266

Beds

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2026/27	2031/32
Bedford	2	2	2	3	3	3	3	3	3	3	4
CUHFT	432	442	452	463	477	492	506	523	538	624	712
E & N Herts	4	4	5	5	5	5	5	5	5	6	7
Hinchingbrooke	208	215	222	228	236	245	254	264	274	328	381
Kettering	3	3	3	3	3	3	3	3	3	4	4
Northampton General	1	1	1	1	1	1	1	1	1	1	2
PSHFT	372	380	389	398	408	419	430	442	454	512	570
QEHKL	76	78	80	82	84	86	88	90	93	106	120
United Lincs	1	1	1	1	1	1	1	1	1	1	1
West Suffolk	9	9	9	9	10	10	10	11	11	13	15
Others	191	193	195	198	202	207	211	215	218	233	244
TOTAL	1,299	1,328	1,359	1,389	1,428	1,471	1,513	1,558	1,601	1,831	2,060

Obesity Adjusted Beds

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2026/27	2031/32
2	2	3	3	3	3	3	3	4	5	6
432	454	476	500	529	560	591	626	661	867	1,108
4	5	5	5	5	5	6	6	6	8	10
208	221	234	247	262	279	297	317	337	458	598
3	3	3	3	3	3	3	4	4	5	6
1	1	1	1	1	1	1	1	2	2	3
372	389	408	427	447	471	495	520	546	689	855
76	80	84	88	93	98	103	108	114	147	186
1	1	1	1	1	1	1	1	1	1	1
9	9	10	10	11	11	12	13	14	18	24
191	197	203	209	217	226	235	244	252	295	336
1,299	1,361	1,427	1,494	1,572	1,659	1,747	1,843	1,939	2,496	3,134

Indicative Cost

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2026/27	2031/32
Bedford	£286,967	£289,786	£293,853	£298,052	£310,130	£315,282	£324,365	£333,553	£342,488	£389,166	£439,846
CUHFT	£58,588,066	£59,082,889	£59,789,233	£60,554,091	£63,020,835	£64,074,617	£65,773,627	£67,621,522	£69,355,502	£78,542,586	£87,516,446
E & N Herts	£546,932	£552,545	£557,170	£564,668	£586,588	£594,753	£606,339	£620,554	£635,687	£703,483	£777,757
Hinchingbrooke	£26,703,983	£27,081,444	£27,546,375	£27,992,886	£29,171,926	£29,766,050	£30,734,477	£31,753,397	£32,717,434	£38,007,508	£42,946,200
Kettering	£281,629	£286,502	£290,446	£291,511	£303,506	£309,106	£318,086	£329,766	£341,319	£398,437	£451,319
Northampton General	£102,676	£103,881	£105,324	£106,163	£110,591	£112,456	£115,458	£119,282	£123,069	£139,459	£159,732
PSHFT	£40,950,734	£41,225,616	£41,707,542	£42,347,822	£43,845,529	£44,479,484	£45,615,652	£46,789,256	£47,872,880	£53,224,063	£58,309,462
QEHKL	£8,137,611	£8,209,601	£8,312,572	£8,406,698	£8,682,244	£8,777,712	£8,972,329	£9,189,805	£9,391,345	£10,576,874	£11,767,897
United Lincs	£123,665	£123,373	£124,032	£124,896	£128,985	£130,543	£133,519	£136,512	£139,151	£150,512	£157,971
West Suffolk	£763,297	£764,945	£771,705	£781,064	£815,046	£835,316	£864,631	£892,905	£917,251	£1,063,668	£1,204,343
Others	£8,707,789	£8,720,615	£8,763,065	£8,814,040	£9,086,861	£9,175,716	£9,358,208	£9,538,618	£9,698,941	£10,335,112	£10,796,349
TOTAL	£145,193,349	£146,441,197	£148,351,317	£150,281,891	£156,062,240	£158,571,035	£162,816,690	£167,325,172	£171,535,066	£193,530,869	£214,527,321

Obesity Adjusted Indicative Cost

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2026/27	2031/32
£286,967	£296,933	£308,462	£320,441	£341,442	£355,531	£374,636	£394,683	£415,081	£531,924	£671,357
£58,588,066	£60,501,499	£62,679,822	£64,968,206	£69,187,281	£71,985,976	£75,616,399	£79,575,751	£83,512,331	£106,123,601	£131,698,200
£546,932	£563,656	£579,794	£599,336	£635,148	£656,969	£682,972	£713,156	£745,203	£910,924	£1,113,891
£26,703,983	£27,750,524	£28,920,600	£30,106,751	£32,138,574	£33,600,462	£35,548,865	£37,643,513	£39,746,920	£52,187,714	£65,994,957
£281,629	£293,229	£304,178	£312,305	£332,652	£346,770	£365,321	£387,690	£410,734	£541,048	£677,387
£102,676	£106,339	£110,346	£113,821	£121,323	£126,271	£132,690	£140,288	£148,109	£188,881	£239,921
£40,950,734	£42,146,889	£43,676,153	£45,212,694	£47,818,329	£49,555,156	£51,913,329	£54,398,037	£56,853,564	£70,396,891	£85,516,758
£8,137,611	£8,410,855	£8,722,665	£9,032,045	£9,549,322	£9,885,193	£10,344,805	£10,850,069	£11,350,842	£14,381,787	£17,846,074
£123,665	£125,969	£129,266	£132,809	£139,863	£144,318	£150,484	£156,819	£162,909	£193,693	£222,337
£763,297	£786,196	£814,793	£846,794	£906,974	£953,964	£1,013,562	£1,074,470	£1,132,282	£1,490,438	£1,883,500
£8,707,789	£8,843,162	£9,011,316	£9,191,072	£9,610,251	£9,842,920	£10,183,615	£10,532,696	£10,867,342	£12,521,175	£14,153,096
£145,193,349	£149,825,251	£155,257,355	£160,836,273	£170,781,160	£177,453,530	£186,326,678	£195,867,171	£205,345,318	£259,468,076	£320,017,477

Theatre capacity

	Laminar Flow	Non Laminar Flow	Day case	Other	Total
HHCT	4	5 Of which two are protected for Ophthalmology	3		12
PSHFT	6	12 One of which is 'mothballed'	No separation from main theatres at Peterborough City Hospital	+1 day case theatre in H&N unit +1 interventional radiology theatre +1 procedure room in outpatients (T&O) +2 DC theatres at Stamford used as procedure rooms	18 (+5)

Stakeholders reviewed and agreed the rationale for excluding long-list options

Criteria	Explanation
1 Logically inconsistent	• The proposed solution will clearly add limited to no benefit in meeting the objectives
2 Additional costs outweigh the potential benefits	• The proposed solution adds rather than takes away additional costs, overheads and complexity to the LHE with little benefits to patients or financial benefits to providers
3 Strategic misalignment with: - The STP and /or - Care pathways	• The proposed solution does not address underlying issues and is not aligned with the aims of the STP • Provider combinations with limited alignment of clinical strategies for optimal delivery of care pathways
4 Substantial competition issues	• The proposed solution reduces patient choice to such an extent that it would be unlikely to be approved by the CMA

7/7 interviewees agreed we should apply this criteria to work up a sensible short list of organisational form changes that might enable successful system transformation and discussed this at the 18/09 workshop

Sources: Stakeholder interview materials, amended for stakeholder feedback

Criteria for ranking possible remaining options

Order of application

Criteria	Summary
1 **Aligns to STP plans that aim to secure sustainable and safe services for patients**	• Must be compatible with the clinical workstreams currently under way, e.g. UEC and ACC vanguard proposals • Enabler to address the capacity mismatch across the patch • Ability to build on local clinical collaborations and work already done by Uniting Care • Aligns with the principles of the five year forward view
2 **Must generate financial savings to ensure safe and sustainable services for patients**	• To continue to deliver high quality services to the people of Cambridgeshire and Peterborough the system needs to be able to operate within the available financial envelope in a sustainable way • The new organisational form needs to demonstrate that significant financial savings can be made through synergies and better use of the physical capacity existing in the system • Ensure long term financial viability of any new provider forms
3 **Must be deliverable and acceptable to patients and stakeholders**	• Ability to align culture and other values between organisations in a relatively short period of time • Maintain safe staffing levels • Maintain commissioner requested services • Maintain patient access • Minimise the extent to which patient choice is reduced (competition considerations) • Acceptable to the public and key stakeholders
4 **Must be affordable, making the best use of public funds**	• The cost of investment must not be excessive relative to the financial benefits • The payback period should be reasonable • Must consider what / whether central funding will be available, and whether alternative funding is available within the Local Health Economy

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

Option	Exclusion rationale	Process by which option excluded

Collaborations with organisations outside the LHE	• Implausible /not feasible options to explore, as providers on the outskirts of the Cambridge and Peterborough system are part of other collaboration talks:
	  ○ United Lincolnshire Hospitals part of Sustainable Lincolnshire (all Lincolnshire providers)
	  ○ Queen Elizabeth Hospitals Kings Lynn
	  ○ Bedford hospital (part of Bedfordshire and Milton Keynes sustainability plan)
	  ○ Kettering General Hospital part of Healthier Northamptonshire (including Northampton General Hospital)
	• Not aligned to system agreed objectives and wider STP programme of work
		• Early September2015 stakeholder interviews

Buddying and informal partnering	• Ruled out on grounds that there are not enough benefits • The proposed solution will clearly add limited to no benefit in meeting the objectives • Buddying is implausible as an intervention on its own, as it is unlikely to effectively impact on the scale of challenges	• Excluded in evidence review stage of Strategic outline case preparation, 18th of September 2015
Contractual partnerships/JVs	• Ruled out all new/additional JVs/contractual partnership on the basis that they are likely to add additional recurring costs and complexity to an already complex baseline of arrangements • SOC recommended further detailed analysis is undertaken on the “As is” baseline of Contractual Partnerships/JVs across the C&P area prior to considering any additional JV arrangements, as there are a number of historical arrangements in the C&P LHE and that this work should be linked to the STP cross organisation CIP work • The Dalton review highlights that financial efficiency savings are at the lower end of the spectrum of savings possible from different organisational forms (after buddying), this is supported by the PWC Project Brown work, which also suggested dis-benefits due to additional costs	• Excluded in evidence review stage of Strategic outline case preparation, 18th of September 2015
Collaborations with other Trusts		
Papworth related transactions (non CUHFT)	• **Ruled out Papworth and either of HHCT/PSHFT, given Papworth’s clinical service pathways; stakeholder responses and strategic misalignment with the STP**: • Papworth’s strategy includes collaborative working with CUHFT, through moving to Addenbrookes site and CUHP; In May 2014 - HM Treasury approved Papworth’s Business Case to relocate to the Cambridge Biomedical Campus (New Hospital project); March 2015 Papworth Hospital reached financial close on the New Papworth Hospital PFI project, land acquired in Dec 2014, £20 million PDC received in 2014/15 and the Trust plans to move Q1 2018. • The 2012 CPT tested PSHFT hosting Papworth, noting neither Board considered it a possible option at the time. • The proposed solution is unlikely to address underlying issues in the system.	• Excluded in evidence review stage of Strategic outline case preparation, 18th of September 2015
CCS related	• Ruled out as majority of services are not delivered in Cambridgeshire and Peterborough LHE and so a	• Excluded in evidence

Option	Exclusion rationale	Process by which option excluded
transactions	CCS merger is unlikely to address underlying issues in the System. • The SOC noted that estates rationalisation could make an impact, and it was recommended that estate rationalisation was explored as part of the shared system wide CIP work.	review stage of Strategic outline case preparation, 18th of September 2015
Out of area chains (Mental Health or Community)	• Ruled out on strategic misalignment, as the proposed solution is unlikely to address underlying issues in the system	• Excluded in evidence review stage of Strategic outline case preparation, 18th of September 2015
UCP plus any acute organisation	• Removed as stakeholders did not want to explore this option further as a short, medium or long term solution, as not aligned with out of hospital plans	• Initial shortlist evaluation 18th of September
CUHFT related transactions	• CUHFT and PSHFT ruled out on strategic misalignment and insufficient savings, given the distance from CUHFT and PSHFT, limiting scope for redirecting patient flows • CUHFT and HHCT ruled out in the initial shortlist criteria evaluation, zero stakeholders in the LHE voted to consider this option further	• Shortlist criteria evaluation and stakeholder voting exercises - 18th of September

Appendix 7 – Strategic outline case short list of options

		Horizontal integration options				*ACO/Contractual options*			*Vertical integration options*	
Option evaluation Criteria		**PSHFT + HHCT merger**	**CUHFT + PFT merger**	**Acute hospital chain** *(EL services)*	**Acute hospital chain** *(all services)*	**UCP LLP change** *(incl. PSHFT + HHCT)*	**UCP services expansion** *(NEL <65's)*	**ACO (all ex. GPs, LAs)**	**MCP**	**OOH Children services**
1. Aligns to STP plans		++	O	+	++	O	O	++	O	O
2. Must generate financial savings *(Back office & clinical support excludes clinical savings[1])*		**£11.5m p.a.**	**£13.4m p.a.**	**£33.1m p.a.**	**£33.1m p.a.**	?	?	**>£33.1m p.a.[2]**	**£1.1m p.a.**	?
3. Must be deliverable and acceptable to patients and stakeholders		+	++	?	?	+	?	?	O	+
4. Must be affordable	**a. Cost of investment**	Medium	Medium	High	High	Low	High	High	Low	High
	b. Pay back period	Medium term	Medium term	Long term	Long term	Medium term	Medium term	Long term	Long term	Long term

[1]1. Figures represent two thirds (66%) of corporate back office pay costs from the smaller organisations cost base and 20% of pay cost savings for clinical support services (i.e. 20% applied to the combined clinical support cost base. The cost base figures were sourced from data submissions from FY15 Trust management accounts of each individual organisation.
2. Does not include any increase from CPFT and CCS, given both are on 4 year Serco BO contracts. LA/GP/CCG costs base unknown, please see Appendix A to D for more detail

KEY: +/++ Positive initial assessment; O Neutral initial assessment ? Requires further investigation

Progress planning:		✓ FY15	✓ FY15	Delay FY17	Delay >FY19	✓ FY15	Delay >FY18	Delay >FY18	✗	Delay >FY18
Recommended options:		**Horizontal integration stepping stones 1 and 2 are explored further first whilst exploring further benefits similar to that of an acute chain later**				**Financial alignment stepping stone 3 progresses whilst plan for greater financial alignment commences**		**Vertical integration on its own not progressed as a org form model. Urgently progress vertical service collaboration.**		

Appendix 8 – Detailed report in the option appraisal process

Option appraisal – notes from the session

3 March 2016

1.1.1 Introduction

This report briefly describes the option appraisal process on the HHCT/PSHFT collaboration conducted on 3 March 2016 at Hinchingbrooke hospital. The main focus is on the areas where scores differed significantly. Where this occurred, this report captures the main points of the discussion which explains why there was variation.

1.1.2 Process

The session followed the process in the option appraisal process v1.5. The facilitator asked each person to individually score each of the section, one at a time, with scores shared with the whole group at the end of each section. The workbook checked that individual scores added up to 100 and there were no more than two tied scores per description.

1.1.3 Variation

Significant variation between scorers was discussed. The criteria numbers and the associated description in the table relate to those used on the scoring sheet.

Criteria	Description	Outlier	Option	Variation in score	Discussion
1	Compatible with the clinical work streams currently underway	C Hubbard and K Rege	1	35	C Hubbard – Scored option 1 at 35 as there is an opportunity for us to work together collaboratively without other back office changes. Back office change would facilitate it, but it is not a requirement that we do it. K Rege scored option 1 at 0 because of alignment with the STP. Addenbrookes joining in future provides an alternative route to achieving improvement in clinical services.
1	Compatible with the clinical work streams currently underway	K Rege	4	70	K Rege scored option 4 as 70 as this is the only option that truly allows free movement of staff across the two trusts. Single governance, policies, employer, stakeholders, single environment better able to facilitate the required changes and move towards the FYFV aims.
9	Maintain safe staffing levels	K Rege	3	95	Option 3 would not deliver from a medical perspective because it is still fundamentally a service level agreement type collaboration which could unravel. Haematology and some of the other services meeting this week have spoken about the need to move staff across a single organisation with joint standards and policies. There are no SLA's under option 4, and a single organisation won't unravel under strain. C Hubbard agreed that some SLA's have had to end in the past.

