Advisory

Peterborough and Stamford Hospitals NHS Foundation Trust

Recommendations of the Contingency Planning Team

12 September 2013

pwc

Reading this report

If you have 15 mins	'At a glance'- pages 5 to 8
If you have 30 mins	'At a glance' - pages 5 to 8 - and the 'Implementation of the recommended approach' - pages 52 to 64
If you have 2 hours	The whole report

Monitor
4 Matthew Parker Street
London
SW1H 9NP

Dear Sir/Madam

We report on Peterborough and Stamford Hospitals NHS Foundation Trust ('the Trust') in accordance with our agreement dated 27 March 2013.

This is our final report.

Save as described in the agreement or as expressly agreed by us in writing, we accept no liability (including for negligence) to anyone else or for any other purpose in connection with this report.

Yours faithfully

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At a glance

1 Background to the work of the CPT

On 7 June 2013, Monitor published the Contingency Planning Team's (CPT) Sustainability Report* on Peterborough and Stamford Hospitals NHS Foundation Trust (the Trust).

This report concluded that, **while clinically and operationally sustainable, Peterborough and Stamford Hospitals NHS Foundation Trust is not financially sustainable in its current form**.

This was the result of the Trust's deficit in FY13 of c.£40m and forecasts that showed that in its current form, the size of this deficit would remain for years to come.

Monitor subsequently asked the CPT to identify and evaluate options to address or reduce the Trust's financial deficit, and to recommend a sustainable approach for the delivery of the services operated by the Trust – while keeping patients' interests at the heart of the solution. For further details, see section 2 of this report from page 9.

2 Keeping patients at the heart of the solution

The CPT process represents an exciting opportunity for the patients of Peterborough, Stamford and the surrounding areas. It is a chance to step back and assess the current position of the Trust, and to consider how services should be delivered in the future while building on the Trust's achievements to date.

The key principles that underpin the recommendations outlined by the CPT in this Options Report are:

- The continued safe provision of services to the people of Peterborough, Stamford and the surrounding areas;
- Location Specific Services (LSS) defined by local commissioners should be provided at their current locations;
- The interests of patients should be put before the interests of the Trust as an organisation;
- The solution must not inadvertently impact other providers; and
- Any solution must be flexible enough to cope with changes in healthcare for the future.

The CPT has actively engaged with patient groups to discuss the process and listen to their views. Further details are provided in section 3 from page 13.

3 Keeping services within the local health economy

As part of the CPT process, local commissioners indicated that the majority of the Trust's services need to be retained at their present locations due to the lack of suitable alternative provision within the local health economy. These services are known as 'Location Specific' and, in this instance, include all major A&E services, associated non-elective activity and maternity services provided by the Trust.

This means that options developed by the CPT need to be consistent with the retention of a major healthcare facility within the Peterborough area to provide a wide range of acute and emergency services.

The CPT's recommendations do, in fact, suggest that more rather than less services should be run from the Trust's facilities – which offers exciting prospects for Peterborough City Hospital (PCH), its patients and staff. The Trust also plans to upgrade services at Stamford Hospital.

The health economy context is detailed in section 4 from page 18.

*For a copy of the Sustainability Report visit: www.monitor.gov.uk/node/3662

At a glance

4 Developing a set of options

Getting to a final set of recommendations was an extremely thorough and considered process. Through extensive engagement with the Trust, its local commissioners, neighbouring providers, patient groups and other parties, the CPT developed an initial long list of more than 30 options.

The CPT set up three advisory groups (the Operations and Finance Group, the Location Specific Service Group, and the Clinical Advisory Group), to provide expert clinical, operational and financial input into the development and assessment of these options. These groups were made up of senior representatives of organisations from across the local health economy.

All of these stakeholders were focused on one thing: finding the best sustainable solution for providing quality services to the local community. The options for delivering sustainable services are detailed in section 5 from page 25.

5 The CPT's recommendation: a four-part solution

The long list of options were refined using an evaluation framework developed by the working groups.

The evaluation process showed that no single option suggested by the advisory groups could, by itself, address the financial deficit facing the Trust. This called for thinking differently and for radical options to be considered.

As a result of the evaluation process, the CPT has identified four sets of actions which, if followed, would deliver a sustainable solution for local patients.

The CPT recommends:

1. **Tackling the inefficiency at the Trust.** Implementing a comprehensive cost improvement programme within the Trust and the local health economy, and working with providers of community and social care to free up bed capacity;
2. **Rapidly progressing joined-up working across the local health economy.** Driving cross-health economy working on revised pathways of care, longer-term contracts, capitated budgets and staff incentives;
3. **Making better use of the underutilised estate.** Redesigning an element of the physical estate at Peterborough City Hospital to provide additional beds and clinical capacity, and launching a competitive tender designed to maximise the opportunity provided by the Trust's assets; and
4. **Seeking support from the Department of Health (DH) or other national stakeholders to bridge any residual deficit.**

To deliver a sustainable solution, this four-part approach requires contributions from all parts of the local health economy, including the taxpayer.

If the Trust together with local commissioners and supported by Monitor and the DH can deliver, the CPT believes that its recommendation represents a real opportunity for patients, commissioners, local healthcare providers and staff to build on the strengths of the Trust and make best use of PCH's excellent facilities.

Section 6 from page 52 details the implementation approach for the recommended solution.

At a glance

6 Making better use of the Trust's estate

As part of the solution, the CPT recommends that the Trust undertakes an open, fair and transparent competitive tender exercise to attract offers for the Trust's services and best use of its estate. The Trust should select the proposal that provides best value to taxpayers in terms of contributing to closing its financial gap, while supporting continuity of service and high quality care to patients in the area. The process would need to be compliant with competition and other relevant legislation.

Consideration of a number of factors have led to this recommendation, including the causes of the deficit covered in the Sustainability Report, interest from other providers, legal advice and, critically, the interests of patients and taxpayers. This part of the solution is likely to make the biggest financial contribution towards tackling the Trust's deficit.

The potential outcomes of a tendering exercise could range from a merger between acute hospitals, a new operator running the Trust's services, or one or more new providers delivering services from the estate. Whatever the outcome, services would continue to be run from the PCH and Stamford Hospital sites.

7 Trust-led delivery supported by Monitor and the local health economy

The CPT believes that the key players in this local health economy, including the current Board of the Trust and commissioners, are motivated to deliver the recommended solution and are willing to drive through the changes without a Trust Special Administrator.

As a result, the CPT recommends a Trust-led leadership model, backed by enforcement action from Monitor and participation from key stakeholders from across the local health economy.

The CPT also recommends that a Peterborough Region Steering Group (PRSG) is established to further improve local health economy working. This steering group should comprise local Clinical Commissioning Groups (CCGs), the Trust and other local stakeholders. This group should be led by an independent Chair.

To provide assurance to patients and taxpayers that the Trust is committed to delivering a sustainable solution within reasonable timescales, the CPT recommends that Monitor seeks a range of undertakings from the Trust using its powers under section 106 of the Health and Social Care Act 2012 (the Act). These are legally binding commitments and should include:

- The appointment of a director and a team to deliver the proposed comprehensive cost improvement programme;
- The appointment of a director and appropriate resources to lead the proposed tender exercise and negotiations with potential bidders;
- Commitment from the Trust to cooperate with the PRSG; and
- Regular progress updates to Monitor against a set of pre-agreed milestones for each workstream.

At a glance

8 Next steps

The CPT's principal objective has been to develop a set of options for the delivery of sustainable services to the local population which address the financial issues currently facing the Trust without damaging patient care or shifting the burden onto other organisations or local populations.

Monitor will now consider whether to proceed with these recommendations.

Meanwhile, the Trust and the local health economy must continue to focus on delivering high quality services to patients.

Section 8 of the report from page 69 provides further details of the next steps.

9 About this Options Report

This report covers:

- A brief background to contingency planning;
- A summary of the CPT's review of sustainability;
- An overview of the environment the Trust operates in;
- How the CPT has developed options to address the issues identified by the sustainability review;
- A recommended approach to secure the sustainable delivery of quality services for local patients;
- The CPT's view on how the recommended approach should be implemented; and
- The CPT's view on the immediate steps that should be taken by Monitor and other stakeholders.

Background to contingency planning

Purpose of this report

This report sets out the CPT's recommended approach for sustaining the delivery of services currently provided by Peterborough and Stamford Hospitals NHS Foundation Trust.

CPT View

To identify a sustainable solution for the services currently delivered by the Trust, it was first necessary to understand the current challenges facing the Trust, and the context within which the Trust operates.

Having completed this work, the CPT worked closely with local health economy stakeholders to develop and evaluate a range of options for the Trust to reduce its deficit.

Overview

In December 2012, Monitor concluded that the Trust was at risk of being unable to meet its liabilities without continued support from DH and, as a result, appointed a Contingency Planning Team (CPT), largely comprising experts from PwC.

The CPT was appointed to develop a sustainable solution for the delivery of services currently provided by Peterborough and Stamford Hospitals NHS Foundation Trust (the Trust) to the local population.

The Trust is recording a sizeable financial deficit. Forecasts suggest this will be the case for the foreseeable future unless radical changes are made.

Purpose of this report

This report sets out the CPT's recommended approach for sustaining the delivery of services currently provided by the Trust. It outlines how the CPT established its long list of options, how it worked with stakeholders across the local health economy to identify a shortlist of options, and how its recommended approach might be implemented.

In order to give readers the context and background to the work performed, the report includes a brief history of the Trust and the events leading to the appointment of the CPT, a summary of the CPT's view on the sustainability of the Trust, and an introduction to the local health economy.

Monitor's role in supporting service continuity

The Health and Social Care Act 2012 (the Act), established Monitor's core duty to protect and promote patients' interests. Monitor is specifically required to support commissioners in delivering continuity of NHS services to those individuals who require them including in the event of the failure of a healthcare provider.

Monitor has a range of regulatory tools with which it can carry out this role, including its provider licence, its enforcement regime, and legislative powers to commence Trust Special Administration (TSA) and, in the case of some private providers of NHS-funded care, apply to court for a Health Special Administration order (HSA).

Under its general powers, Monitor can also appoint a CPT to a healthcare provider to protect and promote the interests of patients in order to ascertain the facts and determine the appropriate regulatory response.

The work of the CPT is similar to that of an independent business review of a challenged organisation in the private sector, commissioned by financial investors to establish a way forward that maximises the value of the business for the benefit of the shareholders, being in this case the taxpayers. The crucial difference with a CPT is that its primary objective is to find a way of securing the healthcare services required by the population currently served by a financially distressed organisation.

Role of the CPT

Monitor appointed the CPT to establish whether the Trust is sustainable and to identify potential solutions to the financial challenge facing the Trust, including a long-term plan for the services delivered by the Trust.

CPT View

Initially, the CPT met with a wide range of national and local stakeholders to help develop a long list of options.

The scope and benefits of the CPT's work

The people of Peterborough, Stamford and the surrounding areas rightly expect their local health services to be the very best; with the highest standards of care, delivered efficiently, effectively and with compassion by appropriately qualified staff.

The role of the CPT is to explore wide-ranging options to resolve the Trust's financial challenges and to recommend a sustainable solution – or a number of recommendations – for providing quality services for local people.

As such, the CPT process represents a real opportunity; it is a chance to step back and assess the current position of the Trust, consider how services could be delivered in the future and look at how the Trust can build on its achievements to date.

The core objectives for the CPT are to:

- Independently assess the financial, clinical and operational sustainability of the Trust in its current form;
- Explore the options available to reduce the cost of the Trust's Private Finance Initiative (PFI);
- Work with commissioners to identify those services that need to be maintained at their current location in the event of provider failure;
- Establish wide-ranging options for reducing the deficit at the Trust;
- Make recommendations on the future configuration of the services currently provided by the Trust to ensure that they are delivered on a sustainable basis for the benefit of the local population; and
- Evaluate whether the proposed changes should be delivered through consensual restructuring or via Trust Special Administration.

Monitor's press release regarding the appointment of the CPT can be found on its website.[1]

Importance of stakeholder engagement

Listening to stakeholders' views has been critical to each stage of the CPT's work. The CPT has spent a significant amount of time meeting with, and considering the views and ideas of a wide range of individuals and organisations.

This has included multiple meetings with local stakeholders such as the Trust Board and Executives, Chief Executives of local providers and patient groups, local commissioning groups and national stakeholders, such as the Department of Health.

Throughout the review, a huge amount of rigorous debate and challenge took place around a wide range of potential options. This was essential in shaping the approach developed by the CPT, and will be critical to the success of the work ahead.

[1] http://www.monitor-nhsft.gov.uk/home/news-events-publications/latest-press-releases/press-release-archive/2012/monitor-seeks-long-te

Phases of work

Contingency planning commenced with a comprehensive review of the Trust's current operations.

CPT View

The CPT's work to date has concluded that the Trust is unsustainable in its current form due to its financial difficulties, and that solutions should be sought in order to secure sustainable delivery of services to patients.

In developing options, the CPT was mindful of the need to mitigate the risk of destabilising other healthcare providers or local commissioners.

Work done to date by the CPT

In June 2013, following the CPT's independent review of the Trust between February and May 2013, Monitor published the CPT's conclusions on the sustainability of the Trust.

The CPT's principal conclusion was that the Trust is currently operationally and clinically sustainable, but the financial performance of the Trust means that, in its current form, it is not financially sustainable.

A summary of findings can be found in section two of this report.

Developing options to address or reduce the financial deficit

This report covers the CPT's evaluation of options to address or reduce the financial deficit, and its recommended approach for the sustainable delivery of the services currently provided by the Trust. The CPT has been tasked by Monitor to recommend a clinically and operationally sustainable solution that would, as far as possible, address the Trust's financial challenges.

Given the scale of the financial challenges faced by the Trust, the CPT recognised the need to think differently and consider radical options for the local health economy as a whole.

However, the CPT also recognised that too often the NHS 'radical options' simply shift financial challenges from one organisation to another and risk destabilising other stakeholders in the local health economy. It believes that such options cannot provide long-term sustainability for patients. The CPT has therefore looked to understand and integrate these broader impacts when evaluating options and in recommending an approach. The CPT has also assessed potential options for their alignment with future commissioning intentions and service developments to create a solution that is consistent with the strategy developed by local CCGs and specialist commissioning teams.

Review of sustainability

Financial challenges at the Trust have led to the appointment of a CPT

Despite a history of good financial performance, the Trust has struggled financially since FY12. Monitor appointed a CPT in March 2013 ,due to concerns over the financial viability of the Trust.

CPT View

Since moving to the new Peterborough City Hospital site, the Trust has been under considerable financial strain, which has resulted in regulatory action by Monitor. Despite some improvement in the financial performance of the Trust, a substantial deficit remains.

The CPT's review of sustainability

Monitor appointed the CPT in March 2013. The first task for the CPT was to conduct an independent review to determine whether the Trust is sustainable in its current form.

The review took place between March and May 2013 and looked at the sustainability of the Trust from three perspectives: operational, clinical, and financial.

This section provides an overview of the methodology and conclusions of the CPT's Sustainability Report*.

Further information setting out an overview of the Trust and the financial position are also provided in the CPT's Sustainability Report.

Operational sustainability

The CPT assessed the Trust as being operationally sustainable in its current form.

Operational sustainability is the extent to which the Trust has the necessary organisational structure, operating model, governance, risk management procedures and operational processes to achieve its corporate objectives and long-term strategy.

Key operational strengths and challenges identified from the review are:

- A comprehensive Trust strategy;
- Board members with a background and experience suited to an organisation in financial distress;
- Evidence of a transparent culture in relation to high levels of incident reporting;
- Evidence of improvements in several areas, although the rate of progress in implementing some changes has been slow;
- Implementation of a revised operating model that must establish a track record of performance;
- A recent track record in delivering Cost Improvement Plans (CIPs), but in an environment of growing activity;
- Development of Service Line Reporting;
- Creation of a comprehensive Board development programme;
- Cause for concern that the breadth of the agenda facing the Trust may limit the rate of progress; and
- Historically low clinical engagement in the CIP and change programme and limited track record in holding directorates to account for performance.

Clinical sustainability

The CPT assessed the Trust as being clinically sustainable in its current form.

Clinical sustainability is determined by the delivery of acceptable levels of clinical performance and the prospect that performance will continue in the long - term (three to five years).

Key operational strengths and challenges identified from the review are as follows:

- Key Performance Indicators reviewed demonstrate that clinical quality is appropriate and, on the whole, the Trust operates within acceptable levels of performance;
- Trust mortality indices indicate acceptable clinical safety in comparison to national peers;
- A recent (February 2013) CQC inspection revealed areas for improvement, although the overall Quality

*For a copy of the Sustainability Report visit: www.monitor.gov.uk/node/3662

Operational and clinical sustainability

The CPT assessed the Trust's operational and clinical sustainability.

The CPT tested the Trust's financial sustainability over three key areas.

CPT View

The Trust is clinically and operationally sustainable in its current form.

The Trust does not pass the test of financial sustainability due to operational and estates-related issues. The result of these is a cash shortfall of at least £40m per year for each of the next five years.

The CPT recommended to Monitor that solutions should be sought to secure the sustainable delivery of services to patients.

and Risk Profile (QRP) indicated no high risks of non-compliance;

- The Trust has shown overall improvement in clinical quality in the last 12 months;
- The Trust has not consistently met the four-hour A&E target, and this is an area the Trust is currently focused on;
- The Trust's catchment population is within recommended limits for a District General Hospital (DGH) and, where the population for some services is too small, the Trust provides these as part of a wider network; and
- The Trust's clinical sustainability is partly dependent on commissioners' plans (such as demand management plans for A&E attendance).

Financial sustainability

The CPT assessed the Trust as not being financially sustainable in its current form.

Financial sustainability is determined by the Trust's ability to:

1. Return to, and maintain, a surplus;
2. Generate cash; and
3. Pay its debts as they fall due.

The Trust incurred an underlying c.£37m deficit in FY13 compared to a total income of c.£223m. In addition, and like other foundation trusts, it is faced with the ongoing challenge of needing to be c.4.5% more efficient in future years in order to counter the effects of cost inflation and tariff deflation.

The Trust's forecasts for the next five years show a deficit of £38m or more each year and a cash shortfall of at least £40m each year.

On the advice of the CPT, the Trust prepared upside and downside scenarios to illustrate a range of potential outcomes. However, even the upside scenario does not show the Trust returning to surplus.

The CPT concluded that the Trust is not financially sustainable, the key reasons being:

- The level of the deficit in FY13 and for the next five years is very large relative to the income of the Trust;
- To eliminate the deficit by cost reduction alone will not be possible. The ongoing efficiency requirements in the NHS are c.4%-5% for the foreseeable future. The Trust has already forecast a challenging level of efficiencies that comprise the national targets and a degree of 'catch up' towards its peers' performance;
- The commissioners' intentions regarding the level of patient activity being directed to the Trust mean the Trust cannot 'grow' its way to reducing the deficit;
- If the CPT were to sensitise the Trust's forecasts the risks would be weighted to the downside, in recognition that the outer years of the forecast are reliant on local health economy strategies rather than the Trust acting in isolation; and
- None of the tests regarding financial sustainability are met by the Trust.

Financial sustainability

The causes of the Trust's deficit can be split into two broad categories, being operational issues and estate issues.

CPT View

Of the c.£40m deficit reported in FY13, £18m could be attributed to operational-related issues, and £22m could be attributed to estate-related issues.

In the absence of any corrective action over the next five years, this deficit will increase due to a forecast decrease in commissioned activity and inflation of PFI-related costs.

Causes of the deficit

To generate a normal surplus the Trust would have to close the £37m deficit and achieve a further £3m of contribution. The Trust is therefore a total of £40m away from a normal level of surplus. The causes of this difference, in FY13, can be split into two categories:

Operational issues - £18m

- The CPT has identified that improving performance across a set of operational measures , e.g. improving theatre utilisation, would reduce the deficit by £10m when comparing the Trust against average performance of similar sized organisations;
- The Trust undertook £5m of activity outside its contract in FY13 for which it was not paid; and
- There are £3m of additional operational improvement opportunities which could be achieved, including a reduction in the outsourcing of elective activity.

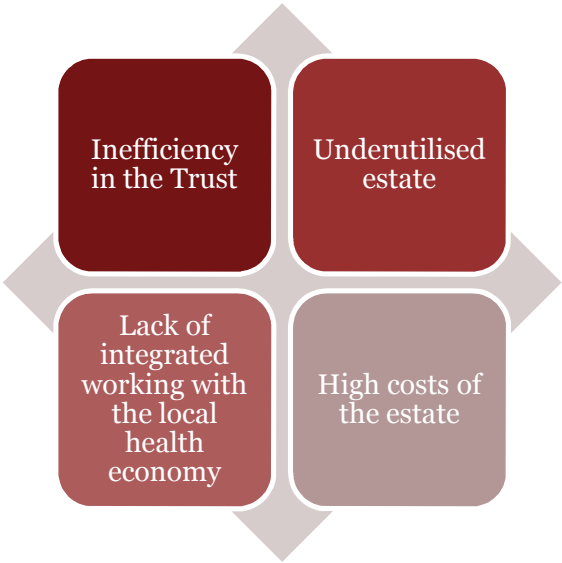
Estate issues - £22m

- Space utilisation. The Trust has identified that additional wards could be accommodated on the fourth floor at PCH, which could bring in additional income and contribution to the deficit, estimated at £9m;
- Private Finance Initiative (PFI) cost. Although the PFI deal was competitive when signed, its unitary charge on a per-bed basis is higher than the average for other projects. Broadly, the PFI is £3m per annum more expensive than its peers; and
- Tariff is calculated as an average across a wide range of Trusts and therefore may not match the costs of Trusts which are significantly exposed to recent PFI funded investments. Given the scale of the Trust's PFI, the value of this effect has been estimated at £10m.

In addition, the CPT has considered the long-term (within the next 5 years) elements of the Trust's deficit. It noted that, in the absence of any corrective action, the Trust's deficit would deteriorate marginally every year as a result of the commissioners' plans to move activity away from an acute setting and due to the level of PFI inflation that is not covered by additional income.

The relevance of causes of the deficit to this report

In the review of sustainability, the CPT identified a number of factors that have led to the current financial challenges facing the Trust. They can be grouped into four areas:



Causes of the deficit and relevance to options

Identifying the underlying causes of the financial deficit is an important step in developing options.

CPT View

The causes of the financial deficit can be grouped into four areas. While the balance of these factors changes over the medium-term, each factor remains significant and will need to be addressed if sustainable services are to be delivered to local patients.

The CPT has mapped the causes of the deficit against these four areas.