Criteria	Description	Outlier	Option	Variation in score	Discussion
					C CBarks –operating under a single governance structure with separate organisations would pose challenges, for example recruitment if the post was employed by one organisation but required to work across two organisations under option 3.
12	Minimise the extent to which patient choice is reduced	All	2	25	C Hubbard - Back office is invisible to patients, it won't impact materially on patient choice. S Graves – we need to agree what patient access means, are we to score this as being from the current place, or whether the collaboration will maintain service across either site. K Rege – Gerry Hackett at CUHT has commented that we need one set of documentation across the whole health economy to facilitate the changes in clinical collaboration to maintain and improve patient access. This criteria is scored on the basis of the CMA view of competition, but we need to describe this holistically
13	Acceptable to the public and key stakeholders including staff	All			There was a discussion over whether this criterion could be scored. L McCarthy said that generally stakeholders would view 'do nothing' as good, but not if they were informed of the consequences of doing nothing. C CBarks said it was most important that we maintain viable services. The status quo is not sustainable, but that is not understood by the stakeholders at this time. S Holden summarised that they need to understand the views of individual stakeholders and K Rennoldson asked if we have communicated the reasons for the change to stakeholders, and whether they understood that services could be lost in a 'do nothing' option. D Fowler said that 'do nothing' equates to reconfiguration of back office services, and then there are opportunities to change clinical services. S Holden summarised that there is a financial imperative behind the business case but there are also opportunities for clinical collaboration. C Walker – there has been an early focus on finance, but now this is extending to clinical opportunities. S Graves – stakeholder views is an area we may not be able to overtly answer. L McCarthy said that public opinion has been heavily weighted against change, but we need to inform the public to help them understand the need for change. C Walker – this will be developed in a FBC. S Graves – the public are not of one single view. The Peterborough public are not in the same position as the Huntingdon public. We need to consider how we communicate the reasons for change with the public. S Graves –Overview and Scrutiny Committees are key stakeholders. Lance has been to his local committee who were calling for a public consultation as they

Criteria	Description	Outlier	Option	Variation in score	Discussion
					assume Hinchingbrooke will close. This is absolutely not the case; one or two services may change as a result of currently unsustainable services and external reviews. S Holden - this collaboration is an enabler to maintain services, both trusts are at financial risk and have some clinically unsustainable services. L McCarthy – the local MP for Huntingdon is a key stakeholder we need to work with to help him understand what 'do nothing' means and what is being proposed. **Based on the points above, it was agreed that it was impossible to give a single answer to this question as there was no agreed position on who the stakeholders are, or which patients need to be engaged with. If we progress to FBC, there was a commitment to engage with key stakeholders. At the OBC stage, it is not appropriate to share anything, until there is a clear view of the future direction and the pace of the proposed change.** S Graves – We need to consider how we phrase the engagement in the OBC implementation plan section. We recognise that we don't have a legal duty to consult, but we need to work to inform stakeholders. There are at least four stakeholders, staff, patients, public and commissioners. There are at least two views of the options, views before an explanation and views after they understand what a do nothing option means. S Holden summarised that there is a clear commitment to explain and involve stakeholders at the right time. C Walker – we want to do it properly, all the individual leaders care about getting it right.
14	The cost of investment must not be excessive relative to the financial benefits	C CBarks C Hubbard	1		C CBarks – scored option 3 high because it is cheaper than option 4. C Hubbard scored option 4 as much higher than option 3 because the benefits from option 4 were so much greater than option 3, in comparison to the increase in cost. L McCarthy - It appears that this option 1 is an investment of £0, but agency etc. will be a further additional investment. Both trusts are already investing beyond the available funds as they are both in a deficit position. Continuing as they are, both trusts are in deficit, and the actual baseline position is more difficult to assess as the current situation could deteriorate, costs are hidden, may need to work up what these hidden costs are.

1.1.4 Closing discussion

Once the group had reviewed the combined total scores for each option, discussion followed:

The group agreed that there has been an open and robust discussion around the different scores. This was demonstrated by the differing scores, which led to good discussion about how each option met the criteria.

S Holden summarised that this project is required to move at pace, but there also needs to be engagement with the public and stakeholders. Is the current timetable prescribed in the MoU right?

S Graves – We are going to do engagement if we go to FBC. Pace needs to allow enough time to do this, but be fast enough to keep people on board. In the OBC, we need a range of views on different levels of engagement with a description of the risks of both and different timescales for each.

S Holden summarised that the group agreed that trusts will need to work together during the engagement period.

S Graves – consider what sort of 'coming together' this will be, we need transformation work alongside the transaction work.

C Hubbard – this will be a journey that we are on, and it is important to implement changes which will benefit patients early on. We also need clinical engagement to help the bottom line.

S Holden summarised that there is a shared intent, and the panel need a structure to take this forward, we also need early clinical wins.

S Graves – we need to write down what the combined intent means, this will give greater confidence that it will deliver.

L McCarthy – we have a joint view of where we are heading, and a good basis to move forward. We still need clarity on how we communicate with stakeholders what the do nothing option means. There is some variability in the scores which is encouraging as it demonstrated that there has not been a 'group think'.

Option 4 a clear preferred option as long as it is delivered in a reasonable timescale to allow engagement with the relevant stakeholders, transformation of some clinical changes and transaction of back office. This will be worked up through the PMB, and discussion between the executives.

Some work up is also required on the financials.

An assurance report on the session will be provided shortly.

Comms will be limited to Executive team and Chairs. Chairs will decide if they share with NED's.

Appendix 9 - The process for identifying back office savings opportunities

The outline organisational structures and associated opportunities for workforce and software system rationalisation have been developed through detailed work with complimentary Executives of both current organisations.

The process involved a number of steps:

1. Gaining an understanding of current divisional, corporate and back-office structures through organograms, including the costs deployed to resource them if staff were all paid at mid-point on the AfC 15/16 pay scale.

2. Comparing the 'organogram costs' to 15/16 actual costs as supplied by Monitor in December 2015 (using full year projections provided by the Trusts), in order to understand whether any differences were due to:

    a) unfilled vacancies,

    b) adhoc agency cost

    c) agency cost to cover substantive vacancies

    d) in year CIP delivery.

3. Designing new structures that the Executives agreed would be sufficient to manage an enlarged organisation efficiently and effectively, considering known future pressures and risks (eg 7 day working).

4. Agreeing which elements of this could be delivered through closer joint working that options 2 and 3 would deliver. Understanding and documenting the assumptions and reasoning around this.

5. Comparing the costing of these new structures (at mid-point on AfC 15/16 pay scale) to 15/16 actual costs (as in point 2 above) and reflecting the pay saving opportunities and wte reductions that fell out of this.

6. Validating savings and structures against other Trusts via Lord Carter's report and other benchmarking data where available.

7. Robust check and challenge meetings of all executive proposed plans as above, by the Chief Executives of both organisations.

The design principles that guided the development of structures for the enlarged organisation are outlined below;

- All three sites at Hinchingbrooke, Peterborough and Stamford will be maintained with clinical service provision remaining the same as it is now.
- There will be a single, Trust wide, executive team and one operational organisation using the same policies, systems and processes across the three sites.
- The Board and all departments will be of the minimum size necessary to effectively and safely manage the Trust, maintaining rapid and flexible decision making and delivering all required performance targets and safety standards.
- Effective clinical leadership will be at the core of the design, to deliver upper quartile performance outcomes, and excellence in patient care
- There will be clear and harmonised roles, responsibilities and accountabilities across the enlarged Trust, with elimination over time of all duplication.

- New layers of management will not be created, and posts will be able to effectively meet the demands and responsibilities placed upon them.

Appendix 10 –Back office savings assumptions

CEO Dept

The Board costs are made up in the majority of Executive and Non-executive Directors, supporting administrative costs and substantive strategic posts where present. Whilst the organisations remain legally separate there will need to be a set of non-executive directors at both organisations, however the costs of an executive director team can be shared in option 3. Supporting administration costs such as PA's and substantive strategic posts follow the executive team reductions although as HHCT are currently light of posts in this department, it is presumed that all of PSHFT costs remain in options 3 and 4 as opposed to doing a simple reduction of the combined total by half. This minimises the savings but is considered more realistic. There is no presumption that the individual staff members at PSHFT would remain in these posts but they would be subject to the usual competitive appointment process. Due to turnover of the small number of posts at this level, we have used benchmarked costs (of similar sized acute trusts) to calculate that option 3 would deliver £1.7M of savings by merging one set of executive directors, whilst a fully merged organisation would deliver an additional £0.2M (£1.9M total).

Finance

Both Finance departments have met, discussed and agreed a structure that would be sufficient to manage an organisation with a £400M turnover, split across three sites and running a deficit. When compared to the current organograms (costed at mid-point) this represents a saving of nearly £1M recurrently although may take a couple of years to realise as two sets of accounting systems will need to merge.

In a scenario where there are two legal entities (options 2 and 3) and operating boards it is felt that due to internal and external reporting functions minimal savings could be achieved. There are however some opportunities around running a joined up procurement team via an SLA process which would reduce pay costs in both options 2 and options 3. This delivers a £300k saving on pay for these options.

HR

Both HR directors have met multiple times to discuss and agree the opportunities there could be for working together more collaboratively. It has been agreed that certain departments within HR such as some of Learning and Development, Occupational Health and Recruitment, could work well under an SLA type arrangement offered in option 2 and 3. The advantages to this are that an improved service could be offered to the staff of both organisations and that in turn could lead to greater morale and staff satisfaction. It is unlikely however that collaborative working in these areas would lead to any significant pay cost reductions within those departments themselves, indeed the management of SLA's may mean a small increase in pay costs should option 2 be the preferred choice.

It is agreed that option 3 offers no further advantage to option 2 aside from the director level saving. Indeed to be reporting and managing two separate boards it is proposed that a site HR Assistant Director would be needed at each organisation in order to operationally run the day to day functions and strategies. This would be at an increased cost of £110k above option 2, although upon challenge by the CEO's the banding of this post would decrease.

In a fully merged organisation (option 4), as well as the improved service to staff deliverable in the options above, there are many more synergies that could be achieved when there's one organisation requiring one set of workforce information data and where one set of operational divisions require business partner support. This option would deliver £850k recurrent pay saving by year 2. Other benefits available in a merged legal organisation should include an improved ability to fill bank shifts on the wards and lower turnover with staff getting career progression and experience across three

sites. This could eventually lead to a reduction in the need to use agency staff in front-line areas particularly, and therefore an improvement in patient safety and satisfaction; although at this stage of the OBC we are unable to take any saving assumptions on agency staff in front line areas.

Estates/Facilities

The two organisations currently run these departments very differently with little to compare. In part this is due to PFI arrangements and a significant proportion of the workforce at PSHFT being part of that contract. This results in restricted pay saving opportunities with any of the options when looking at budget, however due to the difficulties in recruiting suitably qualified staff in some areas of this back office function, the organisations have spent £270k on agency costs in 15/16 with more spend being attributed to capital spend. Both Directors have agreed that collaborative working is likely to eliminate the need for this agency cost and this represents a real pay saving opportunity for all options. Non-pay spend is another area where collaborative working could lead to savings on external contracts such as soft fm and logistics, these savings have suggested a further £560k saving should be possible when working collaboratively. Non-financial opportunities also exist with regard to improved team resilience and personal development opportunities.

Through SLA's it would be possible to deliver the identified savings in option 2 onwards albeit with some investment in the management of the SLA's. Option 3 is considered to require some additional staff to manage the reporting functionality from two separate boards and in order to support the Director to manage three sites effectively. The proposed amount has been reduced in the CEO challenge meetings.

As a fully merged organisation in option 4, the need for the additional staff in option 3 is eliminated whilst also delivering the staff and non-pay efficiencies highlighted above. There is a further advantage in this option of greater space and capital rationalisation of back office departments across the three sites, maximising the use of clinical space in the future where capacity and need is greatest. For the OBC this cannot be financially quantified but it remains an agreed operational advantage of the short and long term effects of a fully merged organisation.

IT/IS

Whilst the two organisations remain separate legal entities there will be a requirement for there to be two sets of patients running on any information system. There will also be the same requirement for external reporting to regulators, commissioners etc. Aside from some very top level management therefore there is limited pay savings that can be achieved until a merged organisation exists. Even at that point many of the pay bands below band 7 would still be required to manage the hardware, training and technical support side of this department. Maximum pay saving opportunities for option 4 are suggested to be £300k plus £500k agency spend, but with minimal achieved prior to that point.

Realistic non-pay savings can be achieved once a combined set of patients is delivered, as this allows negotiation with software system suppliers to merely extend licences. Basing a 30% cost reduction in this area (although the systems may sit in other operational areas) leads to a non-pay saving of £1.7M

Corporate Nursing

It has been agreed by the two Directors that via SLA's in option 2 and option 3, certain functions such as Chaplin service, Professional standards role, lead nurse for Children and Volunteer service could be run collaboratively. This could deliver advantages to both organisations in terms of staff and patients receiving an improved service through greater team resilience and cross pollination of ideas and skills. It is unlikely however that with the same staff and clinical service provision running across sites that there will be any pay savings associated with these benefits.

With one single Board in option 4, duplication of roles can be almost eliminated with all staff working across all three sites. The savings associated with this are not significant however as with the same volume of nursing staff, wards and no change to service provision, there needs to remain a continued strong focus on leading the nursing staff to deliver high standards of quality of care and meet all CQC and patient outcome standards.

Operations

Chief Operating Officers have met, discussed and agreed a structure that would be sufficient to manage an organisation with a £400M turnover, split across three sites but delivering the same commissioned services as currently and with no changes to patient access and site location. The proposed budgeted structure delivers a £500k saving against current operational structures of band 7 and above managerial roles including divisional heads of nursing but excluding matrons. This could be delivered in both options 3 and 4 but would be unachievable whilst there are two executive teams in option 2. This structure also supports the delivery of transformation and CIP delivery across both acute sites.

Clinical Support

For departments such as pharmacy, diagnostic imaging, therapies, and sterile services it would be possible to share Heads of Service posts between both Trusts via an SLA arrangement. This delivers approx. £300k of savings for each of the options. Some posts like Pharmacy and maternity may need both until option 4 as they are legally organisational based.

Appendix 11 – Detailed description of option appraisal

	Option 1 – Do nothing	Option 2 – Shared services	Option 3 – Two boards, one executive team	Option 4 – One organisation
1. Must be deliverable and acceptable to patients and other stakeholders including staff				
Scores	**4.27**	**6.29**	**8.48**	**10.96**
Maintain safe staffing levels	Medical Directors have identified services that are currently unsustainable.	Merged clinical services would provide greater opportunities for staff to develop, gain new skills and rotate across services. This in turn will lead to an increase in staff satisfaction which in turn should lead to improved retention rates in those services and help support safe staffing levels.	Rotas and ability to recruit - Opportunities to share rotas and out of hours cover across both sites e.g. Haematology at HHCT, Gastro 7-day bleed service at PSHFT - Larger critical mass will allow greater opportunities for training, a varied workload, and sub-specialisation –will help recruitment and retention.	Clinical Reference Group and Medical Directors have identified that this option builds on option 3 as new staff would more easily be recruited if they knew that the collaboration was long-term and couldn't be subject to reversal.
Maintain commissioner requested services	Some services will not be sustainable and as a result maintenance will be threatened.	Will support some services, but reliant on SLA's being maintained	Specialist services such as Haematology and Pain Services at HHCT site *could* be provided through the PSHFT team if the two trusts agreed this under an SLA	Specialist services such as Haematology and Pain Services at HHCT site *would* be provided through the current PSHFT team.
Minimise the extent to which patient choice is reduced	Some services will not be sustainable and as a result choice will inevitably be reduced and patients would need to travel further.	Improved patient experience for patients and public visiting our hospitals and safe staffing levels will directly improve patient safety and length of stay.	Opportunity to collaborate to improve efficiency, cross-cover and patient access in: - Radiology - Cardiology - ENT - Respiratory Medicine - Stroke - Haematology - Pain - Ophthalmology - Diabetes All reliant on SLA's between the two organisations	As in option 3 but not reliant on an SLA's therefore the collaboration will be robust and long-term to give patients more assurance that their choices won't be reduced with notice in the future. It would be in the new orgnisations interest to maintain and improve access on all sites.
Ability to align culture and other values in a short period of time	No plan to align cultures	Alignment not required under this option and therefore might be more acceptable to some staff, however if there were increased use of SLAs to provide individual services, then the provider organisation would need to be sensitive to, and align outputs to the needs of the other.	Some opportunities to align as a result of a single executive team, but with two separate organisations with two boards, staff could still feel they belong to one organisation or another and not fully integrate cultures or could take longer.	This option is initially more disruptive but over time will lead to the greatest alignment of cultures in clinical pathways regardless of which site they are delivered on.. "A survey of executives who have managed through mergers, [said that culture clash] was the No. 1 reason for a deal's failure to achieve the promised value."
2. Aligns to STP plans that aim to secure sustainable and safe services for patients				
Scores	**1.25**	**3.63**	**6.09**	**9.03**
Enabler to address the capacity mismatch across the patch	Not addressed as the two trusts are not working together to make better use of the available estate	Medical Directors suggest the following services could be delivered more collaboratively via SLA's, to address capacity mismatch: - ENT - Haematology - Ophthalmology	With both organisations working with a consistent set of policies, procedures, equipment standardisation, staff would be better able to move and work between organisations with continuity of working practices. Balancing of resources could be more flexible than option 2 because staff would be working under one management structure. But, flexing capacity between organisations may be very costly and time consuming to appropriately track and manage via multiple SLAs.	Increases the level of collaboration beyond the other options as clinical teams work for one organisation. . Operating under a single organisation, a single executive team and support services and a single board, many complexities will be removed and use of capacity, particularly for elective activity could be much more flexible.