Operational issues

- Inefficiency in the Trust – areas where the Trust is performing less efficiently than its peer group;
- Lack of integrated working with the local health economy – uncontracted activity and operational improvement opportunities.

Estate issues

- Underutilised estate – space utilisation; and
- High cost of estate – Private Finance Initiative (PFI) and tariff.

This grouping of the causes of the deficit provides a useful foundation for thinking about solutions to the challenges identified, as it is the CPT's view that a targeted approach to each of the causes of the deficit is most likely to lead to a sustainable solution for patients and taxpayers.

Location Specific Services

The CPT has been supporting commissioners to identify services that must continue to be provided at the location of the Trust's sites in the event of its failure, due to the absence of suitable alternative provision. These are known as Location Specific Services (LSS).

The nature of commissioners' views on LSS means that the options developed by the CPT need to be consistent with the retention of a major healthcare facility within the Peterborough area to provide a wide range of acute and emergency services.

The CPT options are based on the provision of these services as a minimum.

Further detail on LSS is provided in appendix 1 to this report.

Health economy context

Health economy context

This chapter considers both national and regional trends and the nature of supply and demand within the local health economy.

CPT View

The NHS is undergoing radical reform in order to address the combined challenge of a constrained financial settlement and rising healthcare needs. These changes are likely to impact on the Trust in its current form and options developed by the CPT need to take account of these trends.

Health economy context

This section of the report provides a high-level view of the context within which the Trust is currently operating and the trends that must be taken into account when considering a sustainable solution for patient services.

The chapter considers both the national and regional trends and the nature of supply and demand within the local heath economy.

National context

Over the next decade the population of the UK is expected to grow by 9%. At the same time, the average age of the population is likely to increase, resulting in growing demand for healthcare.

Between 2000/01 and 2010/11, NHS spending increased by almost 7% per annum in real terms. With the impact of the credit crunch and the related period of austerity in public finances, it is unlikely that healthcare expenditure will experience significant growth in the short to medium-term.

As a result, while healthcare needs will be growing commissioners' budgets are not expected to change by much more than 0.1% in real terms per annum[3].

To address these changes, the government has brought forward a number of reforms to the NHS operating environment during recent years. These include expansion of the role of choice and competition and the introduction of a failure regime. Aligned to this, commissioners across the NHS have begun to explore how services might be reconfigured across local healthcare systems in order to provide greater efficiency, while at the same time improving outcomes and access. The key trends have been the consolidation of specialist services in regional centres to drive improvements in quality and efficiency through economies of scale, and greater use of community provision in order to provide care closer to home and reduce cost.

These developments are likely to affect all providers, but District General Hospitals (DGHs), such as Peterborough and Stamford, are likely to be affected more severely as they will face increasing competition for elective care from market entrants, and reduced demand from commissioners seeking to improve quality and efficiency and bring care closer to home.

The options developed by the CPT take account of these trends and enable the delivery of sustainable DGH services over the medium -term.

[3]Department of Health, ONS, The Kings Fund

Demand side characteristics of the local health economy

Emerging demographic, fiscal, behavioural and policy trends represent important future challenges for the principal commissioners of services from the Trust.

CPT View

In developing recommendations, the CPT has been mindful of the healthcare needs of the local population and has worked with commissioners to evaluate options.

Local healthcare needs

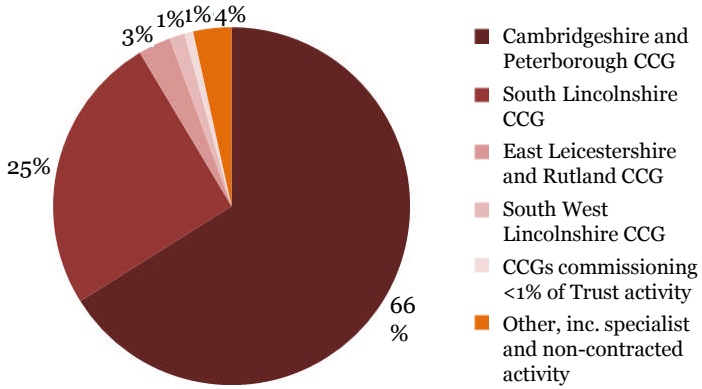
The CPT expects future healthcare needs to be impacted by three trends related to demography:

1) Forecasts suggest that the population in and around Peterborough will grow significantly over the next 10 years - 1.2% p.a. (UK average 0.8% p.a.)[4]. This will impact demand for acute, community-based and social care.

2) Peterborough currently has a relatively young population. Forecasts suggest that the number of births in Peterborough will increase by 16% over the next 10 years, notably above the national average of 10%. This will increase demand for maternity services.

3) Longer life expectancies mean that a higher proportion of the population will be living with chronic diseases. This could place significant demands on commissioner budgets, as well as impact the type and complexity of acute care that is likely to be required in the area.

The Trust's principal commissioners by proportion of activity in FY12



Local commissioning context

In FY12, 91% of the Trust's activity was commissioned by just two CCGs: Cambridgeshire and Peterborough (C&P) CCG and South Lincolnshire (SL) CCG. As the chart shows, the remaining 9% came from a small group of additional CCGs and other sources, such as specialist and non-contracted activity.

Cambridgeshire and Peterborough CCG

C&P CCG is one of England's largest CCGs. The CCG is a federation of eight local commissioning groups, covering all GP practices in Cambridgeshire and Peterborough plus five in North Hertfordshire and Northamptonshire. The 109 practices cover a diverse and ageing population of 864,000 and had a total budget of £854m for FY13. The CCG deals mainly with four providers in addition to the Trust: Cambridge University Hospitals, Hinchingbrooke, Cambridge and Peterborough FT, and Cambridge Community Services.

South Lincolnshire CCG

SL CCG comprises 15 GP practices, split into two localities, and covers a population of 170,000 with a budget for FY13 of £179m. SL CCG was one of four CCGs formed from Lincolnshire PCT.

SL CCG commissions services primarily from the Trust, United Lincolnshire Hospitals NHS Trust, Lincolnshire Community Health Services NHS Trust and Lincolnshire Partnership NHS Foundation Trust.

[4] Office of National Statistics population forecasts

Demand side characteristics of the local health economy

NHS commissioners – across England and in this local health economy – have plans to move activity out of acute trusts and into other settings of care.

CPT View

As part of the CPT's work it is critical to understand commissioning intentions and key schemes that are underway. In developing options the CPT has:

- *Been mindful of the financial pressures facing commissioners and how this may impact income at the Trust; and*
- *Considered how options are aligned with future commissioning intentions so that options reinforce the needs of commissioners, rather than work against them.*

Local commissioners' strategic challenges

While both CCGs have considerable continuity with the PCTs that preceded them, both have only been formally responsible for commissioning services since April 2013. This means that both CCGs have a relatively short track record in shaping local NHS services.

Commissioning intentions

Whilst the Trust's internal plans are of primary importance, CCG commissioning intentions equally influence the sustainability of the services provided by the Trust. The CPT has therefore considered the key commissioning intentions of Cambridgeshire and Peterborough CCG and South Lincolnshire CCG. They are broadly to:

- Reduce emergency bed days for unplanned admissions of older people;
- Increase as far as possible elderly patients receiving care at home or in the local community;
- Improve care for frail and elderly patients and improving end of life care;
- Tackle health inequalities across the CCGs catchment area;
- Reduce the percentage of mothers smoking at the time of delivery;
- Reduce the number of emergency bed days for patients over 75; and
- Improve primary prevention for cardiovascular disease (CVD).

The CPT also reviewed key schemes that are underway, including:

- The commissioning of an Older People Programme, which includes a new elderly care service as part of the future plans for services in Cambridgeshire and Peterborough. The Older People procurement is at PQQ (pre-qualification questionnaire) stage. If the frail elderly population rise at predicted rates, it will be imperative that a whole system approach is implemented to ensure best care for patients. The approach of a full system change to improve A&E performance is also outlined in the latest NHS England Gateway report (ref 00062).[5] The Trust and C&P CCG continue to work closely together on this and the Older People Programme has been considered as part of the recommendations in this report; and
- The provision of an upgraded GP-led minor injury and illness unit at the Peterborough City Care Centre from July 2013.

Impact on development of options

In developing options, the CPT has:

- Been mindful of the financial pressures facing commissioners and how this may impact income at the Trust; and
- Considered how options are aligned with future commissioning intentions so that options reinforce the needs of commissioners rather than work against them.

[5] Accessed at, http://www.england.nhs.uk/wp-content/uploads/2013/05/ae-imp-plan.pdf , on 31 May 2013

Supply side characteristics of the local health economy

There are a large number of alternative providers of NHS, private and community care within the local health economy.

CPT View

It is likely that a number of local providers will seek to form networks and partnerships in order to improve quality and efficiency. This dynamic represents both a threat and an opportunity in developing options. For example, it is important that options take into account existing and future networks operated by providers, and consider the impact of options on those networks. Conversely, there may be opportunities for options at the Trust to create more sustainable solutions for other health economies.

Alternative providers of healthcare

Across the local health economy there are a large number of alternative providers of healthcare services to the NHS. This includes four acute foundation trusts, five acute NHS trusts, two mental healthcare trusts and two community services trusts.

Providers of acute medical services to the NHS

Within the local health economy there are a number of DGHs that provide a range of routine secondary, acute, and hyper-acute care services for the NHS. A small number of these organisations have already highlighted the importance of networks and partnerships in order to remain viable over the medium-term.

In addition to the DGH providers, there are two specialist providers: Papworth Hospitals NHS Foundation Trust (Papworth), the UK's largest specialist cardiothoracic hospital, and Cambridge University Hospitals NHS FT (CUH), a national centre for specialist treatment and biomedical research. These two trusts are currently pursuing a strategy of co-location in order to develop market-leading specialist services for the NHS. This strategy includes the development of a new PFI-funded facility for Papworth on the main CUH site.

In addition to the major publically-owned healthcare providers, there are eight private hospitals that deliver a range of services to the local NHS alongside their work in the privately-funded healthcare market.

Providers of non-acute NHS funded services

The local health economy also contains community services and mental health trusts in Lincolnshire, a community services trust covering the Cambridgeshire area and a mental health trust covering Cambridgeshire and Peterborough.

Consideration of Papworth within the solution set for the Trust

As noted, Papworth is seeking to move from its current facilities to a new 310-bed PFI building at CUH. It is currently seeking approval from the DH and HM Treasury to proceed with the procurement of this facility.

While the CPT considered options that included hosting Papworth at the Trust, Papworth Board's current view is that there are significant future clinical synergies to co-locating with Addenbrooke's Hospital, which would support their aim to further enhance the services they offer. Furthermore, the Peterborough Board do not feel that these same benefits could be achieved at Peterborough Hospital and that co-location at PSHFT would present significant clinical and operational barriers to the extent that this would be unworkable. The Clinical Advisory Group agreed with this view and noted that Papworth's PFI proposal was subject to a separate review by national bodies and so this option was not progressed further through the CPT's work.

Summary of providers within the local health economy

There are a range of acute providers in the local health economy

CPT View

A number of these organisations are struggling to retain their current portfolio of services and are looking to form networks and partnerships in order to continue to serve the needs of their local populations.