	Option 1 – Do nothing	Option 2 – Shared services	Option 3 – Two boards, one executive team	Option 4 – One organisation
Compatibility with the clinical work streams currently underway	Does not preclude the organisations from further clinical collaboration, however without closer collaboration the STP work will not develop at the required pace.	Partial compatibility with: - elective pathway work streams - Estates pathway - Urgent and emergency care	Option 3 increases the chances of effective collaboration beyond those set out in option 2 as executive teams would be in a position to directly steer and control the collaboration of clinical teams for both organisations they would be managing.. The experience of orthopaedics and ENT showed that even with the support of both executive teams, lack of harmonised policies, procedures and procurement add delay to the collaboration. In time, a single executive team and support services should lead to greater harmonisation subject to the two boards agreeing.	One less organisation to negotiate with in delivering the STP future vision for services in Cambridgeshire and Peterborough. Greater ability of management to focus on STP as they wouldn't be continuing to manage unsustainable services.
Ability to build on local clinical collaborations and work already done [with UCP] in the community	Frail medical specialist centre / 'Health Campus' at HHCT aligns to the plans for a 'community hub' location developed by UCP	Build on areas we have collaborated under the Elective Care Programme work stream. Medical Directors suggest the following services could be delivered more collaboratively, some of which could be part of an SLA: - Radiology - Cardiology - ENT - Hand Surgery - Respiratory - Stroke - Nephrology - Haematology - Oncology - Anaesthetics - Ophthalmology - Diabetes	As option 2 plus the older people hub could be better supported by larger clinical teams offering recruitment and retention opportunities for: - community/acute geriatricians - a critical mass that could support some sub-specialist clinical roles - varied training opportunities for all staff groups Reliant on SLA's between the trusts and different IT systems	As option 3 but without organisational barriers
Aligns with the principles of the Five Year Forward View	No	Yes – under the contractual heading	Yes – under collaboration heading	Yes – under the consolidation heading

3. Must generate financial savings to ensure safe and sustainable services for patients

Scores	**0.22**	**6.34**	**8.53**	**19.91**
Continue high quality services within the financial envelope	Historical difficulties in recruiting specialist staff to some back office areas, this option offers little chance to fill these skills gaps through collaboration.	Recurrent saving against baseline of £1.6m including a reduction of £270k agency fees through single merged Estates team, fully merged procurement team.	Savings of £2.1M against baseline costs including a reduction of £278k on back office agency fees. This overall saving is £841k more than option 2. Savings are predominantly a reduction in one set of executive directors, and one set of senior operational managers. A merged set of Executives will be working across the two organisations and will have an improved ability to move and allocate resource according to operational and clinical pressures. This will increase the ability of the organisations to maintain and drive improvements to quality and efficiency standards.	Improved savings of £9M against the baseline costs including all agency fees for back office are eliminated and reduction of £1.7M against non-pay costs on software systems and external contractors.

	Option 1 – Do nothing	Option 2 – Shared services	Option 3 – Two boards, one executive team	Option 4 – One organisation
Ensure long term financial viability of any new provider forms	Financial risk rating will be 1 for each year	Financial risk rating will be 1 for each year	Financial risk rating will be 1 for each year	Financial risk rating: FY17 (Plan) 2 FY18 (F'cast) 2 FY19 (F'cast) 2 FY20 (F'cast) 3 FY21 (F'cast) 3
Significant financial savings through synergies and better use of physical capacity	There are no savings available related to physical assets, or combined savings through joint procurement of systems and external contracts.	Opportunities for better collaboration and synergies: HR - Learning and Development - Organisational Development - Occupational Health - Recruitment Corporate Nursing - Chaplain service - Professional Standards roles - Volunteer Service Unlikely however to result in significant pay cost reductions within those departments as the same volume of staff and patients will need to be served across both sites. There may be some opportunities to venture into SLA's on back office service such as Sterile Services, Health Records and Pathology in the future.	There are no additional synergies available in this option over and above what could be possible in option 2. An advantage could be an improved ability (both speed and effectiveness)to drive quality and operational efficiency improvements with one executive per department, but this is unquantifiable financially for the purposes of the OBC.	A fully merged organisation maximises all available opportunities for working together to deliver savings and use physical capacity better to maximise use of clinical space on both sites to drive income opportunities. This option is the only one where IT systems can be fully aligned (with one set of patients) and financial reporting can achieve the efficiencies of only one set of accounting reports. This allows the merged Trust to negotiate non-pay system savings as well as significant pay savings associated with managing them.
4. Must be affordable, making the best use of public funds				
Scores	***0.53***	***3.61***	***4.46***	***6.4***
The cost of investment must relative to the financial benefits	The costs are equal to the continued deficit position for both trusts	Estimated costs are roughly equal to the value of one full year of the estimated savings. The estimated savings of this option are £1.6m.	Estimated costs are roughly equal to half the value of one full year of the estimated savings. A reasonable estimate of costs include OBC development of £100k (inc VAT), plus legal fees of £800k for a full suite of SLA's plus governance arrangements for the Alliance Board and management of the collaborative, making a total of £900k plus £1.2M redundancy cost	The transition costs of £8M for this option are roughly equal to one full year of the anticipated level of savings. Costs include development of the FBC (legal, due diligence, CMA engagement) £4m, and redundancy £3.2M plus £800K for project management and implementation costs.
The payback period should be reasonable	Not applicable	Payback period of around one year assuming that all SLA's can be agreed in that period	Payback period of around one year assuming that all SLA's and governance arrangements can be agreed in that period. Given the complexity of the governance, and the experience of the Salford trusts, it is suggested that the actual payback period will be two years.	Payback period of around one year assuming that all FBC and competition issues can be resolved in that period. Given the complexity and number of posts which will be redundant, it is suggested that the actual payback period will be two years.
Must consider what/whether central funding will be available within the LHE	Central funding will not be provided indefinitely and will be dependent on a credible turnaround plan	Central funding will not be available for this option	Central funding will not be available for this option	Funding could be sought from national bodies

	Option 1 – Do nothing	Option 2 – Shared services	Option 3 – Two boards, one executive team	Option 4 – One organisation
TOTAL SCORES	**6.27**	**19.88**	**27.56**	**46.3**
RANK	**4**	**3**	**2**	**1**

	Option 1 – Do nothing	Option 2 – Shared services	Option 3 – Two boards, one executive team	Option 4 – One organisation
5. Must be deliverable and acceptable to patients and other stakeholders including staff				
Scores	**4.27**	**6.29**	**8.48**	**10.96**
Maintain safe staffing levels	Medical Directors have identified services that are currently unsustainable.	Merged clinical services would provide greater opportunities for staff to develop, gain new skills and rotate across services. This in turn will lead to an increase in staff satisfaction which in turn should lead to improved retention rates in those services and help support safe staffing levels.	Rotas and ability to recruit - Opportunities to share rotas and out of hours cover across both sites e.g. Haematology at HHCT, Gastro 7-day bleed service at PSHFT - Larger critical mass will allow greater opportunities for training, a varied workload, and sub-specialisation –will help recruitment and retention.	Clinical Reference Group and Medical Directors have identified opportunities to share rotas and out of hours cover across both sites – particularly favourable for services that are currently unsustainable, or struggling Larger critical mass will allow greater opportunities for training, a varied workload, and sub-specialisation – which all help recruitment and retention.
Maintain commissioner requested services	Some services will not be sustainable and as a result maintenance will be threatened.	Will support some services, but reliant on SLA's being maintained	Specialist services such as Haematology and Pain Services at HHCT site could be provided through the PSHFT team if the two trusts agreed this under an SLA	Specialist services such as Haematology and Pain Services at HHCT site could be provided through the PSHFT team
Minimise the extent to which patient choice is reduced	Some services will not be sustainable and as a result choice will inevitably be reduced.	Improved patient experience for patients and public visiting our hospitals and safe staffing levels will directly improve patient safety and length of stay.	Opportunity to collaborate to improve efficiency, cross-cover and patient access in: - Radiology - Cardiology - ENT - Respiratory Medicine - Stroke - Haematology - Pain - Ophthalmology - Diabetes All reliant on SLA's between the two organisations	Greater opportunity to support services across both sites. Areas the CRG identified as having most opportunity for collaboration to improve efficiency, cross-cover and patient access are: Radiology, Cardiology, ENT, Respiratory Medicine, Stroke, Haematology, Pain, Ophthalmology, Diabetes
Ability to align culture and other values in a short period of time	No plan to align cultures	Alignment not required under this option and therefore might be more acceptable to some staff, however if there were increased use of SLAs to provide individual services, then the provider organisation would need to be sensitive to, and align outputs to the needs of the other.	Some opportunities to align as a result of a single executive team, but with two separate organisations with two boards, this could perpetuate and develop differences.	This option is complex and disruptive in the short term. "A survey of executives who have managed through mergers, [said that culture clash] was the No. 1 reason for a deal's failure to achieve the promised value."
6. Aligns to STP plans that aim to secure sustainable and safe services for patients				
Scores	**1.25**	**3.63**	**6.09**	**9.03**
Enabler to address the capacity mismatch across the patch	Not addressed as the two trusts are not working together to make better use of the available estate	Medical Directors suggest the following services could be delivered more collaboratively, to address capacity mismatch: - ENT - Haematology - Ophthalmolog	With both organisations working with a consistent set of policies, procedures, equipment standardisation, staff would be better able to move and work between organisations with continuity of working practices. Balancing of resources could be more flexible than option 2 because	Increases the level of collaboration beyond the other options as clinical teams work for one organisation. . Operating under a single organisation, a single executive team and support services and a single board,

	Option 1 – Do nothing	Option 2 – Shared services	Option 3 – Two boards, one executive team	Option 4 – One organisation
		y	staff would be working under one management structure. But, flexing capacity between organisations may be very costly and time consuming to appropriately track and manage via multiple SLAs.	many complexities will be removed and use of capacity, particularly for elective activity could be much more flexible.
Compatibility with the clinical work streams currently underway	Does not preclude the organisations from further clinical collaboration, however without closer collaboration the STP work will not develop at the required pace.	Partial compatibility with: - elective pathway work streams - Estates pathway - Urgent and emergency care	Option 3 increases the chances of effective collaboration beyond those set out in option 2 as executive teams would be in a position to directly steer and control the collaboration of clinical teams for both organisations they would be managing.. The experience of orthopaedics and ENT showed that even with the support of both executive teams, lack of harmonised policies, procedures and procurement add delay to the collaboration. In time, a single executive team and support services should lead to greater harmonisation subject to the two boards agreeing.	One less organisation to negotiate with in delivering the STP future vision for services in Cambridgeshire and Peterborough.
Ability to build on local clinical collaborations and work already done [with UCP] in the community	Frail medical specialist centre / 'Health Campus' at HHCT aligns to the plans for a 'community hub' location developed by UCP	Build on areas we have collaborated under the Elective Care Programme work stream. Medical Directors suggest the following services could be delivered more collaboratively, some of which could be part of an SLA: - Radiology - Cardiology - ENT - Hand Surgery - Respiratory - Stroke - Nephrology - Haematology - Oncology - Anaesthetics - Ophthalmology - Diabetes	As option 2 plus the older people hub could be better supported by larger clinical teams offering recruitment and retention opportunities for: - community/acute geriatricians - a critical mass that could support some sub-specialist clinical roles - varied training opportunities for all staff groups Reliant on SLA's between the trusts and different IT systems	As option 3 but without organisational barriers
Aligns with the principles of the Five Year Forward View	No	Yes – under the contractual heading	Yes – under collaboration heading	Yes – under the consolidation heading

7. Must generate financial savings to ensure safe and sustainable services for patients

Scores	**0.22**	**6.34**	**8.53**	**19.91**
Continue high quality services within the financial envelope	Historical difficulties in recruiting specialist staff to some back office areas, this option offers little chance to fill these skills gaps through collaboration.	Recurrent saving against baseline of £1.6m including a reduction of £270k agency fees through single merged Estates team, fully merged procurement team.	Savings of £2.1M against baseline costs including a reduction of £278k on back office agency fees. This overall saving is £841k more than option 2. Savings are predominantly a reduction in one set of executive directors, and one set of senior operational managers. A merged set of Executives will be working across the two organisations and will have an improved ability to move and allocate resource according to operational and clinical	Savings of £8.6M against the baseline costs including all agency fees for back office are eliminated and reduction of £1.4M against non-pay costs on software systems and external contractors.

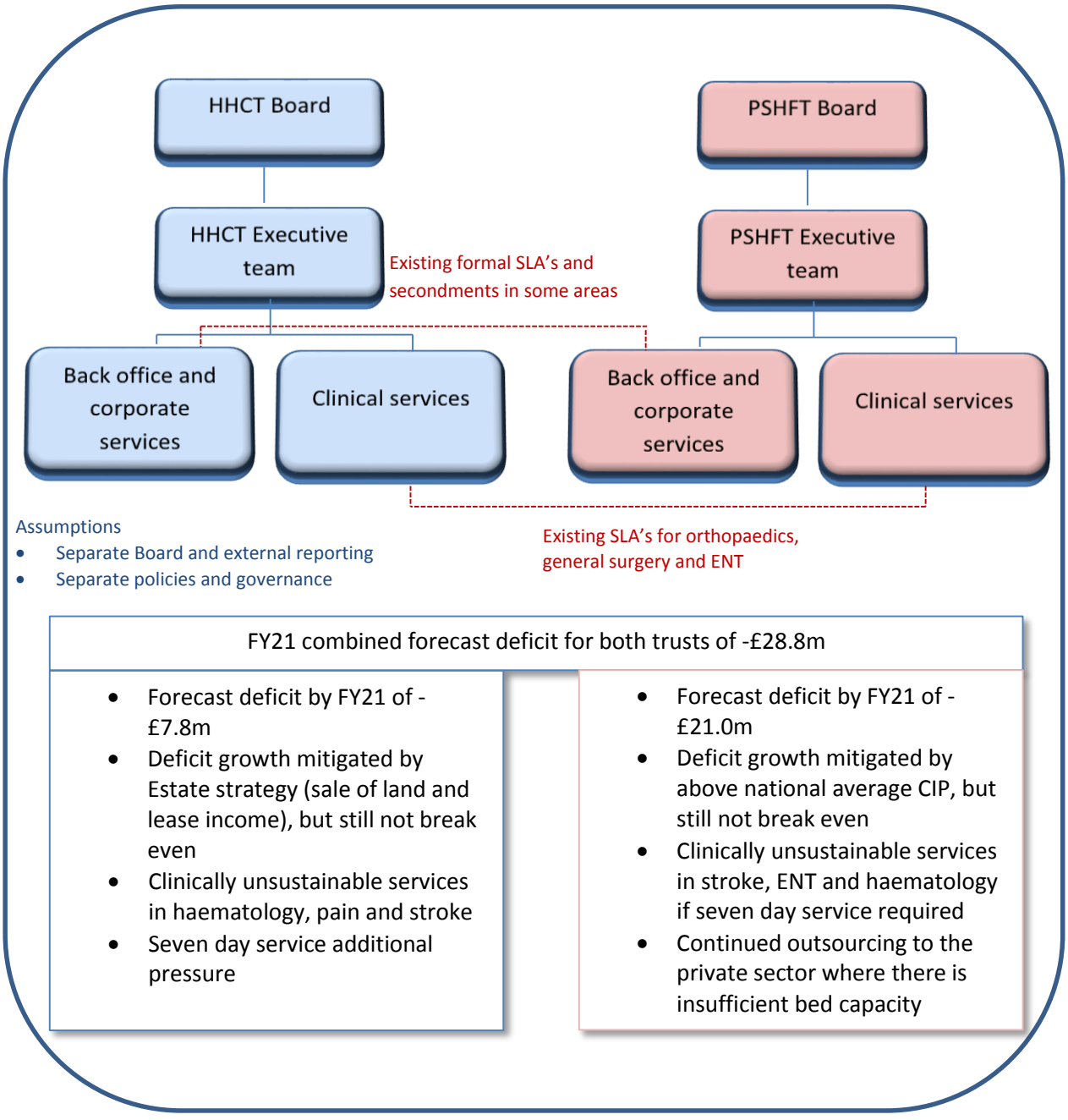
	Option 1 – Do nothing	Option 2 – Shared services	Option 3 – Two boards, one executive team	Option 4 – One organisation
			pressures. This will increase the ability of the organisations to maintain and drive improvements to quality and efficiency standards.	
Ensure long term financial viability of any new provider forms	Financial risk rating will be 1 for each year	Financial risk rating will be 1 for each year	Financial risk rating will be 1 for each year	Financial risk rating: FY17 (Plan) 2 FY18 (F'cast) 2 FY19 (F'cast) 2 FY20 (F'cast) 3 FY21 (F'cast) 3
Significant financial savings through synergies and better use of physical capacity	There are no savings available related to physical assets, or combined savings through joint procurement of systems and external contracts.	Opportunities for better collaboration and synergies: HR - Learning and Development - Organisational Development - Occupational Health - Recruitment Corporate Nursing - Chaplain service - Professional Standards roles - Volunteer Service Unlikely however to result in significant pay cost reductions within those departments as the same volume of staff and patients will need to be served across both sites. There may be some opportunities to venture into SLA's on back office service such as Sterile Services, Health Records and Pathology in the future.	There are no additional synergies available in this option over and above what could be possible in option 2. An advantage could be an improved ability (both speed and effectiveness)to drive quality and operational efficiency improvements with one executive per department, but this is unquantifiable financially for the purposes of the OBC.	A fully merged organisation maximises all available opportunities for working together to deliver savings and use physical capacity better to maximise use of clinical space on both sites to drive income opportunities. This option is the only one where IT systems can be fully aligned (with one set of patients) and financial reporting can achieve the efficiencies of only one set of accounting reports. This allows the merged Trust to negotiate non-pay system savings as well as significant pay savings associated with managing them.
8. Must be affordable, making the best use of public funds				
Scores	***0.53***	***3.61***	***4.46***	***6.4***
The cost of investment must relative to the financial benefits	The costs are equal to the continued deficit position for both trusts	Estimated costs are roughly equal to the value of one full year of the estimated savings. The estimated savings of this option are £1.6m.	Estimated costs are roughly equal to half the value of one full year of the estimated savings. A reasonable estimate of costs include OBC development of £100k (inc VAT), plus legal fees of £800k for a full suite of SLA's plus governance arrangements for the Alliance Board and management of the collaborative, making a total of £900k plus £1.2M redundancy cost	The transition costs of £8M for this option are roughly equal to one full year of the anticipated level of savings. Costs include development of the FBC (legal, due diligence, CMA engagement) £4m, and redundancy £3.2M plus £800K for project management and implementation costs.
The payback period should be reasonable	Not applicable	Payback period of around one year assuming that all SLA's can be agreed in that period	Payback period of around one year assuming that all SLA's and governance arrangements can be agreed in that period. Given the complexity of the governance, and the experience of the Salford trusts, it is suggested that the actual payback period will be two years.	Payback period of around one year assuming that all FBC and competition issues can be resolved in that period. Given the complexity and number of posts which will be redundant, it is suggested that the actual payback period will be two years.

	Option 1 – Do nothing	Option 2 – Shared services	Option 3 – Two boards, one executive team	Option 4 – One organisation
Must consider what/whether central funding will be available within the LHE	Central funding will not be provided indefinitely and will be dependent on a credible turnaround plan	Central funding will not be available for this option	Central funding will not be available for this option	Funding could be sought from national bodies
TOTAL SCORES	**6.27**	**19.88**	**27.56**	**46.3**
RANK	**4**	**3**	**2**	**1**

Further detail of the information available for the option appraisal is given below.

Option 1 - Do nothing for now

Figure 1 - Summary of option 1



Both trusts will continue to operate as two separate organisations with back-office and clinical teams working largely as they do now (Figure 1). This assumes no greater collaboration than exists currently. It does not mean however that collaboration of any kind cannot occur at some point in the

future, and due to unsustainability of certain services there will almost certainly need to be future changes to services at one or both sites.

The System Transformation Programme forecasts that activity demand will continue to rise, even after QIPP, over the coming years. If we continue to deliver hospital inpatient care as we do now, population and rising acuity pressures mean we would need an additional 219 hospital beds in five years' time across both PSHFT and HHCT to meet the demand for elective and non-elective care. There are insufficient finances to create these additional beds which may mean that service provision would need to be altered or ceased entirely to fit within available capacity. While there has been come collaboration in orthopaedic and ENT specialties, this is on a small scale and does not address the capacity mismatch across the organisations. Option 1 will therefore result in increased outsourcing of low-risk activity and increased in-hospital cancellations of operations.

Aligns to the Sustainability and Transformation Plan

Option 1 does not preclude the organisations from further clinical collaboration without back office integration, however without closer collaboration the STP work will not develop at the required pace.

The mismatch between demand and the available capacity is not sufficiently addressed under this option as the two trusts are not working together to make better use of the available estate. The strategy to provide a frail medical specialist centre / 'Health Campus' at HHCT by co-locating acute medical care with primary care, therapy, step-down/intermediate care capacity, pharmacy and older peoples mental health contributes to aligning capacity and demand for this population sector and can still be achieved under option 1. This strategy is aligned to the plans for a 'community hub' location developed by UCP and could be extended to South-East Peterborough patients in particular.

ENT and orthopaedics have provided examples of how the two trusts can collaborate effectively to use spare capacity in one trust to support excess demand in the other. This has resulted in some reduction in outsourcing to the private sector while reducing waiting times for patients. Without further collaborations the two trusts ability to meet growing demand within their own capacity while delivering efficiencies, will be limited. The existing arrangements may end as SLA's can by definition be ended by either party with notice. Examples include the SLA's between HHCT and CUHFT.

Must generate financial savings to ensure safe and sustainable services for patients and stakeholders

The cost for back office at both organisations currently stands at £126M. This includes £800k of agency costs that is in place across both organisations in back office services.

Due in part to historical difficulties in recruiting specialist staff to some back office areas i.e. Estates and Facilities, this option offers little further chance to fill these skills gaps via opportunities arising from collaboration. Spending £800k per annum recurrently on agency fees does not represent value for money and diverts funds away from investment in frontline services.

CQC reports of both organisations highlight areas for investment and improvement and given the deficit position, medium to long term lack of investment could begin to impact significantly on the quality of services each provides.

In addition to the lack of pay related savings there are no savings available related to physical assets, or combined savings through joint procurement of systems and external contracts.

Must be deliverable and acceptable to patients and stakeholders

Medical Directors have identified services that are currently unsustainable i.e. Haematology and Pain Services at HHCT. Where it is not possible to recruit staff, or the scale of operation is insufficient to sustain specialist staff and resources, services will have to stop or be outsourced to another provider which would be unacceptable to patients and the public.

There will be no impact on patient choice in the short term, but in the longer term as has been described in the OBC main document, some services will not be sustainable and as a result choice could be reduced

Must be affordable, making the best use of public funds

Option 1 appears to involve zero investment, however as both trusts are in deficit, without collaboration there will be significant ongoing use of agency. Therefore the actual investment in continuing services is much higher and will require further investment by the tax payer. Examples include the duplication of IT systems which both trusts are required to procure as part of the national drive towards electronic patient records. Requirement for safe staffing levels to meet national initiatives is not included in the baseline position as it is unknown what additional investment this will entail.

Option 2 - Some back office and clinical collaboration

Under the Dalton Review (2014), this collaboration represents a contractual agreement between the two trusts. This option assumes increased levels of collaboration beyond, or to formalise, the areas where we already support each other. The level of sharing ranges from part time secondment of individuals, through to one or more completely shared services, hosted by one of the organisations but working equally across both (Figure 2).

Figure 2 - Back office and clinical collaborations

Part time secondment	Shared services
•Staff will work as part of an extended team across both trusts' sites; or •Staff have a substantive contract with one trust but work on secondment for all or part of their week, or for a defined period of time for the other. •Presence on both sites •Attend external meetings on behalf of the organisation they are employed by on that day •Duration of agreement agreed by both organisations, with neither being committed beyond the agreed term •Examples include Director of HR from PSHFT on secondment to HHCT and PSHFT procurement management working part time at HHCT	•Services provided to the employing trust, and the other trust under a series of service level agreements (SLAs) or contracts. •For shared clinical support services e.g. radiology both trusts maintain separate groups of patients and management of 18 week pathways, external and internal reporting etc. •Examples include HHCT membership of the Pathology Partnership

Arrangements already exist for visiting consultants in some specialties, making use of scarce clinical resource. While this can help both organisations and benefit patients, it can lead to organisational difficulties as the trusts have their own group of patients to care for but less flexibility over resources to meet individual fluctuating demands. This has on some occasions led to breaches in patient access targets for one or both trusts and the ending of SLA's.

A further complexity is the varying governance, policies and processes that exist in separate organisations. While attempts would and should be made to streamline these in order to improve patient safety and operational efficiency, there is no guarantee that two separate executive and non-executive Boards would agree to this arrangement, leaving clinicians at risk of working with two sets of governance processes and thereby increasing risk.

Creating a shared back office across the two organisations is attractive as it provides efficiencies in areas with minimal direct patient contact. However, patient records and IT are an area of concern. A clinician on the project has observed that one set of documentation is a key enabler to facilitate the

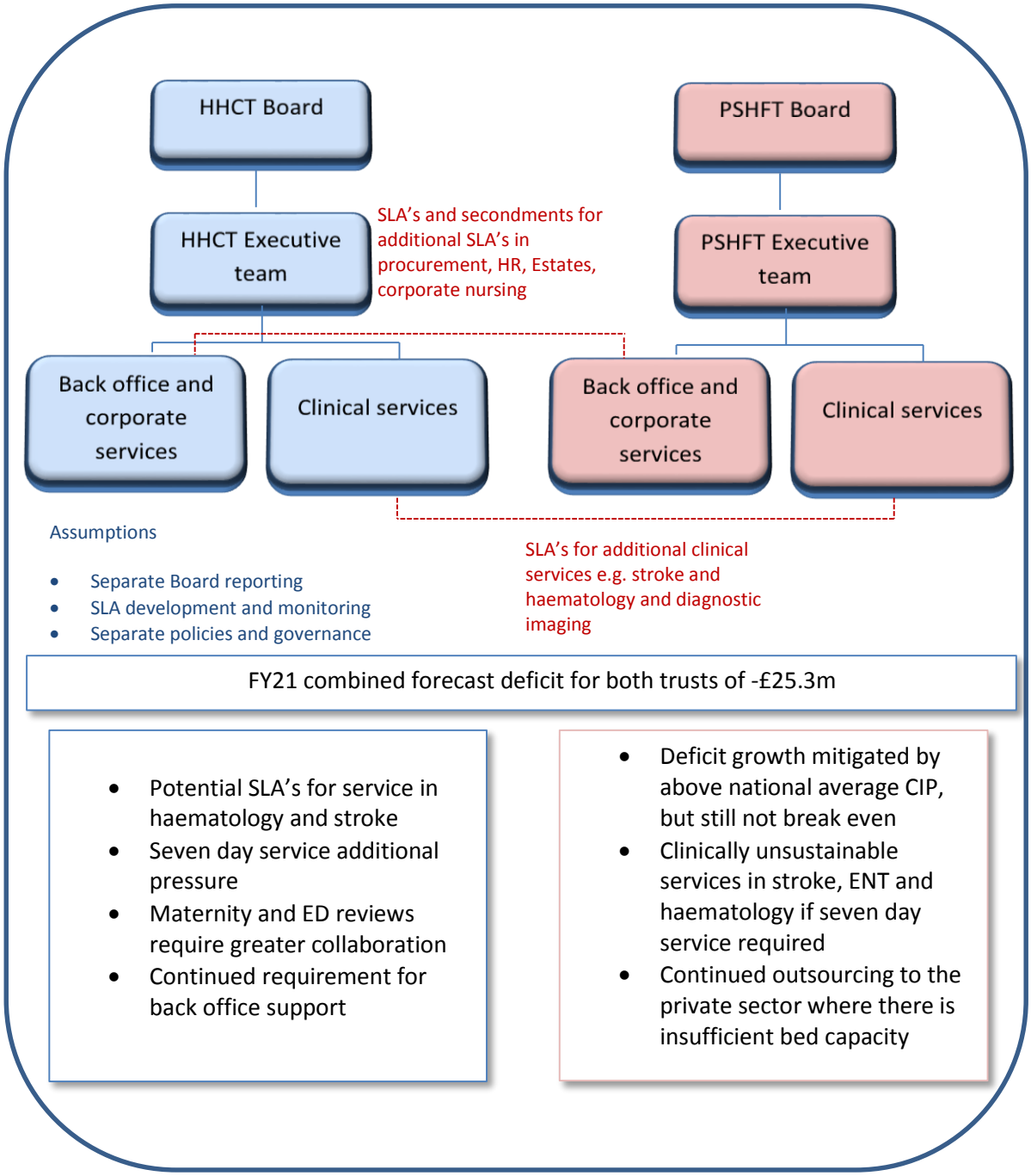
clinical collaboration required to maintain and improve patient access. IT and information services cannot be merged whilst there are two separate organisations due to the requirement for separate statutory reporting.

Creating shared non-clinical back office services does not encounter these difficult operational realities and in some areas such as procurement, estates management etc. some true efficiencies could be realised through one organisation providing services for the other under an SLA arrangement. With one single team, specialist skills of individuals in estates for example could be shared across both sites and reduce the need for agency staff. Other savings are likely to be achieved in the future through larger procurement and contract agreements with external suppliers.

Figure 3 illustrates how option 2 will build on the current SLA's which already exist between the trusts.

Whilst both organisations are still two legal entities there will still be a requirement for external reporting and regulation to remain separate, and this limits the workforce savings available in other areas of back office functions. For example, both trusts are required to submit separate accounts, patient data and performance reports.

Figure 3 - Option 2 HHCT/PSHFT SLA's



The work plan for each shared service will be agreed jointly by the trust at least annually, and performance will be monitored and reported in line with normal SLA management practice. As with any SLA, either organisation is able to serve notice and cease to be involved with the arrangement. For the provider organisation this could leave additional excess staffing costs for a period of time and for the employing organisation it could leave them at risk of being unable to provide a local service to their patients and meet contractual and performance requirements at short notice.

This option may have a positive impact on bed capacity as clinicians from one trust make greater use capacity in the other.

Aligns to the Sustainability and Transformation Plan

Both trusts are actively engaged in seeking increased collaboration in the Sustainability and Transformation Plan work streams.

Option 2 will build on areas we have collaborated under the Elective Care Programme work stream. Medical Directors suggest the following services could be delivered more collaboratively, some of which could be part of an SLA:

- Radiology
- Cardiology
- ENT
- Hand Surgery
- Respiratory
- Stroke
- Nephrology
- Haematology
- Oncology
- Anaesthetics
- Ophthalmology
- Diabetes

The transfer of ENT activity from PSHFT to HHCT and use of HHCT theatres and wards by PSHFT orthopaedic surgeons is already managed under service level agreements. Learning from this collaboration provides a template for expansion in other clinical services and supports the STP theme of providing care across boundaries.

Areas identified for future back office collaboration under option 2 are shown in **Figure 4**.

Option 2 would also offer opportunities to share clinical resource and capacity between organisations. For example, SLAs could be established to undertake a proportion of one trust's elective activity at the other site on a regular basis. This would help address the mismatch between capacity and demand across the patch.

Figure 4 - Option 2 collaboration opportunities

Must generate financial savings to ensure safe and sustainable services for patients and stakeholders

This option delivers a recurrent saving against baseline of £1.6m including a reduction of £270k agency fees by having a single merged Estates team. The saving also includes a fully merged procurement team which can be run on an SLA basis to deliver a reduction in substantive pay costs for the procurement team as long as they were co-located on a single site.

There is only a minimal substantive pay reduction in Estates due to the large variation in the types of site both organisations have e.g. large PFI at PSHFT and large retained estates at HHCT. In addition, the health campus vision at HHCT will demand that specialist staff remain working on site.