	Size and specialism *	CQC	Monitor	Other
Cambridge University HospitalsNHS FT	*Turnover: £617m* DGH and national centre for specialist treatment and biomedical research	• Compliant at last inspection (published December 2012).	• The Trust is in breach of its licence for persistent failure of the 62 day cancer, referral to treatment, A&E targets and poor financial performance and governance.	• World-class reputation as a medical teaching and cancer centre. • The Trust plans significant expansion of routine secondary activity, of its specialist activity, and of biomedical research.
Hinchingbrooke Health Care NHS Trust	*Turnover: £107m* DGH covering a population of 160,000 in western Cambridgeshire	• Compliant at last inspection (published December 2012).		• Positive patient satisfaction survey results reported since the Circle franchise began in 2012. The first Trust whose management functions are delegated to the private sector. Circle took over a ten-year franchise and offers a growing number of joint consultant appointments to expand services.
Kettering General Hospital NHS FT	*Turnover: £190m* DGH covering a population of 300,000 in north Northamptonshire	• Non-compliant (published August 2013) regarding regulations 9 (care and welfare), against which a Warning Notice was issued and remains in place, and 11 (safeguarding people from abuse).	• The Trust is in breach of its licence for persistent failure to meet the four hour A&E target and poor financial performance and governance.	• The Trust is increasing its co-working with Northampton General Hospital NHS Trust. • Its current business plan is 'to consolidate and develop' its position as the 'secondary care provider of choice' in its area.
Papworth Hospital NHS FT	*Turnover: £129m* UK's largest specialist cardiothoracic hospital and main heart and lung transplant centre	• Complaint at last inspection (published December 2012)		• The Trust has proposed a 310-bed, £165 million PFI on the Cambridge Biomedical Campus, with increased clinical and research integration with CUHFT. The business case for this development is awaiting approval. • International reputation for cardiothoracic services and related clinical research.
Queen Elizabeth Hospital, King's Lynn NHS FT	*Turnover: £165m* DGH covering a population of 250,000 primarily in West Norfolk	• Non-compliant (published August 2013) regarding nine regulations: 9 (care and welfare); 10 (assessing and monitoring); 13 (management of medicines); 17 (respecting and involving people); 18 (consent to care and treatment); 20 (records); 22 (staffing); 23 (supporting workers); and 24 (cooperating with other providers).	• The Trust is in breach of its licence for poor financial performance, failure to demonstrate how the Trust could return to financial sustainability and potential quality governance concerns.	

•Information sourced from most recent financial accounts
•Note: The CQC and Monitor information on these provider organisations is based on the latest publically available information as at June 2013

Summary of providers within the local health economy

There are two local mental healthcare providers and two community service organisations in the local health economy.

CPT View

Cambridge Community Services' application for foundation status was not supported by Cambridgeshire and Peterborough CCG and its portfolio of services is being put out to tender by the CCG.

•Information sourced from most recent financial accounts
•Note: The CQC and Monitor information on these provider organisations is based on the latest publically available information as at June 2013

	Size and specialism*	CQC	Monitor	Other
United Lincolnshire Hospitals NHS Trust	*Turnover: £408m* Three main hospital sites covering a population of 700,000 across Lincolnshire	• Non-compliant at 3 locations: Lincoln County Hospital (published January 2013) regarding regulation 22 (staffing); Pilgrim Hospital (published February 2013) regarding regulations 9 (care and welfare) and 22 (staffing); and Grantham and District Hospital (published April 2013) regarding regulations 22 (staffing) and 23 (supporting workers).		• In July 2013 the NHS Trust Development Authority ("TDA") confirmed that five trusts, including ULHT, will be placed into special measures.
Cambridgeshire Community Services NHS Trust	*Turnover: £158m* Comprehensive health and social care across Cambridgeshire, plus other services in Luton, Peterborough and Suffolk	• Non-complaint at two locations: Hinchingbrooke Hospital Holly Ward (published April 2013) regulations 9 (care and welfare) and 15 (safety and suitability of premises); and the Priory (published April 2013) regarding regulations 10 (assessing and monitoring the quality of provision) and 22 (staffing).		• In October 2012, NHS Midlands and East concluded the Trust would not continue its journey to become an FT. The Trust Development Authority will lead the process to identify a sustainable future for the trust.
Cambridgeshire and Peterborough NHS FT	*Turnover: £164m* Mental health and specialist learning disability services across Cambridgeshire and Peterborough, and children's community services in Peterborough	• Non-compliant: MH Services (CPFT) at Addenbrookes (published August 2013) regarding regulations 11 (safeguarding people who use services from abuse) and 22 (staffing).		• The Trust's vision sees it becoming an integrated mental health and long-term conditions organisation and a major provider of 'out of hospital' care in the East of England. • Increased collaborative work with the region's acute trusts is envisaged.
Lincolnshire Community Health Services NHS Trust	*Turnover: £109m* Comprehensive health and social care across Lincolnshire	• Compliant at last inspection (published April 2013)		• The Trust's strategic objectives relate largely to consolidation: providing high-quality services, improving the patient experience, a quality-driven financial strategy and community engagement.
Lincolnshire Partnership NHS FT	*Turnover: £98m* Specialist health services for people in Lincolnshire with learning disabilities and mental health, drug, or alcohol problems	• Compliant at last inspection (published August 2013)		• The Trust's current business plan focuses on developing an innovative clinical strategy and new models of care, an internal organisational development and people plan, and a business development strategy to support the Trust's growth and market positioning.

Options for delivering sustainable services

Approach to addressing the sustainability challenges

The CPT has considered how a combination of different options might address or materially reduce the financial deficit facing the Trust.

CPT View

A comprehensive solution is required that capitalises on efficiency opportunities, makes better use of the estate, facilitates better working across the local health economy and addresses some of the high costs of the PFI building.

Developing sustainable services for patients

The aim of this phase of work has been to identify a way forward for the Trust that can:

- Create a solution which is clinically, operationally and financially sustainable, delivering quality services for people served by the Trust;
- Address or materially reduce the financial deficit of the Trust;
- Maintain operational and clinical performance; and
- Is supported by commissioners and other local providers.

What is a sustainable solution for the Trust?

The objective of the CPT was to find a mechanism by which the Trust could be judged to be sustainable using the tests set out in the sustainability review.

Structure of this chapter

This chapter sets out how the CPT, in partnership with the local health economy, has identified and evaluated options to address or materially reduce the deficit faced by the Trust.

It also sets out the CPT's proposed approach to creating a sustainable solution for the services currently delivered by the Trust.

Key principles underpinning the development of the recommended options:

- The continued safe provision of services to the people of Peterborough, Stamford and the surrounding areas;
- The different causes of the deficit require targeted solutions;
- The LSS required by commissioners need to be provided at their current locations;
- The proposed solution must not inadvertently impact other providers; and
- Any solution must be flexible to cope with changes in healthcare for the future.

Contribution required from a single solution

The size of the financial deficit means that any single solution would require either a drastic change to reduce cost or grow revenue, or a significant contribution from a single party, as highlighted in the examples below.

15%

The Trust would need to reduce its cost base (including the PFI) by 15% in one year to address the gap

26,800

Activity would need to increase by 26,800 inpatient spells (39%) at PCH to address the gap

£40m

Taxpayers would be required to fund £40m annually to address the gap

*Figures are the amount required to close the year 1 deficit and do not take into account inflation or anticipated changes to the deficit in future years

Developing options

The challenges facing the Trust require the CPT to consider all potential options and to build on existing ideas from within the local health economy.

Identifying and evaluating options

Given the scale of the financial deficit facing the Trust and the nature of the underlying causes, it was necessary to collect as many ideas as possible and consider options from a wide range of sources. Equally, due to the nature of the problems facing both the Trust and the local health economy, it was essential that the CPT's analysis built upon the earlier work of others as much as possible.

As a result, the CPT's process for identifying options included face-to-face meetings with key stakeholders, close working with the CPT's advisory groups, the insight of CPT members and a review of existing analysis conducted by the local health economy.

One-to-one meetings with stakeholders

The CPT conducted face-to-face meetings with management and staff from the Trust, with senior representatives from nearby NHS healthcare providers and the Trust's main commissioners.

Close working with advisory groups

The CPT formed three advisory groups comprising operational, financial and clinical representatives from local providers, commissioners and NHS England Area Teams, as well as representatives from patient groups. Each of these groups contributed its expertise to the process and helped the CPT to develop options and a framework by which to evaluate them. Importantly, they helped the CPT understand the deliverability of potential options given the local health economy context, and the impact of the options on other providers.

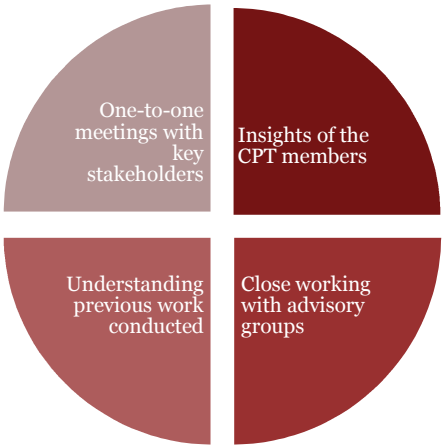
Understanding previous work conducted

In addition to reviewing relevant publicly available reports prepared by the Trust[6], the National Audit Office[7] and the House of Commons Committee of Public Accounts[8], the CPT reviewed previous work conducted by organisations within the local health economy.

Insight of the CPT members

Members of the CPT brought their insight and experience from previous work in this area.

Inputs into the development of options



[6]Peterborough and Stamford Hospitals NHS Foundation Trust - Business Case, FY12/13 to FY16/17. Draft: 31 May 2012 (Revised - 13 July 2012)
[7]Peterborough and Stamford Hospitals NHS Foundation Trust - Report by the Controller and Auditor General, National Audit Office, November 2012
[8]House of Commons Public Accounts Committee - Twenty-Eighth Report, Department of Health: The Franchising of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust', January 2013

Working with local health economy participants

The CPT worked closely with key stakeholders from the Trust and the local health economy to guide, challenge and inform the options process.

CPT view

Options have a higher chance of success if supported by other stakeholders in the local health economy.

Engaging stakeholders

In order to secure strong engagement from stakeholders across the local health economy, the CPT formed three core working groups that have checked, challenged and advised the CPT in the development and evaluation of options. Each working group was independently chaired. The three groups and their functions are explained below.

Clinical Advisory Group (CAG)

This group provided independent clinical advice and challenge to the CPT and local stakeholders, ensuring that, where appropriate, the work of the CPT was informed by clinical evidence and judgements.

The group comprised:

- An independent clinical chair;
- Clinical directors from the Trust;
- Clinical representatives from Cambridgeshire and Peterborough CCG and South Lincolnshire CCG;
- Senior clinical representatives from 12 acute, community, mental, and ambulance trusts from across the local health economy; and
- Senior representatives from the CPT.

Location Specific Services Group (LSSG)

This group supported the Trust's main commissioners in developing a working list of LSS, and provided input to the development of options from a commissioning perspective.

The group comprised:

- An independent clinical chair;
- Senior clinical and managerial representatives from Cambridgeshire and Peterborough CCG and South Lincolnshire CCG;
- Representatives from NHS England's East Anglia Area Team and Leicestershire & Lincolnshire Area Team;
- Healthwatch for Cambridge and Peterborough; and
- Senior representatives from the CPT.

Operations and Finance Group (OFG)

This group worked with the CPT to inform options development and to ensure that the CPT took account of the implications of options on other providers.

The group comprised:

- An independent chair;
- The Trust's Chief Executive Officer and Director of Finance;
- A Finance Director, Operations Director, or other appropriate Director from 12 acute, community, mental, and ambulance trusts from across the local health economy; and
- Senior representatives from the CPT.