There are opportunities identified to establish SLA's for Heads of Service in clinical support services such as pharmacy, diagnostics, emergency planning, sterile Services, health Records and Pathology (although note that HHCT is already in a shared service with tPP) in the future. This will result in a minimum of £260k pay savings per annum and could result in efficiencies associated with physical space, providing opportunities to use redundant space for clinical income opportunities. As yet the estates opportunities are unquantified as they cannot be guaranteed.

Other back office 'soft' benefits include opportunities for staff to develop, gain new skills and rotate across services which may lead to improved staff morale and therefore recruitment and retention rates.

There are additional costs associated with developing each SLA and the ongoing management associated with monitoring patient flows and coordinating patients across the two sites.

Deliverable and acceptable to patients and stakeholders

The Medical Directors identified services with potential for collaboration based on current service vulnerabilities. If collaboration in these areas helps to support continued delivery of services at their current locations, then this will be a viewed as a positive step for patients and local stakeholders. A reduction in agency spend, better alignment of capacity leading to reduced elective cancellations are other examples which would be positive to patients and local stakeholders.

Merged clinical services would provide greater opportunities for staff to develop, gain new skills and rotate across services. Development opportunities are usually linked to an increase in staff satisfaction which in turn should lead to improved retention rates in those services and help support safe staffing levels. All of this should lead to an improved customer service experience for patients and public visiting our hospitals and safe staffing levels will directly improve patient safety and length of stay.

The need to align whole organisational cultures is not required under option 2 and therefore might be more acceptable to some staff, however if there were increased use of SLAs to provide individual services, then the provider organisation would need to be sensitive to, and align outputs to the needs of the other. For any teams (clinical or back-office) combined under this option, culture would be a factor to manage at service level. Readiness to do so will be a factor in the selection of the service to be shared and other departments and teams which depend on the shared service.

Must be affordable, making the best use of public funds

The estimated costs are roughly equal to the value of one full year of the estimated savings. It is assumed that there will be no full business case development under this option. The estimated savings of this option are £1.6m.

SLA's will be developed which may require legal advice, and management time. A reasonable estimate of costs include OBC development of £100k (inc VAT), plus legal fees of £400k for a full suite of SLA's including clinical, making a total of £500k plus £600k redundancy cost.

Option 3 - Two boards, one executive team and one operational organisation

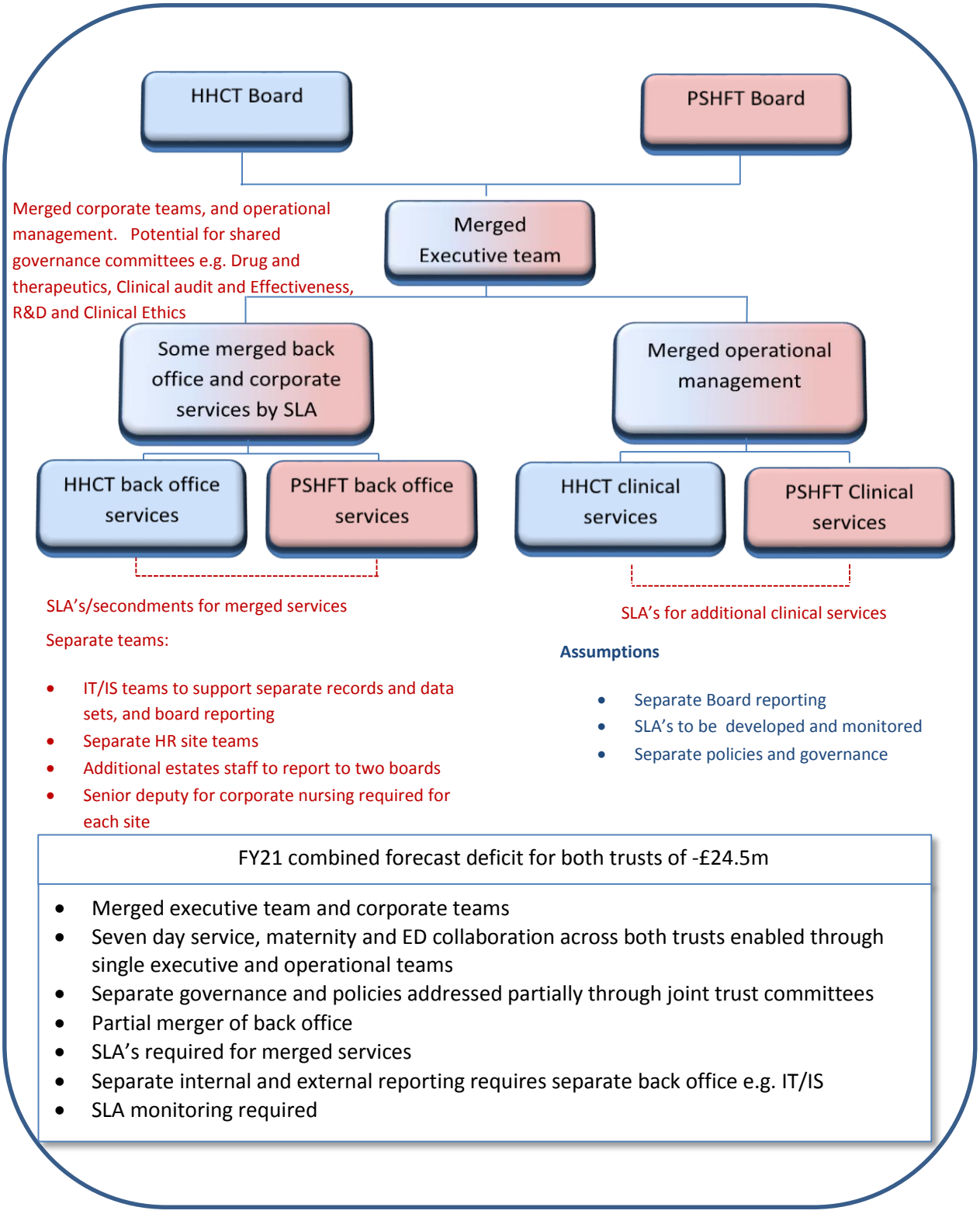
Under the Dalton Review (2014), this collaboration represents a contractual arrangement. This option is the least well known in the acute sector of the NHS and is therefore more theoretical. In September 2015 NHS England released a set of 13 acute care vanguards that had been approved to link together local hospitals in order to improve clinical and financial viability.

A single executive team will be accountable to two Boards, with two separate and distinct groups of non-executive directors, for the delivery of all services and strategic direction of both organisations. Both organisations retain separate legal identities, with separate meetings to consider matters relating to their own trusts, and each remains accountable for external governance and regulatory requirements. Due to this there are some departments such as Finance and IT where the majority of the staff would need to remain in place to support two separate external reporting functions, two sets of patients and two legal groups of staff.

Under this option, as far as possible, clinical and operational teams will be able to merge as described by the executive teams. Each support team will have a single base but a presence on both trust sites.

Outside of the acute NHS sector there are other examples of where a single executive team has reported to two separate boards, however there is little available evidence as to whether this was successful and/or lessons learnt as to how to make this model work effectively.

Figure 5 - Option 3 HHCT/PSHFT 'chain'



Risk and reward

There will be an agreed approach to risk and reward for both trusts. Hempsons solicitors (2016) suggest that this would be an area for agreement at a joint 'Alliance board'.

Board accountabilities

The boards will comprise the non-executive directors of each trust with executives from the single team sitting on both boards. The PSHFT board will continue to be accountable to their governors whereas the HHCT board will continue to be accountable to the Secretary of State for Health through

the NHS TDA. The executive and advisors to the boards will act and advise in accordance with these separate accountabilities.

Significant transactions such as major capital investment and other financial commitments will be reserved matters for both Boards. Hempsons (2016) suggest a joint 'Alliance board' meeting will be held periodically to coordinate members, agree annual or five year strategies and allocate risk and reward.

Management structure

The two boards will set the strategic direction for their trusts. The executive will provide a networked view of leadership and delivery for the operational management team(s) depending on the structure agreed.

Working as part of a chain, there is an expectation that the executive team will provide strategic direction, with a consistent approach across both organisations to principles, philosophies and 'ways of working'. Policies and standard operating procedures, governance arrangement, SFIs, approval processes etc. will all be aligned. However, this is within the context that individual boards, operating under separate regulatory frameworks, and with the time horizon defined by the duration of the chain agreement will have the final decision, and by definition may not always agree.

Back office

The single executive team will be supported by combined back office functions that will merge wherever possible to one or other of the trusts or externally, and staff will transfer to one of the trusts to meet the combined needs of both organisations. For any 'merged' functions (back office, or clinical); services will be provided to the other trust under a series of service level agreements (SLAs) or contracts.

The shared philosophies and principles will allow adoption of merged policies, with a process where the two boards fail to agree. The back office functions will be responsible for providing the separate accounts, contracts, audits, inspections, and both trusts will have separate quality, financial and performance metrics and ratings.

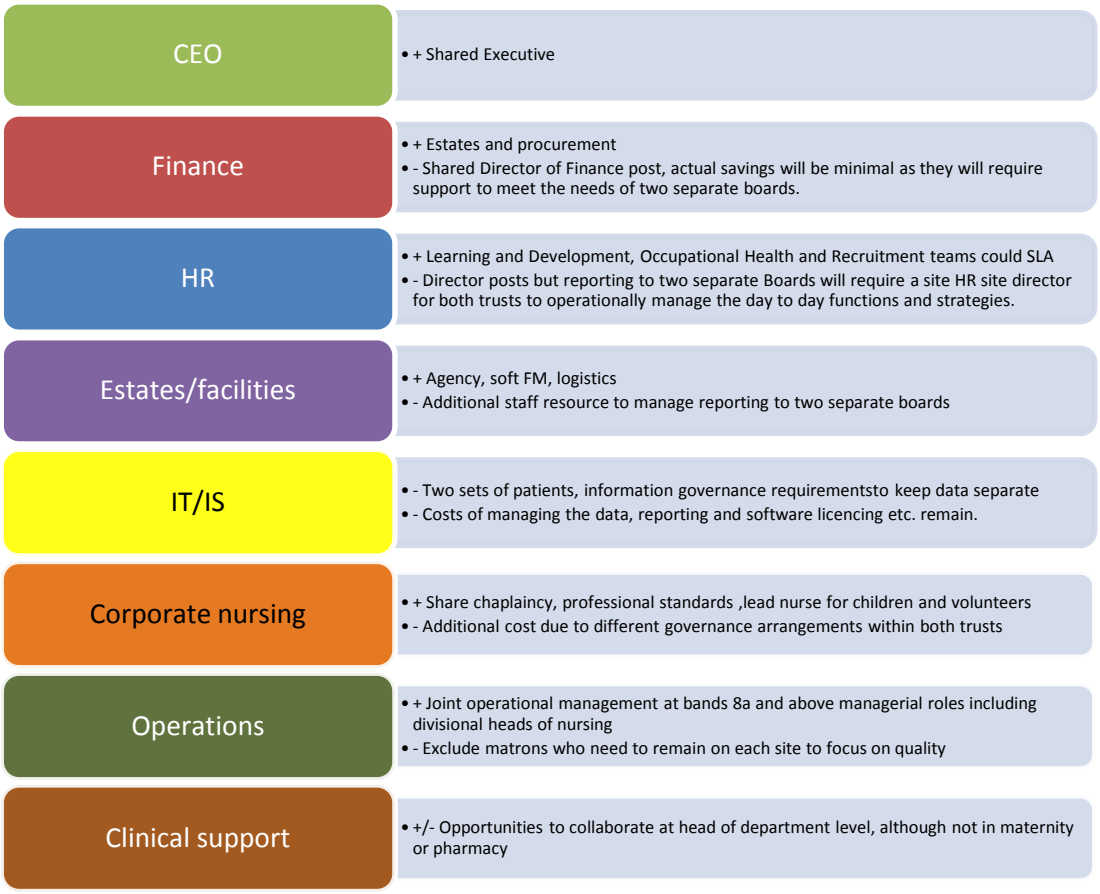
There will be a programme of work for the back office functions, signed off in advance by both Boards. This programme will be varied by the executive team during the year with significant changes being a reserved matter for consideration by the Boards.

Aligns to the Sustainability and Transformation Plan

This option increases the chances of effective collaboration beyond those set out in option 2 as one executive team can directly oversee and align clinical teams for both organisations. This could lead to integration in a shorter timespan than in option 2.

The experience of orthopaedics and ENT shows that even with the support of both executive teams, lack of harmonised policies, procedures and procurement adds delay to the collaboration. Therefore a single set of these created by a single executive will assist in greater harmonisation. Opportunities for shared corporate services are shown in **Figure 6**.

Figure 6 - Option 3 collaboration opportunities



Opportunities for single governance committees within a comprehensive shared structure under this option include Drug and therapeutics Committee, Clinical Audit and Effectiveness, R&D and Clinical Ethics.

Option 3 would not necessarily deliver the required level of medical collaboration although if a clinical service chain model is followed then this would deliver full collaboration whilst it was in place. Haematology and some of the other clinical services have identified the requirement to move staff across a single organisation with joint standards and policies. Previous attempts at working to an SLA have had to end once one or the other parties have come under strain e.g. haematology. In theory therefore this arrangement could be dissolved although one might consider this unlikely once the change is fully embedded and savings are realised as it would require investment to dissolve the arrangement.

As with the previous options the strategy to provide a specialist 'frail medical specialist centre' by collocating acute medical care with primary care, therapy, step-down/intermediate care capacity, pharmacy and older peoples mental health will focus on providing care for this population. A merged executive team working across two organisations will have an improved ability to move and allocate resource according to operational and clinical pressures which will support greater use of available capacity.

Must generate financial savings to ensure safe and sustainable services for patients and stakeholders

This option would deliver savings of £4.3m against baseline costs but costs still include £500k of agency spend in IT predominantly which cannot be eliminated whilst there are two sets of patients (a requirement of two separate legal entities) and therefore two separate departments. This overall saving is £2.7m more than option 2.

The savings are predominantly made up of a reduction in executive directors and senior operational managers on top of those delivered in option 2.

A merged executive team will work across two organisations and have an improved ability to move and allocate resource according to operational and clinical pressures. This will increase the ability of the organisations to maintain and drive improvements to quality and efficiency standards.

Must be deliverable and acceptable to patients and stakeholders

Patient benefits relating to collaboration on clinical and non-clinical services are equal in option 3 to option 2. In fact most external stakeholders are unlikely to see much difference in care delivery with option 3 than they would see in option 2. With more services being run in a merged fashion, then choice of provider becomes reduced for patients, although in most instances there are other alternative providers within a reasonable geographic distance that could be a viable alternative.

Option 3 is arguably the most difficult in which to achieve alignment of cultures as there is a risk staff will feel they work for either one, or both organisations. If there are issues that the two boards take a different stance on, this will perpetuate those differences. Because the two organisations remain separate and distinct from one another, these differences will continue in the long term unless the executive leadership team invest considerable energies in ensuring the same values, behaviours and culture are present throughout both organisations.

A single executive team running services as one operational organisation would be subject to a referral to the UK Competition and Markets Authority (CMA). Early analysis would suggest that competition exists between the two trusts in maternity services, with mothers in the southwest of Peterborough exercising choice between PSHFT and HHCT. The trusts would need to engage with the CMA to ensure patient choice was not adversely effected by progressing with this option.

Must be affordable, making the best use of public funds

The estimated costs are less than one third of the value of one full year of the estimated savings. It is assumed that there will be no full business case development.

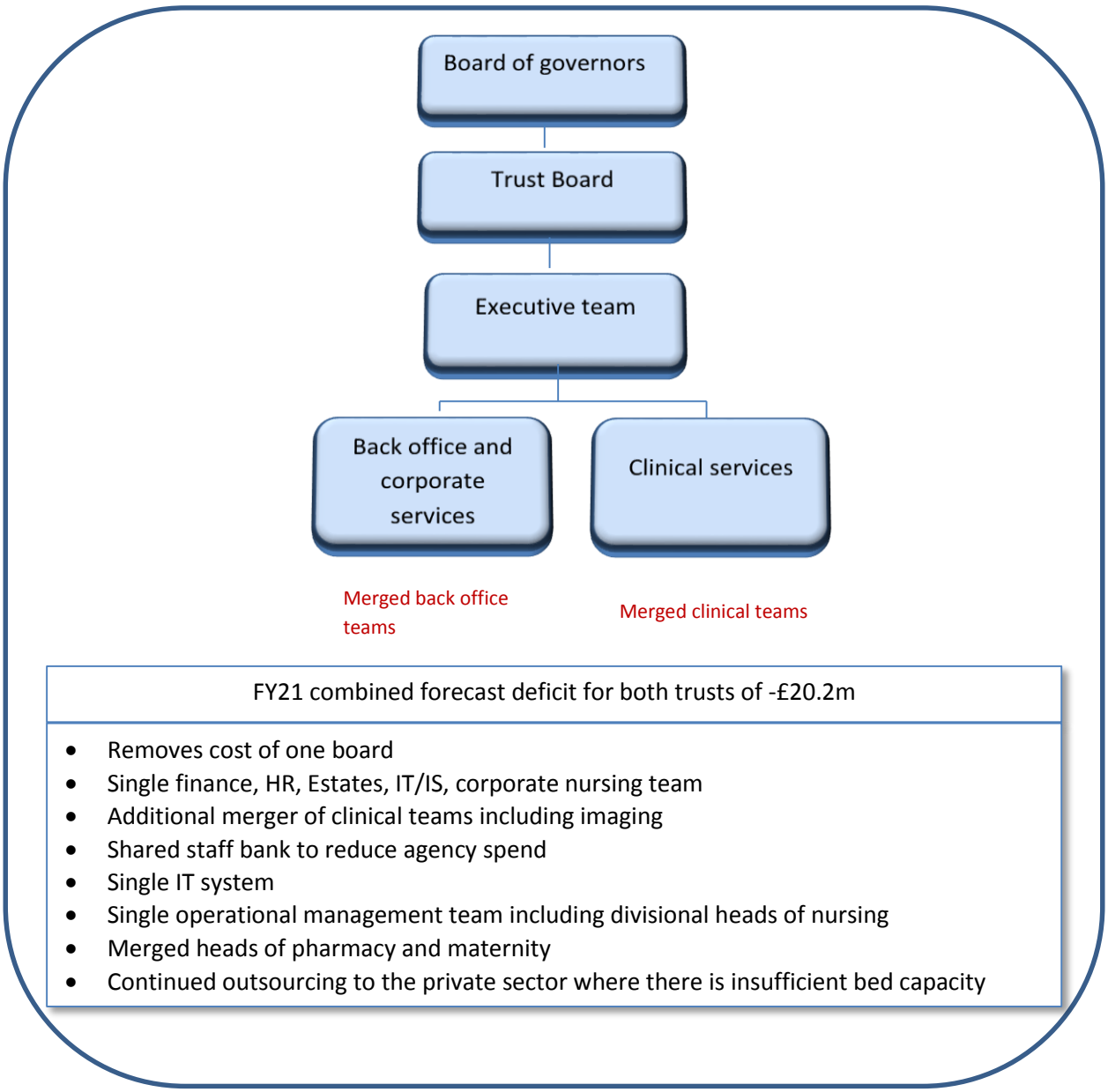
Savings are estimated at £4.3m.

SLA's will be developed which may require legal advice, and management time. A reasonable estimate of costs include OBC development of £100k (inc VAT), plus legal fees of £800k for a full suite of SLA's plus governance arrangements for the Alliance Board and management of the collaborative, making a total of £900k plus £700k redundancy cost.

Option 4 - Full union of both trusts to create a single organisation

Under the Dalton Review (2014), this collaboration represents a consolidation. A single trust will be created from the two trusts with a single board (Figure 7), a new structure with staff automatically transferring into the new organisation, or applying for posts within it. All services, corporate, back office and clinical teams will be part of the same organisation, managed by a single executive team.

Figure 7 - Option 4 merged organisation



As a single organisation, this option allows one set of patients and staff from a clinical and non-clinical system point of view which then allows one single set of external reporting and governance arrangements. This allows the maximum back office saving as only one set of back office staff to produce these reports is needed, and only one set of IT systems. The arrangement is also permanent and therefore the savings are more robustly assured to be long term and final, and will also deliver efficiencies across the health system with other organisations (CCG's, community providers etc) having a single entity to contract with (though these are not quantified in savings). The advantages of having single clinical teams have been described in previous options although having teams employed and driven by a single board may enable clinical improvements and efficiencies to be delivered at a faster pace and/or go further and be more sustainable.

The risk to this option are based around the complexities and time required to join two organisational cultures, and whether the distraction of this will cause issues in performance and/or quality delivery. This will need to be tightly managed to ensure it does not occur. A further risk that will need tightly managing is the public perception and concerns that services might be shut at either site either now or in the future.

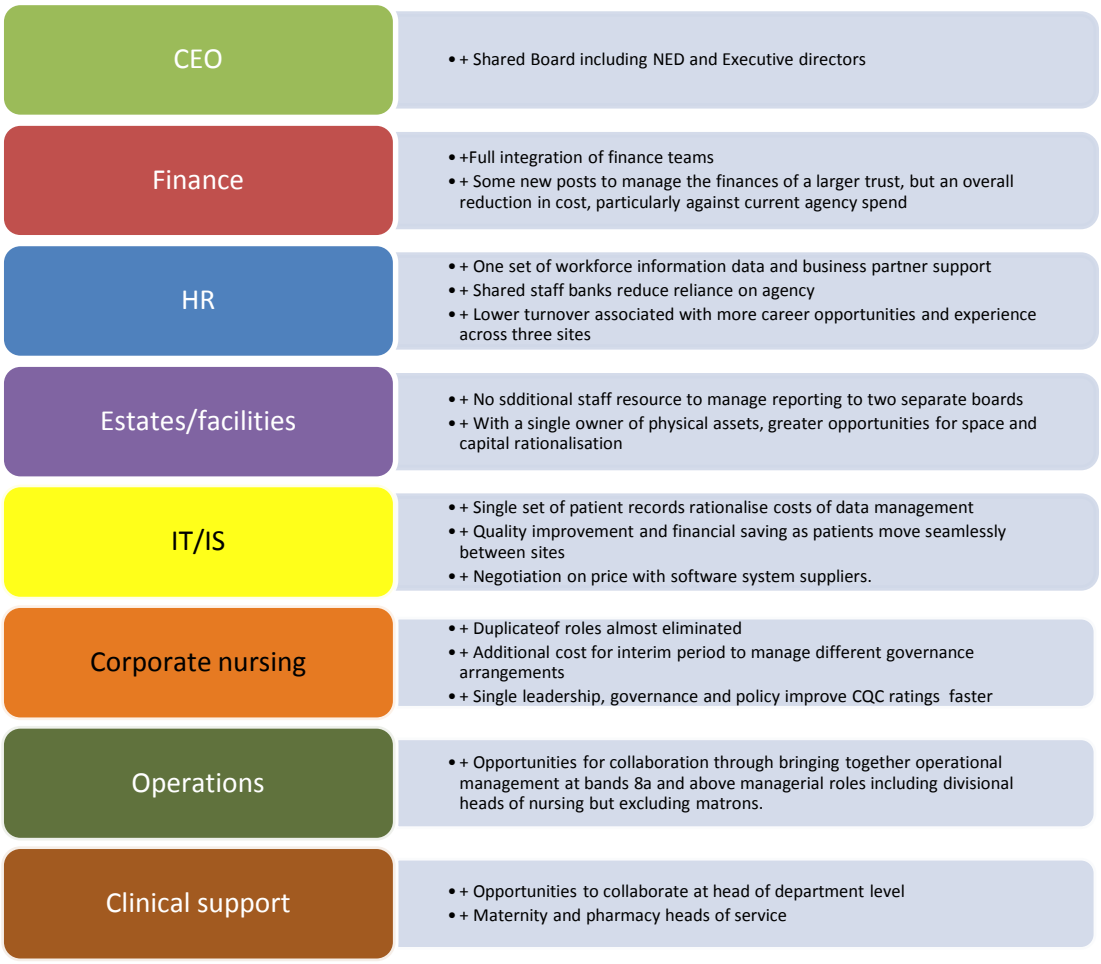
has the advantage For the high level assessment, the merger process has been assumed to take between 12-18 months and the savings are based on the high level executive assessment. The benefits and risks of this option are described in more detail in the option appraisal.

Aligns to the Sustainability and Transformation Plan

Option 4 increases the level of collaboration beyond the other options as clinical teams will work for one organisation. Learning from the pilot transfer of elective activity for orthopaedics and ENT showed that even with the support of both executive teams, differences in policies, procedures, equipment and procurement add significant complexity to the collaboration. Operating under a single organisation, a single executive team and support services and a single board, many of these complexities will be removed and use of capacity, particularly for elective activity could be more flexible. There will be a lead in period for harmonisation, until single policies are adopted across the whole organisation.

Opportunities for shared corporate services are shown in Figure 8.

Figure 8 - Option 4 collaboration opportunities



Clinical benefits

With larger combined clinical teams, there are greater opportunities to sustain services across both sites. For example, with the additional five ED consultants recruited at PSHFT there will be more opportunities to sustain urgent care services at HHCT. The additional radiology capacity recruited at PSHFT will make sustainable services, and seven day reporting more sustainable across the new enlarged organisation.

Activity forecasts show that activity demand will continue to rise (even after QIPP) over the coming years. Of the four options being considered, option 4 reduces or eliminates the most barriers to flexible management of elective capacity and therefore best supports delivery of the STP.

As with other options, the strategy to provide a specialist 'frail medical specialist centre' by collocating acute medical care with primary care, therapy, step-down/intermediate care capacity, pharmacy and older peoples mental health is focussed on providing care for the growing elderly population. This strategy would be better supported by larger clinical teams offering recruitment and retention opportunities for community and acute geriatricians, a critical mass to support some sub-specialist clinical roles and varied training opportunities for all staff groups.

Must generate financial savings to ensure safe and sustainable services for patients and stakeholders

This delivers a saving of £9m against the current agreed baseline of FY16 costs. All agency fees for back office are eliminated as it can be presumed there will be enough staff within the two current organisations, to fill all substantive posts within the new organisation.

This also includes a minimum reduction of £1.7m against non-pay costs on software systems and external contractors.

As an improved financially viable organisation, more senior time can be spent focussing on improving the quality and efficiency of the new Trust, driving increased income and reductions in operating costs. This alongside the recurrent back office saving will allow greater investment in front line services, further driving improvements in quality of care.

A fully merged organisation maximises all available opportunities for working together to deliver savings and use physical capacity better to maximise use of clinical space on both sites to drive income opportunities.

This option is the only one where IT systems can be fully aligned, with one set of patients, and financial reporting can achieve the efficiencies of only one set of accounting reports. This allows the merged Trust to negotiate non-pay system savings as well as significant pay savings associated with managing them.

Must be deliverable and acceptable to patients and stakeholders

There may be an initial mixed response from local patients in both localities. Huntingdon population in particular may have concerns this option represents a threat to their local provision of services and there will need to be a strong communications campaign to ensure the local population is assured that delivering this option is not considering ceasing service provision at any site. The campaign needs to highlight the current concerns about service sustainability and if delivered effectively then patients will recognise that this option will strengthen their local services and this would be popular and acceptable.

This option, although it offers the greatest potential benefit for efficiency savings and operational sustainability, is complex and disruptive to staff in the short term. "A survey of executives who have managed through mergers, [said that culture clash] was the No. 1 reason for a deal's failure to achieve the promised value."

Compared with the other options, there are issues of complexity:

- Monitor and the NHS Trust Development Authority need to approve mergers of foundation trusts and NHS trusts through separate review processes
- There are risks to bringing different cultures, and different organisational identities 'under one roof'.

- Success is dependent on stakeholder buy-in
- Prolonged periods of uncertainty are arguably most damaging to the sustainability of service, morale and recruitment

This option provides greatest opportunities for improving rotas and to recruit. The Clinical Reference Group and Medical Directors have identified opportunities to share rotas and out of hours cover across both sites which will be particularly favourable for services that are currently unsustainable e.g. haematology at HHCT and the gastroenterology seven day bleed service at PSHFT.

The larger critical mass will allow greater opportunities for training, a varied workload, and sub-specialisation which all help recruitment and retention.

This business case does not propose changes driven by national guidance for maternity, urgent and emergency care which remain the responsibility of commissioners but a merged organisation would be better placed to respond to any commissioner reconfiguration.

Must be affordable, making the best use of public funds

The estimated savings under this option are £9m associated with reductions in Board costs and corporate pay and total elimination of the agency spend in back office areas.

The transition costs of £8m for this option are roughly equal to one full year of the anticipated level of savings. Costs include development of the full business case including legal, due diligence, CMA engagement costs of £4m, and redundancy costs of £2.5m plus £800k for project management and implementation costs.

Appendix 12 – Clinical services which will benefit from merger

	Description HHCT/ PSHFT	Does Option 4 largely address the issues/risks identified?
Sustainability/ quality opportunity		
Accident & Emergency	Current inability to recruit and retain medical and nursing staff due to size and case mix & career opportunities PSHFT have just appointed 4 A&E consultants.	Partially System Transformation UECV workstream. Option 4 will allow a faster and more sustainable long-term ability for staff to work together to get a higher level of training, skills and experience. Other options don't guarantee the sustainability of this and may not therefore deliver improved rates of recruitment.
Acute Medicine	Roles and service delivery models are moving and changing, requiring nursing & AHP staff to develop to match changing models. Challenge for a smaller workforce. Nursing risks (recruitment and retention) 2 consultant vacancies (currently covered by locums) PSHFT – has appointed 2 consultants but still has 2 additional vacancies but has 3-4 additional vacancies	Partially Issued relieved best though option 4 as a single organisational form will help drive and deliver a single team working in a joined up way to cover service gaps in delivery on both sites on a long term robust basis – also linked to System Transformation UECV workstream
Ambulatory Care	Opportunities (linked to economies of scale) - OPAT	Yes – see **Error! Reference source not found.**
Breast Service	1 vacancy (covered by locum) 2 breast radiologists due to start May/June (joint posts with CUH) Opportunities for efficiency/collaboration – but no sustainability risks. PSHFT – appointed one new consultant	Yes – see **Error! Reference source not found.**

	Description HHCT/ PSHFT	Does Option 4 largely address the issues/risks identified?
Sustainability/ quality opportunity		
Cardiology	HHCT one substantive consultant, with budget for 2.4 WTE to meet training needs. Opportunities for sub-specialism with greater catchment, e.g. repatriation of specialist procedures (PCI)	Yes – see **Error! Reference source not found.**
Respiratory	See Thoracic med	
Clinical haematology	Unsustainable. No substantive HHCT consultants. Locum cover by general physicians not Haematologists. Unable to recruit.	Yes – see **Error! Reference source not found.**
Diabetes	Opportunities for efficiency/collaboration but no sustainability risks. Multidisciplinary / SpNs / Podiatry	Yes – see **Error! Reference source not found.**
Diagnostic imaging / Interventional radiology	HHCT & PSHFT outsourcing reporting/ use of locums as both unable to fill all consultant posts. Joined up IT essential.	Yes – see **Error! Reference source not found.**
Endoscopy	Good news story @ HHCT. Full JAG accreditation. High Quality, 7-day bleed rota. Nurse endoscopist – national society chair – high profile. Sustainable & resilient (Opportunities for PSHFT to benefit)	Yes – see **Error! Reference source not found.**
ENT	1 in 4 on-call cover at both trusts unsustainable	Yes – see **Error! Reference source not found.**
Gastroenterology	No seven day bleed service at PSHFT PHSFT likely to benefit from linking with HHCT Endoscopy – See endoscopy above	Yes – see **Error! Reference source not found.**
General Surgery	Recruitment and retention challenges due to the reduced case mix	Yes – see **Error! Reference source not found.**

Sustainability/ quality opportunity	Description HHCT/ PSHFT	Does Option 4 largely address the issues/risks identified?
Geriatric Medicine	See - Acute medicine - Orthogeriatrics (single consultant) - Stroke Dementia services development (key to the Health Campus Strategy) good quality service. Opportunities come with scale.	Partial – see *acute med.*
Gynaecology	No IP gynae service (elective or non-elective.) Most work is DC in the TC.	Yes – see **Error! Reference source not found.**
Maternity	Options for providing future capacity under different service models. Linked to STP work. HHCT No recruitment issues. Quality & Patient experience scores high.	No as no current problems System Transformation workstream
Neonatology	Level One unit provided by CCS. Opportunity being explored via STP work.	No as no current problems System Transformation workstream
Nephrology	HHCT advice and support provided by Addenbrookes on an honorary contract	Yes – see **Error! Reference source not found.**
Neurology	HHCT single handed consultant	Yes – see **Error! Reference source not found.**
Oncology	See… - McMillan Centre - Radiotherapy	Yes – see **Error! Reference source not found.**

Sustainability/ quality opportunity	Description HHCT/ PSHFT	Does Option 4 largely address the issues/risks identified?
Ophthalmology		Yes – see **Error! Reference source not found.**
Oral and max facs	Opportunity to undertake more activity at PSHFT – dedicated theatre/proc room not used.	Yes – see **Error! Reference source not found.**
Ortho-Geriatrics	HHCT single consultant PSHFT – has a single dedicated consultant.	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	Location for elective surgery and possible development of spinal service within larger service. R&R for trauma nurses – not possible @ HHCT	Yes – see **Error! Reference source not found.**
Paediatrics	Options being developed under STP work.	Partially System Transformation workstream
Pain	HHCT not commissioned for a pain service. When spinal back pain service ceased the impact on PSHFT chronic pain referrals increased creating a capacity and demand challenge. PSHFT has a fully staffed complete MDT service including specialist pain psychologists, therapists and lead nurses providing a range of treatment options.	Yes – would provide an opportunity for services to be delivered locally for Hunts patients as previously.
Palliative care	HHCT. Fragile. One WTE consultant cover HHCT 16 nurses. Rotate through community. PSHFT has two consultants working into the local hospice	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.