Other stakeholders

The CPT has also engaged with over 400 individuals at the Trust, covering a wide range of staff, and other stakeholders, including patient representatives, Members of Parliament and local councillors.

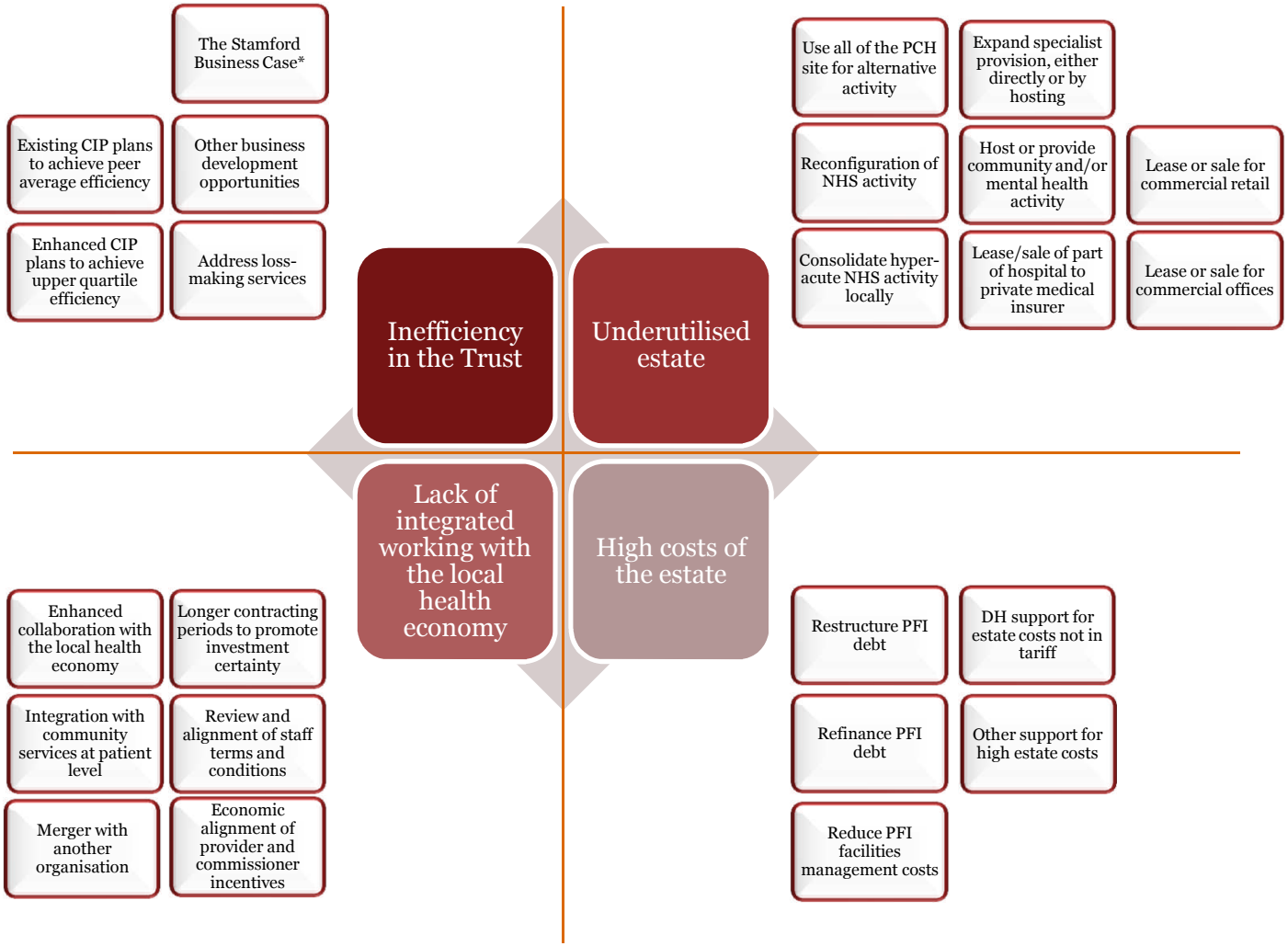
Long list of options

A wide range of options were suggested by stakeholders.

CPT View

The CPT developed an initial long list of options, considering all potential areas, and grouped against the four key challenges identified in the sustainability review.

The CPT and its stakeholders developed a long list of options against the four key challenges identified in the sustainability review. This list was tested with each of the CPT's advisory groups to validate the comprehensiveness of the options. The CPT then evaluated each option using a range of qualitative and quantitative analysis, the results of which are set out in the pages that follow.



*The redevelopment of Stamford Hospital and other business development opportunities have been grouped together with options to address inefficiency, as they relate to smaller scale changes that the Trust is looking to pursue to reduce the deficit and improve its operational performance.

Both the Stamford business case and the business development opportunities are discussed in the sustainability report on page 81 and in Appendix P, respectively.

Establishing the options evaluation criteria

An evaluation process and framework was developed with support from the CPT's advisory groups.

CPT View

Working with the advisory groups, the CPT identified four criteria against which each option should be appraised and identified what a high scoring option would look like for each of the criteria.

Establishing the evaluation criteria

The CPT, in partnership with its advisory groups, developed a framework to evaluate the options. The design of the framework was guided by four principles developed by the advisory groups (see right)

For each part of the evaluation framework, the CPT developed descriptions of what good and poor performance would look like. These are set out in the box below. With the evaluation framework in place, the CPT conducted an assessment of each option within each solution group using qualitative and quantitative information drawn from the advisory groups and analysis developed by the CPT.

Design principles of the evaluation framework.

Options should:

1. Seek to improve financial, clinical and operational sustainability for the services operated by the Trust;
2. Not have a destabilising impact on the local health economy;
3. Not adversely affect patient access, quality or choice; and
4. Be implementable within a reasonable timeframe and in a manner that is consistent with the current NHS environment.

What the scores mean against each evaluation criterion

Impact on services provided by the Trust:

Strong ● : Significantly enhances operational or clinical sustainability and makes a substantial contribution to the financial challenges faced by the Trust.
Good ◕ : Enhances operational and clinical sustainability and makes a significant contribution to the financial challenges faced by the Trust.
Weak ◑ : Provides a positive financial contribution but compromises clinical or operational sustainability.
Poor◔: Results in a significant decline in clinical or operational sustainability.

Impact on patients

Strong ● : Likely to lead to significant improvements in quality, access or choice for patients in the region (the Trust's patients and other Trusts' patients).
Good ◕ : Likely to provide a small positive impact on quality, access or choice for patients in the region.
Weak ◑ : A reduction in quality, access or choice for patients could arise if not properly managed.
Poor ◔ : A significant decline in quality, access or choice for patients is likely to occur and challenging to mitigate.

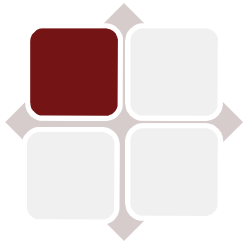
Impact on the local health economy

Strong ● : Significantly enhances the net financial or clinical prospects of other providers in the region and/or provides financial and clinical benefits for commissioners. Strong alignment to the commissioning agenda.
Good ◕ : Provides some positive benefits for other local providers or commissioners with limited adverse consequences. Good alignment to the commissioner agenda.
Weak ◑ : Creates some adverse impacts on other local providers and commissioners. Weak alignment with the commissioner agenda.
Poor ◔ : Significant adverse effects on other providers within the local health economy and/or is reliant on additional funding from commissioners. Poor alignment with the commissioner agenda.

Deliverability

Strong ● : Benefits of the solution can be realised within a short timescale, are widely supported by stakeholders and have few legal hurdles.
Good ◕ : Benefits can be realised within a reasonable timescale. Some support from stakeholders and a limited number of legal challenges.
Weak ◑ : Benefits take time to be realised, are likely to be resisted by stakeholders or present challenging legal issues.
Poor ◔ : Benefits take a long time to be realised, are likely to be challenged by stakeholders and/or present significant legal issues.

Identifying improvements to efficiency



The sustainability review identified a number of ways in which the efficiency of the Trust could be improved.

CPT View

An extensive efficiency programme should be implemented. This programme should also explore opportunities created by:

- *repatriating work outsourced by the Trust to other providers;*
- *developing a more integrated service for patients; and*
- *other business development opportunities.*

The opportunity to improve efficiency

In the course of its sustainability review, the CPT identified a number of areas where the Trust was less efficient than its peers. The OFG and CAG strongly believe that the Trust needs to pursue these inefficiencies as a first course of action to make sure it does all it can to address the financial challenges it faces.

Through consultation with Trust staff, the OFG and commissioners, the CPT identified a number of other options open to the Trust to reduce cost and grow revenue to make a contribution towards the deficit.

This section of the report describes what options may be available to the Trust and scores them against the evaluation criteria.

Ways in which efficiency might be improved

Addressing efficiency issues and delivery of CIPs

In the sustainability report, the CPT identified that savings in the region of £10m per annum could be achieved if the Trust could reach the average level of efficiency delivered by its peers across a number of areas (the 'baseline target'), and around £15m per annum if it could reach the upper quartile (the 'stretch target').

Over the next five years the Trust's CIPs target is £57m, including circa £8m of 'catch up' to achieve average efficiency levels, with the balance representing the standard annual efficiency improvement requirement. Reaching upper quartile would see the Trust catch up the remainder to average and an additional £5m, equivalent to £64m of CIPs over the next five years.

Despite this urgent need, delivering these CIPs will be challenging. Although the Trust has some recent success in achieving CIP targets, it does not have a proven track record of delivering this level of savings and also has new management structures that are bedding in.

Furthermore, delivering CIP targets in years three to five are likely to require significant co-working with commissioners. Historically, cooperative working with CCGs has proven challenging due to failings on both sides.

Importantly, the savings listed under the 'baseline target' column in the table below represent savings the Trust needs to make to maintain the deficit at around £40m, and deliver its CIPs plan.

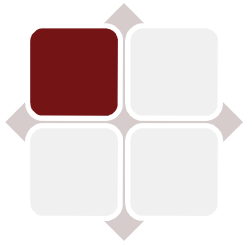
The 'stretch target' represents additional savings that the CPT believes – if achieved by the Trust – could make a contribution to the financial deficit. Hence, the difference between the stretch and baseline targets is shown as the contribution to the deficit.

Working with the Trust, the CPT has identified a number of opportunities to move beyond the FY14 plans.

Potential efficiencies

Efficiency area	Baseline target (£)	Stretch target (£)	Contribut-ion to deficit(£)
Workforce	6,169,000	9,925,751	3,756,751
Corporate functions (non-pay)	1,178,000	1,491,722	313,722
Bed savings/LOS	550,000	1,680,000	1,130,000
Outpatient efficiency	343,000	687,000	344,000
Theatres	937,000	1,405,500	468,500
Subtotal	9,177,000	14,559,973	5,382,973
Other	777,000	777,000	0
Total increased contribution	9,914,000	15,336,973	5,422,973

Other improvements to efficiency



As well as the direct operational efficiencies discussed on page 31, there are other opportunities for more efficient working at the Trust which could make a positive contribution to the Trust's financial performance.

CPT View

These areas include working with other parts of the local health economy to achieve integration, more efficient use and redevelopment of the Stamford site, and reviewing the current service portfolio.

Closer working with other parts of the local health economy

There is a significant opportunity for the Trust to work more closely with other parts of the local health economy so that patients receive the appropriate level of care in the appropriate setting. For example, closer working with community services would allow the Trust to contribute to an integrated pathway of care for the patient. This may help to free up capacity, as patients could be discharged into community facilities.

Equally, the Trust and other parts of the local health economy have started to work better together to address the rise in A&E and urgent care attendances, especially amongst the frail and elderly.

The benefits to the Trust of these actions vary. While there is likely to be a benefit for patients and commissioners as a result of avoiding acute care, reducing activity at the Trust could have both positive and negative financial consequences. Under the current tariff, reducing urgent care readmissions is likely to be positive, as is action to reduce the length of stay. But reducing unplanned care could have negative financial consequences for the Trust if another use for the estate cannot be found and related staff costs are not reduced.

More efficient use of the Stamford site

The Trust has proposed a way of using the Stamford site more efficiently, which can also deliver a contribution towards the forecast financial deficit. This involves the partial sale of the site, with the proceeds funding capital expenditure to allow ongoing outpatients, endoscopy and procedures requiring local anaesthetic.

Having reviewed the proposals developed by the Trust, the CPT does not propose any intervention in the ongoing work by the Trust in relation to Stamford. However, the Stamford site has potential for development and this should be considered as part of a wider option.

Other business development opportunities

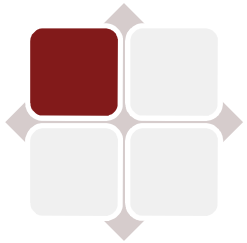
The Trust has identified a range of business development opportunities that it believes would help to address the gap and could bring benefits to local patients. The Trust projects the impact of this activity to be £10m of revenue with an estimated contribution of £2m towards the deficit.

The CPT believes that these opportunities (and other business development strategies) should be explored further with commissioners as part of the efficiency programme. In determining whether to go ahead with these activities, commissioners will need to take into account the impact on patient care and any knock-on impact on other local providers.

Discontinuing loss-making services

There is an opportunity for the Trust to review whether it can discontinue loss-making, clinically necessary services in order to free capacity at the Trust's sites to perform more profitable activity. This would need to be done in collaboration with commissioners to make sure suitable alternative provision exists for these services. At present the Trust has insufficient financial information to undertake this exercise however, this is currently being addressed.

Evaluation of options for improving efficiency



Delivering the CIP plan is not the only way to improve efficiency.

CPT View

All of the efficiency measures identified should be pursued, as they can make a contribution to the gap faced by the Trust without impacting on other providers or patient care.

	Impact on the Trust	Impact on patients	Impact on the local health economy	Delivery	Overall	Commentary
Addressing efficiency areas and delivering CIPs safely	◑	◕	●	◕	◕	This represents the minimum the Trust needs to do. It will make a contribution but will be challenging to deliver.
Better working with other parts of the local health economy	◑	●	●	◑	◕	Can improve the quality and experience of care received by patients and help to free up space at the Trust.
Address loss-making services	◔	◔	◕	◕	◔	Contribution to the deficit is small per year but may have an adverse impact on patient access.
More efficient use of the Stamford site	◑	◕	◕	◕	◕	Small ongoing contribution with the potential to improve the quality of patient care delivered.
Other business development opportunities	●	◕	◔	◔	◕	Could deliver a contribution in excess of £2m towards the deficit and will have a positive impact on patients.

Conclusion

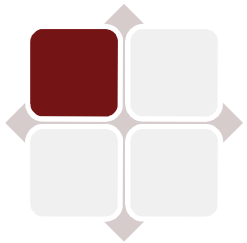
The Trust must improve its efficiency by delivering CIPs, while at all times retaining appropriate controls to protect patient care. Other options should also be pursued that make a contribution towards the financial challenges without adversely affecting patients or inadvertently destabilising the local health economy. However, even if the Trust were to deliver all of the efficiency schemes identified above (which in itself would be a considerable challenge without significant local health economy co-working), it would not fully close the financial gap. Additional activity, cross-health economy working and, after all other areas have been exhausted, central support, are also required to close the financial gap.

KEY

◔◑◕●

Greater shading indicates a greater positive impact or likelihood of successful delivery (see page 30)

Impact of the options for improving efficiency



CPT View

Successful delivery of the efficiency workstream could reduce the overall size of the gap. The Trust has appropriately targeted a higher level of CIPs in the first two years.

However, even full delivery of this programme still leaves a sizeable deficit that other options need to address.

Impact of the efficiency programme

The Trust has set out in its Long Term Financial Model (LTFM) c.£57m of efficiencies over five years that comprises the national efficiency requirement as well as additional efficiency as the Trust seeks to 'catch up' with most other foundation trusts. The efficiencies are a key area of opportunity for the Trust.

There is a close link between the achievement of the efficiencies and more effective working of the local health economy. For example, making improvements in the length of stay for patients by reducing delayed transfers of care where patients are not able to be appropriately moved into community or other forms of care are dependent on the availability of bed space in other forms of care.

The Trust is looking to capitalise on a range of business and service development opportunities. It has prudently not assumed the provision of these services in its LTFM and the estimated contribution is c.£1m in year 1 and year 2, shown in the table below. This has been added to the CIP efficiency challenge and is referred to later in this report.

Supporting the delivery of the efficiency programme

The CPT believes that the Trust would require additional capacity and capability in order to deliver the full extent of the efficiency workstream. Alternative models for securing this support are considered in the following chapter.

Furthermore, given the necessity of whole local health economy working to deliver on the latter years of the efficiency agenda, it will be essential to secure the engagement of commissioners with this workstream. The CPT's recommendations on how this could be achieved are discussed in the following chapter.

Potential impact of efficiency options

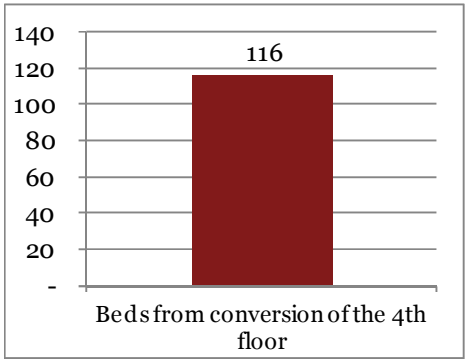
Potential contribution £m	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Normal efficiency requirement	11.2	11.0	9.1	8.9	8.8	49.0
Catch up efficiency	1.8	2.0	0.9	0.9	2.7	8.3
Total CIP in the Trust's LTFM	13.0	13.0	10.0	9.8	11.5	57.3
Business and service development opportunities	1.0	1.0	-	-	-	2.0
Sub total	*14.0*	*14.0*	*10.0*	*9.8*	*11.5*	*59.3*
Other items (including CIP stretch to upper quartile)			2.6	2.6	2.6	7.8
Total	14.0	14.0	12.6	12.4	14.1	67.1

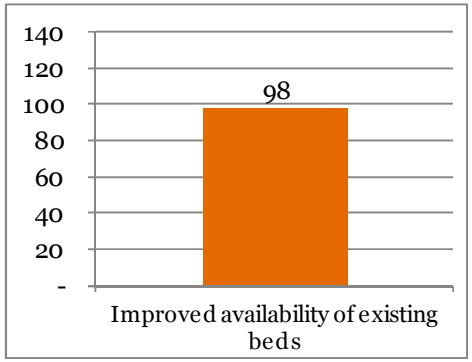
Options for hosting additional activity currently delivered elsewhere in the NHS at Trust sites

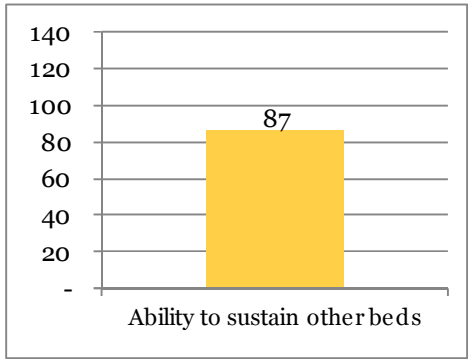
The sustainability report highlighted potential efficiency gains which would free up capacity at PCH.

CPT View

There is further opportunity to generate additional capacity. Primarily this is the conversion of the 4th floor. In addition, a further option would include improved availability of existing beds. Finally, the estate has the ability to sustain other beds.







There are a range of ways to increase the number of beds at the Peterborough Hospital site

The CPT's report on sustainability highlights that one of the principal causes of the deficit is that the PCH estate is underutilised. The original build allowed for a level of flexibility that is currently not being utilised by the Trust for patient services.

With the assistance of the Trust, the CPT has identified that additional beds could be generated at the PCH site primarily through conversion of the 4th floor (up to 116 beds) of the main building. A further option would include improved availability of existing beds through reduction in length of stay and the commissioners' plans to shift activity into a community setting (98 beds). Finally, the estate has the ability to sustain further beds (estimated at 87 beds).

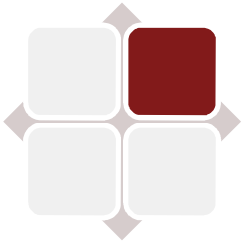
There is a possibility that further capacity could be generated, e.g. at Stamford (not all of the site is currently used for clinical purposes), or through a larger building programme, but this would require significant additional cost and work to ensure supporting facilities could cope.

In working with the Trust, the CPT has calculated an indicative cost of £20.1m for the structural works and fit-out requirements based on seven wards, converting four wards on the 4th floor of PCH and other ways to increase bed estate. The building work would likely take c.6 months for the increases to bed estate and in excess of one year for the adjustments to the 4th floor. Further work is required to confirm the estimate by the Trust.

The additional capacity identified by the CPT (especially on the 4th floor) represents a significant opportunity for the Trust, as the fixed costs of operating the facilities (i.e. unitary charge and some facilities management costs) are being incurred, even though there is little revenue generating activity taking place from these facilities. This means that any additional revenue generated is likely to result in a significant contribution to the bottom line.

The exact amount of contribution towards the Trust's deficit depends on many factors. We have set out on page 38, the potential contributions from different bed types.

Options for increasing clinical or commercial activity at the Trust



There are a number of alternative uses for the potential spare capacity within the Trust's estate.

CPT View

The CPT has identified six potential sources of activity that could contribute to closing the financial gap.

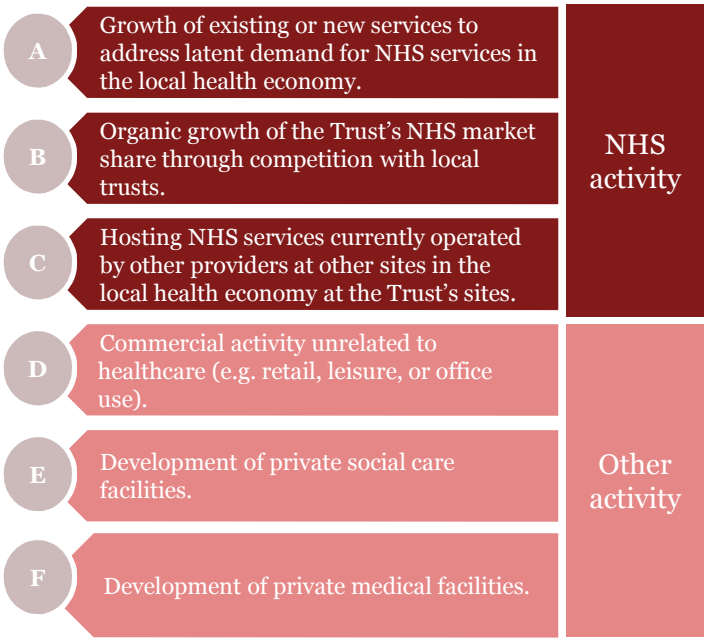
Sources of additional activity at Trust sites

The CPT has considered six potential sources of additional activity that could be delivered from the Trust site. Three of the options involve use of the space by additional NHS activity, while the other three relate to the generation of non-NHS revenue. Each of these is considered over the next few pages. Any additional activity would need to be provided by the Trust with no adverse impact on the quality of current services and patient choice.