Sustainability/ quality opportunity	Description HHCT/ PSHFT	Does Option 4 largely address the issues/risks identified?
	and runs the community macmillan service.	
Pathology	TPP at HHCT. Own service at PSHFT.	TPP
Plastics and dermatology	Sustainable but opportunities for >efficiency through >scale	Yes – see **Error! Reference source not found.**
Radiotherapy	CUH unable to cope with demand. 3rd LINAC @ PSHFT operational Autumn '16 Opportunity for HHCT catchment patients to access additional LINAC capacity @ PSHFT closer to home. Supported by Cancer Network	Yes – see **Error! Reference source not found.**
Respiratory	Papworth move to Addenbrookes may impact on HHCT residents and PSHFT flows	Partial Link to Papworth relocation
Rheumatology	Stable service with good reputation at HHCT and PSHFT	
Spinal surgery	HHCT unsustainable in its current form. Single handed Consultant leaving imminently. – see correlated impact under pain services No service at PSHFT	Yes – see **Error! Reference source not found.**
Stroke	HHCT unsustainable under current arrangements (issues = mix of financial/contractual & clinical– no stroke physicians). Also no acute stroke care.	Yes

	Description	Does Option 4 largely address the issues/risks identified?
Sustainability/ quality opportunity	HHCT/ PSHFT	
Therapy services	HHCT opportunities for efficiency through scale. Poor weekend cover PSHFT consultant gap – some service fragility	Yes – see **Error! Reference source not found.**
Urology	New service at HHCT 2-3 years ago. Now established locally, 4 consultants, service doing well. Opportunities for efficiency through scale	Yes – see **Error! Reference source not found.**

Appendix 13 – Financial assumptions

1. PSHFT assumptions

Assumptions

	Notes	Units	Plan 2016-17	Forecast 2017-18	Forecast 2018-19	Forecast 2019-20	Forecast 2020-21
Inflationary and growth factors	Note 1						
Demographic increase	Note 2		2.4%	2.4%	2.4%	2.4%	2.4%
Tariff (deflator)/inflator			1.8%	0.1%	-0.1%	0.0%	0.9%
Other income			1.0%	1.0%	1.0%	1.0%	1.0%
Pay & Pension inflation			3.3%	2.0%	1.6%	1.6%	2.9%
Drug cost inflation			4.5%	2.8%	3.6%	4.2%	4.2%
Other non-pay inflation (incl. PFI)			1.7%	1.80%	1.90%	2.10%	2.2%
Income and expenditure account impact							
Cost improvement, savings and income							
CIPs	Note 3	£'m	£13.0	£11.2	£6.3	£6.4	£6.6
S&T Funding	Note 4	£'m	£10.8	£10.8	£10.8	£10.8	£10.8
PFI Funding Support		£'m	£10.0	£10.0	£10.0	£10.0	£10.0
Investments and other costs							
Penalties	Note 5		£2.5m	£2.5m	£2.5m	£2.5m	£2.5m
Non-cash releasing CIP's			£0.0m	£0.0m	£0.0m	£0.0m	£0.0m
Severance costs			£1.3m	£1.3m	£1.3m	£1.3m	£1.3m
PMO costs			£1.0m	£1.0m	£1.0m	£1.0m	£1.0m
Project Orange			£1.0m	£1.0m	£0.0m	£0.0m	£0.0m
Operational Contingency			£1.7m	£1.7m	£1.7m	£1.7m	£1.7m
7 day working	Note 6		£0.0m	£0.0m	£0.0m	£0.0m	£0.0m
CQUIN			£4.0m	£4.0m	£4.0m	£4.0m	£4.0m

Notes:

1	Inflationary and growth factors - we have used the STP planning guidance assumptions around inflation and tariff inflator.
2	Demographic increase has been derived using information from the draft 16/17 APR activity planning process (and aligns with the STP model for the C&PCCG portion). Forecast to continue in the same percentage in future years.
3	CIPs - assumption of 3% plus £5m in years 16/17 and 2% in 17/18 and beyond
4	S&T Funding - assumed funding continues year on year
5	Penalties - assumption that only emergency readmissions of £2.5m would be applied. This expectation is based on Monitor's directions and is assumed to continue
6	7 Day working - assumed it will be self-financing
7	Depreciation does not include impact of additions outside the Trust's normal £5m capital programe eg PAS
8	CNST is inflated by STP assumptions for non-pay

2. HHCT assumptions

Assumptions

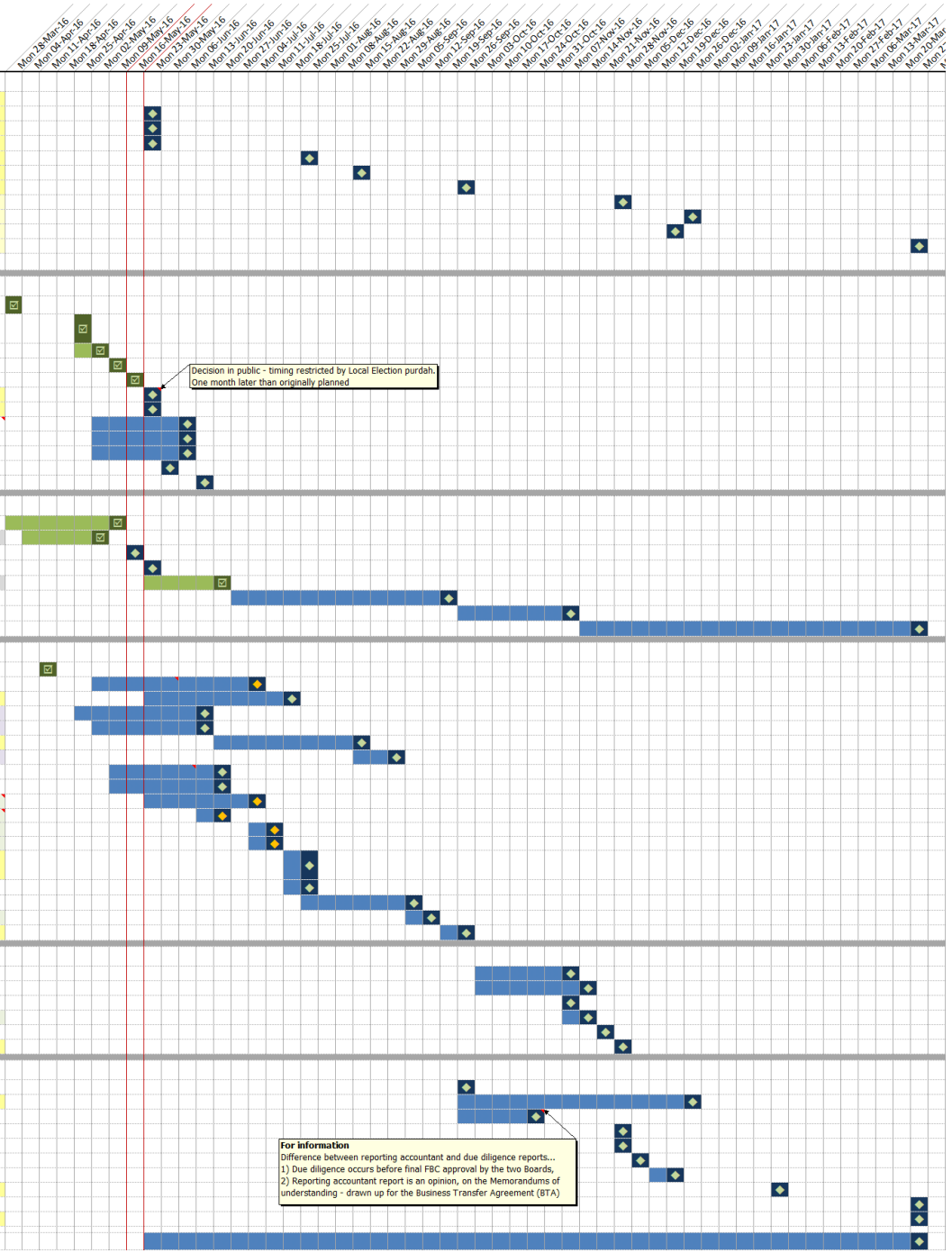
	Plan 2016-17	Forecast 2017-18	Forecast 2018-19	Forecast 2019-20	Forecast 2020-21
Inflationary and growth factors					
Demographic increase	2.0%	2.0%	2.0%	2.0%	2.0%
Tariff (deflator)/inflator	1.8%	0.1%	-0.1%	0.0%	0.9%
Other income	1.0%	1.0%	1.0%	1.0%	1.0%
Pay & Pension inflation	3.3%	2.0%	1.6%	1.6%	2.9%
Drug cost inflation	4.5%	2.8%	3.6%	4.2%	4.2%
Other non-pay inflation (incl. PFI)	1.7%	1.8%	1.9%	2.1%	2.2%
Income and expenditure account impact					
Cost improvement, savings and income					
CIPs	6.7	5.2	4.7	3.5	2.8
S&T Funding	4.0	4.0	4.0	4.0	4.0
Investments and other costs					
Penalties	1.7	1.2	0.7	0.0	0.0
Operational Contingency	1.0	1.0	1.0	1.0	1.0
7 day working					
CQUIN	1.9	1.9	1.9	2.0	2.0

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

Merger Transaction Plan Gantt Chart - *[FBC Decision by end Sep-16, Implementation Plan Approval by end of Nov-16 & Formal Transaction (Go-Live) 1st April 2017]*

Monday 16-May-16

Ref	Status	Description	Start	Finish
		FBC - Milestones		
MOU1	Complete	**MOU/Project commencement**		**Fri 11-Dec-15**
MOU2	On track	**OBC Public Board - Decision HHCT**		**Mon 23-May-16**
MOU2	On track	**OBC Public Board - Decision PSHFT**		**Tue 24-May-16**
FBC1	On track	**FBC work commences**		**Wed 25-May-16**
FBC2	On track	**FBC Financial Base-case to Trust Boards**		**Tue 26-Jul-16**
FBC3	On track	**CMA Phase 1 - complete**		**Mon 15-Aug-16**
FBC4	On track	**Full Business Case - HHCT/PSHFT - Decision in Public**		**Tue 27-Sep-16**
FBC5		***Final Implementation Plan (PTIIP) - Public Boards ****		*Tue 29-Nov-16*
FBC6		***NHS I FBC Review process concludes ****		*Fri 30-Dec-16*
FBC7		***Formal Board/Governor approvals ****		*Tue 20-Dec-16*
FBC8		***Transaction go-live ****		*Sat 01-Apr-17*
		*If FBC approved on 27-Sep-16		
		OBC (Completion & Regulator Review)		
	Complete	Outline Business case (OBC) DRAFT to Boards (Private)	Fri 11-Dec-15	Thu 31-Mar-16
	Complete	Outline Business case (OBC) Near-final Draft - **Review** (Private Boards)		Fri 29-Apr-16
	Complete	OBC - Comments/Suggestions - FINAL FREEZE date	Fri 29-Apr-16	Wed 04-May-16
	Complete	OBC Final Draft to Project Management Board	Wed 11-May-16	Fri 13-May-16
	Complete	Trust Boards' papers published (in the public domain)		Tue 17-May-16
MOU2	On track	**OBC Public Board - Decision HHCT**		**Mon 23-May-16**
MOU2	On track	**OBC Public Board - Decision PSHFT**		**Tue 24-May-16**
	On track	**NHS Improvement - OBC Review:**	Mon 02-May-16	Fri 10-Jun-16
	On track	TDA OBC Review (6-weeks)	Mon 02-May-16	Fri 10-Jun-16
	On track	Monitor OBC Review (6-weeks)	Mon 02-May-16	Fri 10-Jun-16
	On track	**NHS I output1** = initial feedback to PMB		Tue 31-May-16
	On track	**NHS I output2** = Feedback letter		Tue 14-Jun-16
		Engagement period (93 working days)		
	Complete	Engagement Planning --> Comms plan finalised	Thu 31-Mar-16	Fri 13-May-16
		Local Elections - purdah	**Thu 07-Apr-16**	**Thu 05-May-16**
	On track	Internal Staff Briefings (HHCT & PSHFT) - pre Board	Tue 17-May-16	Fri 20-May-16
	On track	Internal Staff Briefings (HHCT & PSHFT) - post Board	Tue 24-May-16	Wed 25-May-16
		EU referendum - purdah	**Thu 26-May-16**	**Thu 23-Jun-16**
	On track	Public Engagement - 1 (to inform FBC)	Mon 27-Jun-16	Mon 19-Sep-16
		Public Engagement - 2 (post FBC)	Wed 28-Sep-16	Fri 11-Nov-16
		Ongoing communication...	Mon 14-Nov-16	Fri 31-Mar-17
		FBC - development		
	Complete	Agree FBC outline structure		Wed 13-Apr-16
	At risk	Identify / Recruit / Appoint / Procure FBC Resources	Mon 02-May-16	Mon 04-Jul-16
FBC1	On track	**Full Business Case - work commences**	**Wed 25-May-16**	Wed 20-Jul-16
	On track	*CMA - Pre-notification engagement with CMA (TBC)*	*Fri 29-Apr-16*	*Fri 17-Jun-16*
	On track	CMA - Phase 1 (pre-work? Patient Benefits case?)	Wed 04-May-16	Fri 17-Jun-16
FBC3	On track	**CMA - Phase 1***	**Mon 20-Jun-16**	**Mon 15-Aug-16**
		CMA - Phase 1 (contingency)	*Mon 15-Aug-16*	*Fri 02-Sep-16*
	On track	PSHFT LTFM	Mon 09-May-16	Fri 24-Jun-16
	On track	HHCT LTFM	Mon 09-May-16	Fri 24-Jun-16
	At risk	Due Diligence - Procurement (5-weeks shortest possible)	Wed 25-May-16	Mon 04-Jul-16
	At risk	NHSI (regulator) Procurement Business Case Approval	Mon 13-Jun-16	Fri 24-Jun-16
	At risk	Due Dilligence 1a (LTFMs) £ base case - initial report to Boards	Mon 04-Jul-16	Fri 15-Jul-16
	At risk	Due Dilligence 1b (+ other initial draft sections of FBC - TBC)	Mon 04-Jul-16	Fri 15-Jul-16
FBC2	On track	**FBC Financial Base-case (inc. external review/report) [+other sections TBC] to Trust Boards**	Mon 18-Jul-16	**Tue 26-Jul-16**
		Respond to due diligence + Boards' feedback	Mon 18-Jul-16	Fri 29-Jul-16
		Complete FBC (Inc. near final draft to Boards in August)	**Wed 27-Jul-16**	**Fri 09-Sep-16**
		Due diligence2 (Final Assurance Report)	Mon 05-Sep-16	Fri 16-Sep-16
FBC4		**Full Business Case - HHCT/PSHFT - Decision in Public**	Mon 19-Sep-16	**Tue 27-Sep-16**
		Post FBC Approval - Implementation Planning		
		Staff and Public engagement on Implementation	Mon 03-Oct-16	Fri 11-Nov-16
		Respond stakeholder/engagement feedback	Mon 03-Oct-16	Fri 18-Nov-16
		Updeated FBC (Implementation Plan)		Mon 07-Nov-16
		Due diligence / External assurance of PTIIP	Mon 07-Nov-16	Fri 18-Nov-16
		FBC + Final Implementation Plan to Trust Boards		Mon 21-Nov-16
FBC5		**Final Implementation Plan (PTIIP) - Public Boards**		**Tue 29-Nov-16**
		Transaction Approval --> Go-Live		
		Transitional Funding formally agreed & in place		Wed 28-Sep-16
FBC6		**NHS I FBC Review**	Wed 28-Sep-16	**Fri 30-Dec-16**
		Reporting Accountants	Wed 28-Sep-16	Tue 25-Oct-16
		Accounts Report - Board Approval		Tue 29-Nov-16
		Business Transfer Agreement (BTA) Draft		Tue 29-Nov-16
		BTA final for approval		Tue 06-Dec-16
		Board Transaction Approval	Mon 12-Dec-16	Tue 20-Dec-16
FBC7		**Formal Board/Governor approvals - Assurance letters**		**Tue 31-Jan-17**
		Statutory Order Granted (NHS I)		**Fri 31-Mar-17**
FBC8		**Transaction Go-Live**		**Sat 01-Apr-17**
		Implementation planning	Wed 25-May-16	Fri 31-Mar-17



Peterborough and Stamford Hospitals NHS Foundation Trust

17 May 2016

Comms action plan – phase 2 of PSHFT/HHCT collaboration work

Introduction

This communications plan charts the actions required to deliver phase 2 of the overall comms strategy. Phase 2 marks the point where the boards of Hinchingbrooke Health Care Trust (HHCT) and Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) discuss the Outline Business Case in their individual public meetings to be held in May 2016.