Options for securing additional NHS activity (Options A-C)

The CPT's initial consideration of the options suggested that Options A and B should be de-prioritised at the current time for the following reasons:

- The fiscal climate facing the NHS means that growth in NHS income over the next few years is unlikely to be significant;
- Commissioners have signalled that their focus will be to shift activity away from acute settings towards community settings;
- Increasing market share in a market that is not growing would have an adverse impact on other local providers, a number of whom already face financial challenges; and
- The timescales involved in organic growth are long and unlikely to result in a significant contribution to the Trust's deficit within the next few years.

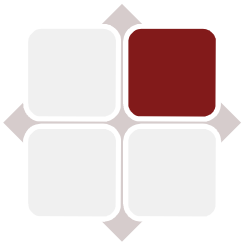


Identifying NHS activity that could be hosted at the Trust's sites (Option C)

The CPT's initial analysis suggested that the most attractive way of securing additional activity to the Trust's site would be to work with the local NHS to identify whether the activities of existing providers could be hosted at PCH in order to provide additional clinical services from the spare capacity.

Working with the LSSG, the OFG and the CAG, the CPT identified four alternative sources of NHS activity and considered the various ways in which these activities could be delivered at the Trust.

Options for hosting additional activity currently delivered elsewhere in the NHS at Trust sites



There is potential for additional NHS activity to be undertaken by the Trust.

CPT view

There are a number of different ways in which reconfiguration could occur to make best use of the PCH site.

C1. DGH activity

As set out in chapter four, within the local health economy there are a number of DGH hospitals and small private providers offering similar services to those delivered at the Trust site. There is the potential for service redesign and consolidation across the region. The CPT identified two ways in which the Trust's estate could be utilised to support the local health economy with this challenge:

C1a: The consolidation of a number of acute services across the local health economy at the Trust's sites; and

C1b: Reallocation of services between the Trust and another DGH. This would result in the other DGH becoming a 'cold site' focusing on the delivery of outpatient and diagnostic services and elective care. (This may or may not result in the integration of the two organisations.)

C2. Specialist NHS activity

While the vast majority of NHS patients living in the geographic area served by the Trust seek treatment locally (at the Trust or other local DGH), a small number of patients each year seek treatment from specialist organisations.

Across the NHS, a number of specialist centres have set up regional outposts in order to provide outpatient and daycase activity closer to their patients. The CPT considered the potential advantages that the Trust hosting such an outpost could bring to patients, commissioners and the Trust's financial challenges.

C3. Mental health activity

Within the geographic region served by the Trust there are currently 15 facilities with a total of 47,131 sq m operated by the two principal mental health providers. The CPT considered whether it would be attractive to transfer some of the activity from these facilities to the PCH or Stamford sites.

C4. Community activity

Within the geographic region served by the Trust there are currently eight facilities with a total of 36,485 sq m operated by the two principal community service organisations. The CPT considered whether it would be attractive to transfer some of the activity from these facilities to the PCH or Stamford sites.

Specialist services

At present, NHS England is undertaking a review of specialist services across the country in order to identify the most appropriate way of delivering them in the future. This review, which will report later in 2013, is likely to explore the existing configuration and may help to identify specialist services in need of a new facility.

Should NHS England come to the view that consolidation is required and that some organisations need new facilities, the CPT believes that it would be prudent for NHS England to explore whether the additional capacity identified within the world class facilities at PCH could form part of the solution.

Options for hosting additional activity currently delivered elsewhere in the NHS at Trust sites

The CPT considered the financial contributions from the different options.

CPT view

The CPT's analysis indicates that either specialist activity or additional DGH activity would make the greatest contribution to the financial deficit facing the Trust.

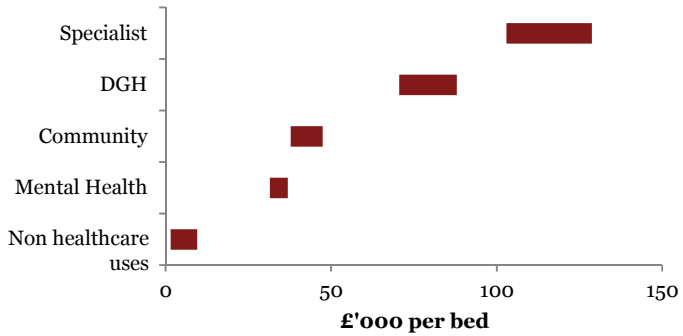
Evaluating options for securing additional NHS activity for the Trust's sites

Having identified the principal ways in which additional NHS-funded activity could be hosted within the Trust, the CPT conducted an evaluation of each option against specific criteria.

The CPT undertook some high level financial analysis of the potential returns that each option could generate and consulted with commissioners, the CAG and the OFG. This financial analysis, together with consideration of which options could be combined, was intended to illustrate the potential contribution of different types of activity to the financial deficit, rather than identifying the specific type of activity that would best form part of a sustainable solution.

A summary of the evaluation is presented on the following page.

Potential contribution per bed for different activity types (per annum)



Source: CPT analysis

Conclusions on the type of NHS activity that it could be attractive to host at the Trust's sites

Each of the options for transferring NHS activity to the Trust presents its own benefits and challenges. From the CPT's analysis, specialist activity would bring the greatest contribution per bed, however, there are limited opportunities for the Trust to capture specialist activity within the current structure of the local health economy.

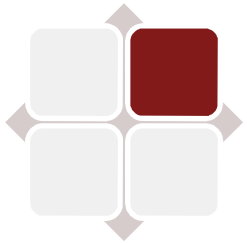
As a result, redirecting patient flows from other DGH sites to the PCH site is likely to make the greatest contribution to the financial deficit. The CPT recommends the Trust maximises its spare capacity and brings as much additional activity on site as possible, accepting that any affected DGH(s) would need to adapt to such a change.

A core strategy to increase DGH activity could be supported by smaller transfers of specialist, community and mental health activity, as well as additional DGH activity that may arise as a result of redesign of services in the region.

Additionally, there may be other significant blocks of Ministry of Defence or nationally commissioned activity, like that of the NHS Institute for Innovation and Improvement, which require a new base and should be considered as part of a potential solution[9].

[9] This scenario could change should current market conditions alter.

Evaluation of options for increasing NHS-funded activity



The table, right, summarises the impact of transferring NHS activity currently being provided elsewhere to PCH.

CPT view

Moving patient flows from a specialist trust or a local DGH to the PCH site looks likely to make the greatest contribution to the financial deficit.

This core strategy should be supported by smaller transfers of other types of services.

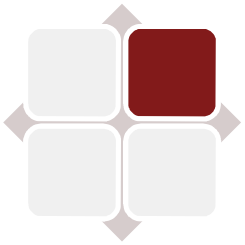
	Impact on the Trust	Impact on patients	Impact on the local health economy	Delivery	Overall	Commentary
C1. DGH activity						
a. The consolidation of a number of acute services across the local health economy at the Trust's sites	◔	◕	◕	◔	◑	Unlikely to deliver a large contribution to the gap within a short timescale.
b. Reconfiguration of services between the Trust and another DGH	◕	◕	◑	◑	◕	This is likely to form a core solution, with further work required to mitigate any negative impacts on the patients of other DGHs e.g. in relation to increased travel times to receive treatment.
C2. Specialist NHS activity	◑	◑	●	◑	◑	Unlikely to be the principal contributor but may act as a top-up.
C3. Mental health activity	◔	◑	◕	◔	◔	Unlikely to be the principal contributor but may act as a top-up.
C4. Community activity	◔	◑	◔	◑	◔	Unlikely to be the principal contributor but may act as a top-up.

KEY

◔◑◕●

Greater shading indicates a greater positive impact or likelihood of successful delivery (see page 30)

Options for increasing non-NHS clinical or commercial activity at PCH



Some of the space at PCH could be put to non-NHS use.

CPT View

Some non-NHS uses of the building would be viable, but the contribution they make to the gap depends on the synergies between existing activities and any potential commercial use. These synergies are the levers for maximising returns.

Identifying options to increase non-NHS-funded activity (Options D-F)

The CPT has explored options to bring non-NHS commercial activity into the Trust. These activities could make a significant revenue contribution to the Trust and have a relatively limited impact on neighbouring healthcare providers because they would not necessitate the transfer of NHS activity or any local reconfiguration.

The main categories of commercial use are:

- Retail and office space;
- Private social care; and
- Private healthcare.

Retail and office space

The letting of high-quality office space in central Peterborough this year has achieved rents of £118 - £135 per sq m[10]. This compares to the current Trust estate cost of £450 per sq m. The Trust estate is costly relative to similar space in the local market that would be fit for purpose. However, there may be organisations that see synergies from co-location with an acute centre.

Private social care

The Trust estate costs also look high relative to social care activity – the CPT estimates revenue per bed from social care activity in the East of England to be 51% lower than the Trust's estate costs per bed [11].

However, there is a potential synergy between acute facilities and social care capacity – particularly if the latter is a route to move patients out of acute beds and into a more appropriate level of care. A social care operator may be prepared to pay above market rates if the beds were used by patients with higher than average acuity for social care and high occupancy was relatively certain (because of proximity to the acute beds). It may also be possible to structure an arrangement where risk and reward is shared between the Trust and any social care operator, thereby aligning incentives to move patients out of acute beds.

Private healthcare

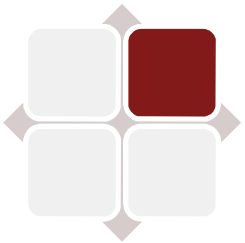
The design and quality of the Trust building means that a private health experience could be delivered relatively easily. There are also synergies with other activities at the Trust (e.g. a supply of staff, access to pathology and other support services, access to theatre capacity, and back-up support for private patients that require emergency transfers).

One of the barriers to pursuing options related to private healthcare is that the market is currently saturated and not growing significantly; there are a large number of private health providers, and the medical insurance and self-pay health market is relatively flat at the moment. To maximise the contribution from a private health option, it would need to be structured in a way that allowed the Trust to gain significant market share. To be done at scale, this would mean attracting the regional market rather than just patients within the local Peterborough market. Based on the interactions with private providers, the CPT understands this could be achieved through new ways of contracting with consultants and managing patient pathways.

Having considered the options, the CPT believes healthcare use is likely to be most attractive where activities have an obvious synergy with the services that the Trust already delivers, require an acute hospital configuration,and have the potential for the Trust to generate surpluses.

[10] Focus – commercial real estate
[11] Comparison of Knight Frank estimates of social care fees by region with Trust data

Conclusions on options for increasing non-NHS clinical or commercial activity



CPT View

Private health is likely to offer the largest returns compared with other types of commercial use.

Conclusion on options to increase non-NHS clinical or commercial activity

Options to use capacity at the Trust for non-health related commercial activities are likely to be limited, given the relative benefit of clinical activities and constraints within the existing PFI contract. Using capacity at the Trust to deliver social care services has potential benefits, especially helping the Trust to free-up acute beds. Again, however, the Trust is a relatively expensive location for social care/nursing home provision, so its attractiveness will depend on exploiting synergies between co-located acute and social care.