The plan charts the comms actions required to brief all stakeholders, which will be delivered jointly by the Chief Executives and Chairs at PSHFT and HHCT, with the support of their respective communications teams.

This plan has been written ahead of any decisions made by both boards, so the Key Messages listed below may change to reflect this.

Objectives

- To be open and transparent in our proposal to work more closely
- To give stakeholders the opportunity to contribute to the process as it develops
- To support our staff through any change processes
- To further develop stakeholder understanding of the clinical and other benefits of closer working and why service change is necessary
- Ensure communications are joined-up, consistent, credible, timely and well-co-ordinated
- Ensure we set up robust and effective and engagement systems in readiness for phase 3 (stakeholder engagement phase)

Key Messages

1. Clinically stronger by working together
2. Organisationally stronger by working together
3. Financially stronger by starting to reduce back office costs
4. Our proposals do not include any changes to A&E nor maternity services at either hospital trust

Tactics

- Public board meetings on 23 May 2016 at Hinchingbrooke and 24 May 2016 at Peterborough
- Series of CEO Open Forums to staff across both organisations
- Co-ordinated stakeholder briefings via email, telephone etc**, plus** briefings to specific groups (see action plan for how this will be delivered)
- 'Ask the CEO' email facility for all stakeholders to use
- Media interviews as appropriate

Target audiences

- Staff in both organisations (including PFI service providers at both Trusts)
- Non Exec Directors in both organisations
- Governors and members at PSHFT
- Patients in both Trust catchments
- Volunteers in both Trusts
- Union Representatives across both Trust catchments
- MPs in both Trust catchments
- Health Scrutiny Committees across both Trust catchments
- Local authorities across both Trust catchments
- Cambs and Peterborough CCG colleagues/other healthcare provider colleagues and NHS England
- GPs in both Trust catchments
- Healthwatch Cambridgeshire and Healthwatch Peterborough
- Other patient representative groups across both catchments
- National and local media/health service media
- Regulators

Communications methods

- Chairs/CEOs/Deputy CEOs attending face to face stakeholder briefings
- Dedicated intranet pages in both Trusts
- Updates on websites of both Trusts
- Targeted emails
- Handouts/flyers/slide packs
- Internal Trust publications
- Team Brief (monthly) in both organisations
- GP publications
- Member/patient publications
- Press releases/statements
- Social media channels

Action plan

Date	Action	Channel	Who	
8 Apr	Joint board meeting between HHCT & PSHFT board members #2	meeting	-	✓
13 Apr	HHCT/PSHFT Collaborative Project Board - Hinchingbrooke	Meeting	-	✓
26 Apr	PSHFT public board meeting - CEO to announce that the Outline Business Case is being discussed in public at May board meetings	Meeting	-	✓
26 Apr	Staff message re Outline Business Case being discussed in public at May board meetings issued to staff at PSHFT and HHCT	Briefing	CEO/ Comms	✓
27 Apr	Hinchingbrooke board workshop	Meeting	-	✓
28 Apr	Team Brief at PSHFT includes staff message re Outline Business Case being discussed in public at May board meetings	Briefing	CEO/ Comms	✓
29 Apr	HHCT/PSHFT Collaborative Project Board - Peterborough	Meeting	-	✓
30 Apr	March in Huntingdon to be led by MP Jonathan Djanogly in opposition of 'merger plan'.	*for info*	-	✓
4 May	Team Brief at HHCT – reinforce message re Outline Business Case being discussed in public at May board meetings	Briefing	CEO/ Comms	✓
5 May	PSHFT joint board with Council of Governors – update provided	meeting	CEO/ Execs	✓
5 May	**END OF PURDAH FOR LOCAL GOV ELECTIONS** for info only			
w/c 9 May	CQC re-inspection visit to HHCT	*for info*	-	✓
w/c 15 May	Draft to be created of messaging/other materials to be	Prep	Comms	✓

	used post board meeting re outcome			
18 May	Board meeting papers to be published on website of each Trust/press release issued	See appendix 1 for how this will be delivered	Comms	
18 May	***Note:*** *Lines to be agreed by both Trusts for use in any media interviews prior to the board meetings to ensure consistent messaging*	-	-	
23 May	HHCT public board meeting	Meeting (See appendix 1)	-	
23 May	Possible media interview requests - CEO to front any interview requests, co-ordinated by comms team	Interview (See appendix 1)	CEO/ Comms	
24 May	PSHFT public board meeting	Meeting (See appendix 1)	-	
24 May	Possible media interview requests - CEO to front any interview requests, co-ordinated by comms team	Interview (See appendix 1)	CEO/ Comms	
24 and 25 May	Stakeholder briefings to be issued post both board meetings to update key stakeholders on the next steps	Briefingss (see appendix 1)	CEO/ Comms	
25 to 26 May	Post-meeting CEO staff forums to be staged at both Trusts	Meetings (See appendix 1)	-	
26 May	Team brief at PSHFT – use to reinforce messaging to staff	Briefing (See	Comms	

		appendix 1)		
26 May	HHCT board meeting	-	-	
26 May	**START OF PURDAH – EU REFERENDUM** for info only			
31 May	Planning for engagement programme to begin	-	Comms	
1 June	Team Brief session at HHCT – use to reinforce messaging to staff		Comms	
23 June	**END OF PURDAH - EU REFERENDUM** for info only			
27 June	Start of proposed 8-week engagement programme		Comms/ PMB team	
28 July	Annual Public Meeting at PSHFT – provide update on progress		Comms/ Exec Team	

Announcement to stakeholders re Outline Business Case being discussed in public board meetings in May 2016

The table below charts the methods by which we will communicate the outcome of the board decisions taken by HHCT and PSHFT at their meetings at the end of May 2016.

Date/Time	Action	Comms channel used	Who?
26 Apr	Some stakeholders to be pre-briefed re Outline Business Case being discussed in public in May board meetings	Briefings – under embargo to: • MPs • union reps • scrutiny committees • Healthwatch • local and health media	CEO/Deputy CEO/Chair/ Comms team
26 Apr	Public board meeting at PSHFT - CEO to announce that the Outline Business Case is being discussed in public at May board meetings	meeting	
26 Apr	Message re Outline Business Case being discussed in public at May board meetings issued to staff at both Trusts	Briefing	CEO/ Comms
26 Apr	Remainder of external stakeholder briefings to be completed, as required	Briefing	
28 Apr	Team Brief at PSHFT - reminder re Outline Business Case being discussed in public at May board meetings	Briefing	CEO/ Comms

Date/Time	Action	Comms channel used	Who?

16 May	Pre-briefing issued to some stakeholders re board papers being made public	Briefings – under embargo to: • MPs • union reps • scrutiny committees • Healthwatch • local and health media	CEO/Deputy CEO/Chair/ Comms team
18 May, 9.30am	Upload board meeting papers to website of both Trusts	website	Comms
18 May, 9.30am	Message issued from CEOs to staff in both Trusts regarding board meeting dates and how they can obtain more information afterwards	Email, intranet (Remind staff how they can raise any questions they may have) Include on weekly / monthly briefing news agendas in each Trust	Comms
From 18 May, 9.30am	Briefing issued to: • All local health and social care provider partner CEOs/Chairs in Cambridgeshire and border counties (and specifically our contacts in the STP) • Healthwatch Cambs and Healthwatch Peterborough • Health scrutiny committee chairs and members • Volunteer groups at both Trusts • Friends/charity groups linked to both Trusts • Any patient group reps • PSHFT members	Call/email	CEOs/Dep CEO/HR directors/ comms *(need to agree who does what)*
18 May, 9.30am	Media embargo lifted Promote comms messaging online	• Website • Facebook • Twitter • LinkedIn	Comms team

	NOTE: *Decide whether we will engage in any interview requests, or keep to single statement only*	Interest highly likely from: • Radio • Local TV news • Local newspapers • Health media	Comms and CEOs/Dep CEO
18-20 May	Stage a succession of staff briefings throughout each Trust for staff to pose questions	Face to face briefings	CEOs/Deputy CEOs/Chairs
23 May	**Hinchingbrooke Public Board Meeting**	**Consider any media requests for cameras at the meeting**	**Comms**
23 May	Prepare for possible media interview requests	-	Comms / CEOs
23 May	CEO staff forum after board meeting	Hand out updated FAQs / briefing sheet	CEOs
23 May	Update all information for staff and stakeholders regarding the outcome of the meeting	• Media Statement • Trust intranet • Trust website • Email/verbal update to stakeholders	CEOs/ Comms
24 May	**Peterborough and Stamford Public Board Meeting**	**Consider any media requests for cameras at the meeting**	**Comms**
24 May	Prepare for possible media interview requests	-	Comms / CEOs
24 May	CEO staff forum after board meeting	Hand out updated FAQs / briefing sheet	CEOs
24 May	Update all information for staff and stakeholders regarding the outcome of the meeting	• Media Statement • Trust intranet • Trust website • Email/verbal update to stakeholders	CEOs/ Comms

25 May	CEO staff forums at both Trusts	Hand out updated FAQs / briefing sheet	CEOs/ Deputy CEOs
26 May	CEO staff forums at both Trusts	Hand out updated FAQs / briefing sheet	CEOs/ Deputy CEOs
26 May	Team Brief at PSHFT – chance to reinforce msg to leadership team etc	Briefing	CEO/Deputy CEO
27 May	CEO staff forums at both Trusts	Hand out updated FAQs / briefing sheet	CEOs/ Deputy CEOs

Appendix 16 – Risk Rating matrix

CONSEQUENCES/ SEVERITY	LIKELIHOOD					
	Impossible 0	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
No adverse outcome - 0						
Insignificant - 1		1	2	3	4	5
Minor - 2		2	4	6	8	10
Moderate - 3		3	6	9	12	15
Major- 4		4	8	12	16	20
Catastrophic - 5		5	10	15	20	25

KEY: No risk | Low risk | Moderate risk | Significant risk | High risk

RATE	LIKELIHOOD	DESCRIPTION
0	Impossible	The event cannot happen under any circumstances.
1	Rare	The event may occur only in exceptional circumstances.
2	Unlikely	The event could occur at some time.
3	Possible	The event might occur or re-occur at some time.
4	Likely	The event is likely to occur or re-occur in most circumstances.
5	Almost Certain	The event is expected to occur or re-occur in most circumstances.

RATE	CONSEQUENCE	DESCRIPTION
0	No adverse outcome	No injuries. No loss.
1	Insignificant	First-aid treatment (e.g. cuts, bruises, abrasions). Moderate financial loss.
2	Minor	Short-term medical treatment required (sprains, strains, small burns, stitches etc.) Moderate environmental implications. High financial loss/ compensation claim. Moderate loss of reputation. Moderate service interruption.
3	Moderate	Semi-permanent injury/damage (lasting up to 1 year), Over 3 Day staff injuries under RIDDOR, MDA reportable, short term sickness <4 weeks. Litigation possible but not certain
4	Major	Excessive or permanent injuries (loss of body parts, mis-diagnosis – poor progress etc.). (Major injuries under RIDDOR). Short term negative impact on recruitment and retention. High environmental implications. Serious financial loss. Serious loss of reputation. Serious service interruption. Litigation/Prosecution expected.
5	Catastrophic	Death, Toxic off site release with detrimental effect, National adverse publicity, affects large numbers of people (i.e. cervical screening disaster) Litigation/Prosecution expected/certain. Medium to long term negative impact on recruitment and retention. Major financial loss. Major loss of reputation. Major service interruption.

Appendix 17 – Current Project Risk Register – to take us up to FBC decision

Risk No.	Risk description	Risk Owner / Manager	Initial Risk rating	Last Month (Apr 16)	Current Month (May 16)	Review date	Actions to mitigate risk	Date of last update
007	Not enough of the right skilled resource is available to deliver to project milestones.	Mrs Walker	20	12	20	15/06/16	External and internal resources paper presented to PMB Specification for external resource due 31st may for approval. Organisations to identify individuals for back fill	11/05/16
014	Delay to timescales caused by OBC decision not taken until public board in May 16	Mrs Walker	16	16	16	15/06/16	Project team to continue with FBC actions despite no formal decision taken to proceed.	11/05/16
001	The two Boards do not agree to the same recommendation made in the OBC.	Mrs Walker	16	12	12	15/06/16	Hold an early board to board to manage expectations and agree a shared vision. Ensure updates are regular and detailed Ensure evidence for the options appraisal is robust Ensure all evidence, assumptions and finances are externally and independently assured Engage all regulators in supporting the recommended option of the OBC Ensure a clear clinical vision is shown in OBC External assurance on Option Appraisal process External assurance present during the Options Appraisal Preferred option discussed at Trust Board's in March 16	11/05/16
002	The CMA rule against the Boards' agreed recommendation.	Mrs Walker	16	12	12	30/07/16	Engage fully in pre-notification discussions with CMA. Work in collaboration with Monitor competition expertise Agree patient benefit case with Monitor before submission	11/05/16
004	Negative public opinion increases political influence	Mrs Walker	16	12	12	30/05/16	Robust communications and stakeholder management plan, regularly reviewed at PMB Detailed plan following OBC approval **Board decision to be taken in public so case for change can be made clearer**	11/05/16
009	Involving the CMA early in pre-notification discussions could lead to a public perception of decision already made.	Mrs Walker	16	12	12	30/05/16	Advice to be sought from previous Trusts as their approach. Clear PMB decision on when to start pre-notification as preferred options becomes clear. Robust communications plan following OBC approval	11/05/16

012	The OBC is not sufficiently robust or "fit for purpose" to support a preferred option	Mrs Walker	12	9	9	30/05/16	External assurance report from PA and two early Board comments have steered the remaining 'fit for purpose' actions. Continue to work with Monitor on confirming appropriate assurance for the OBC. Final version follows multiple improvement comments from both boards.	11/05/16
005	Focus on performance and/or quality standards dip • if staff become distracted by the rumours around the project • if key posts are vacant too long or difficult to recruit in to due to uncertainty of organisation	Mr McCarthy and Mr Graves	12	9	9	30/06/16	Regular staff briefings to keep staff updated and motivated Continuing Trust performance management frameworks	11/05/16
011	Inconsistency of messaging to stakeholders undermines project objectives via a lack of common understanding	Mrs Walker	15	9	9	30/05/16	Have one comms lead driving the plan on behalf of all organisations	11/05/16
006	Back office management becomes too diluted at any site by temporary-post sharing and: • Other key projects get delayed • Morale of individuals suffers	Mrs Walker	12	8	8	30/06/16	Execs to escalate concerns to CEO at each organisation. CEO's to discuss issues log every fortnight	11/05/16
015	Public communications between HHCT/PSHFT collaboration and STP work becomes confusing and leads to public misunderstanding, negativity and loss of reputation of the collaboration being honest.	Mrs Walker	n/a	n/a	9	11/05/16		11/05/16
010	OBC is not bold enough and/or is delayed by lack of ambition and commitment within organisations	Mrs Walker	12	9	6	30/05/16	Positive leadership from CEO level within both organisations. Covering letters and agreed executive summary make the case for change stronger. Communications internally and externally support the case for change on clinical sustainability grounds	11/05/16