Private health has the potential to generate significant additional revenues for the Trust and it is the option that has the biggest potential to deliver financial improvements at the Trust. However, it is contingent on being able to establish a significant footprint in the regional private health market.

Any private health facility would have to be comparable to existing private provision in terms of experience, cost, and outcomes. On its own, however, this may not be sufficient – it may, at most, give the Trust a share of the local private market. The challenge would be delivering this at scale to maximise returns. This option relies on insurers being willing to route volume through the facility – which would be contingent on the cost of delivery, achieving outcomes that rival (or beat) other private providers and delivering a 'private health experience'.

An alternative strategy would be to target a bigger, regional, market by considering business models that cut the cost of private healthcare, maintain the patient experience and deliver high outcomes (e.g. by operating at scale). This would mean challenging existing models of working with private physicians, managing cost through the patient pathway, and developing a reputation as a regional centre of excellence.

	Impact on the Trust	Impact on patients	Impact on the local health economy	Delivery	Overall	Commentary
D. Commercial retail and office use	◔	◔	◔	◔	◔	Market interest is likely to be limited due to relatively high rent and a lack of synergies with the Trust.
E. Private social care	◕	◔	◔	◑	◑	The Trust is a relatively expensive location for social care, so synergies with existing activity would be crucial.
F. Private healthcare	◕	◔	◔	◑	◕	Offers the greatest benefits but relies upon capturing a regional market.

KEY

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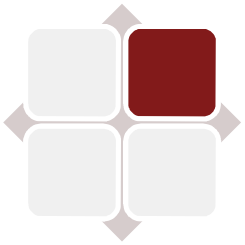
Greater shading indicates a greater positive impact or likelihood of successful delivery (see page 30)

Mechanism to increase clinical or commercial activity at PCH



A competitive tender is likely to identify the best use of the estate.

CPT View

Any tender process should seek innovative solutions that maximise the returns possible from all aspects of the estate.

A tender should cover both the use of the estate and the organisational structure that the bidder proposes would be used to implement their solution for the additional space.

Generating best value from additional space and activity

The CPT identified a number of types of activity that could be brought into the PCH site under current market conditions and discussed their relative merits. This has shown that an existing DGH or a private healthcare operator would represent the most attractive and likely source of additional activity.

However, legal advice has indicated that neither the CPT, Monitor or any other body has the power to compel another DGH or private provider to support the delivery of an option for the Trust. In light of this, two mechanisms have been used historically within the NHS to develop such an arrangement:

- The merger of two parties; and
- The creation of a joint venture between two parties.

The CPT has explored how best to structure a solution that could result in a commercial relationship that would bring the required activity to the PCH site at a financially attractive rate.

To support this work and to assess the likely level of interest in the space, a limited 'soft market testing' exercise has been undertaken with stakeholders in the local health economy and parties potentially interested in the space at PCH.

During this market testing, it became clear that there are a wide-range of potential interested parties with varying ideas on:

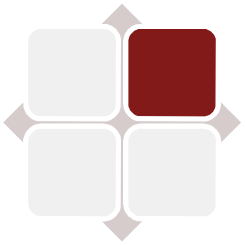
1) How they would like to use the space at PCH; and
2) The organisational structure and mechanism in which they would seek to implement their plan, e.g. via a merger/joint venture.

In order to ensure that best value is generated for the patient and taxpayer, the CPT is proposing that a competitive tender exercise is undertaken which would allow interested parties to submit bids covering how they would use the space at PCH and the mechanism for implementation.

Although a tender process is likely to take c.18 months to complete, it has the following benefits:

- It is likely to be considered a fair process and therefore reduces the possibility of a review under competition laws;
- It satisfies the EU public procurement rules and principles as described in the Policy and Standards Framework;
- It is likely to generate the highest possible level of interest and therefore is likely to drive the best value for the taxpayer;
- It allows bidders to form their own view of what the best structure is to implement their approach and to bid accordingly. For example, a solution involving a merger to form a larger organisation may give greater synergies and economies of scale. Conversely, restricting the tender to the additional space is likely to give only a lower 'rental-type' return;
- Where a private bidder is involved, there may be a shift in the burden of risk away from the taxpayer; and
- If the tender process chose a merger as the solution, among other options, the resulting organisation would be larger and could better support improved clinical co-working.

Mechanism to increase clinical or commercial activity at PCH



A competitive tender is likely to identify the best use of the estate.

CPT View

Any tender process should seek innovative solutions from interested parties that maximise the returns possible from all aspects of the estate, including the delivery of existing services and new services that commissioners may wish to commission.

Next steps

The soft market testing undertaken by the CPT assessed the likely approaches of potential NHS and private sector participants to the tender.

This exercise has indicated that potential options would combine the delivery of the efficiency plan with new activities at the Trust, derived from a variety of sources aligned to commissioners' intentions.

While high level and conceptual in nature, the CPT believes there is sufficient interest to proceed with the proposal – with parties being asked to formally consider their approach.

The tender process

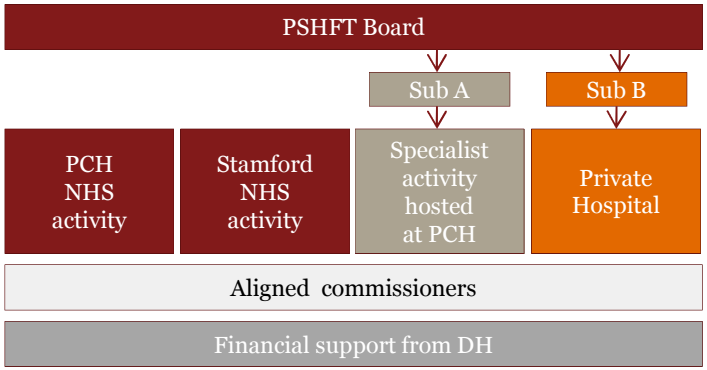
The design of a tender should seek innovative solutions that minimise the future costs of the organisation to the taxpayer while protecting patient services.

This could result in either additional NHS or commercial activity being undertaken within the Trust's estate, or a combination of the two. Equally, the process could lead to a variety of different organisational structures for the Trust going forward, a high level view of further solutions is shown on the following page.

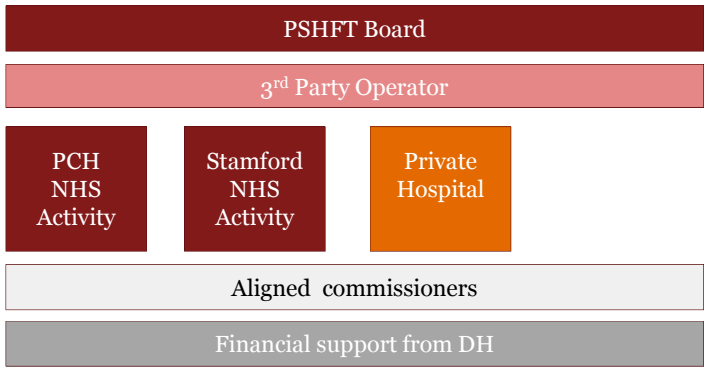
The design of any tender process would require careful attention and would require potential bidders to demonstrate how they would seek to improve patient quality, maximise the world class asset of PCH, and limit the taxpayer costs over the lifetime of their proposed bid. The CPT estimate that a tender process is likely to take c.18 months to complete.

Potential organisational structures arising from the proposed competitive tender

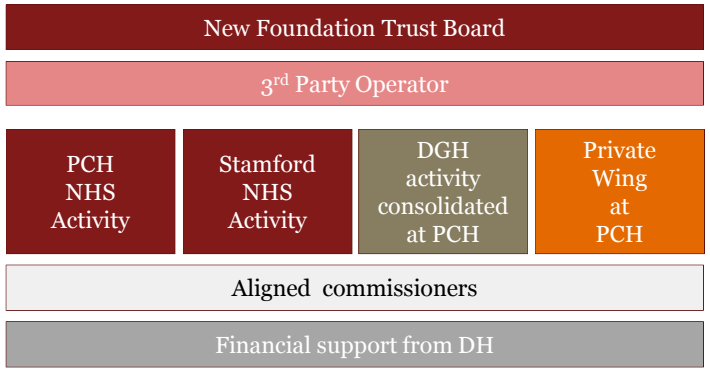
1. PSHFT working with subcontractors maximising the use of PCH



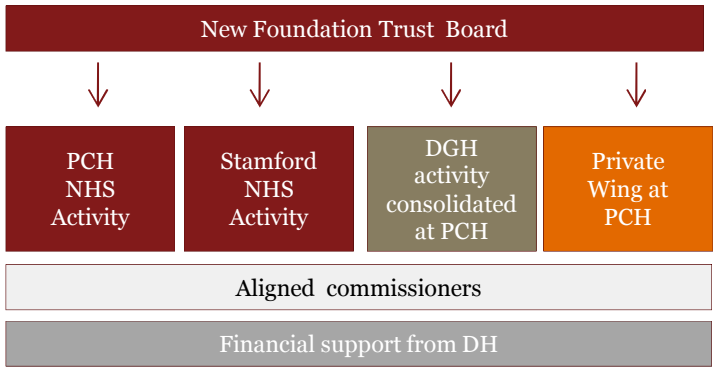
2. PSHFT works with an external operator to maximise the use of PCH



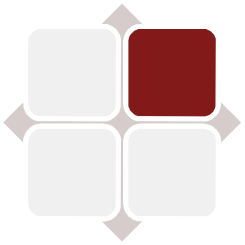
3. Consortium model bringing together DGH activity consolidated on the PCH site



4. NHS merger leads to the consolidation of DGH services at PCH and the closure of PDC funded estate



Potential contribution of additional activity scenarios



There are a wide range of potential outcomes from the proposed tendering process, each of which would reduce the financial deficit by a different amount.

CPT View

Additional activity has the potential to make a substantial contribution, but none of the scenarios fully close the financial gap identified. However, a tender process would aim to maximise returns.

Contribution of additional activity

Alongside the variety of organisational structures that might arise from a tender process, there are a wide range of commercial outcomes from the process, each of which would reduce the financial deficit, but by a different amount. As a guide to the potential contribution that could arise from the proposed process, the CPT has analysed the impact of three potential outcomes from the tender.

Outcome A:

Use of the spare capacity at PCH by:

- Working with specialist providers to transition and deliver their current non-specialist activity from PCH rather than the specialist site; and
- Developing a 100-bed private healthcare unit on the 4th floor of the PCH site with the benefits shared between the Trust and a private provider.

Outcome B:

Developing a strategy to strengthen the acute brand through:

- Partnerships with specialist providers;
- Close working with a local DGH to establish a hot/cold site model, working between the Trust and the DGH and resulting in some consolidation of inpatient activity within the PCH; and
- Developing a 100-bed private healthcare unit on the 4th floor of the PCH site with the benefits shared between the Trust and a private provider.

Outcome C:

The successful bidder works in partnership with another DGH to:

- Provide elective care from PCH, Stamford and another local DGH site;
- Deliver the consolidated complex and urgent acute activity from PCH; and
- Develop new services currently delivered by specialist centres.

Impact on the financial gap

A high level analysis of these scenarios suggests that the options considered under the additional activity scenarios have the potential to make a substantial contribution to the Trust's financial challenges.

However, none of the scenarios fully close the financial gap identified. As a result, additional actions in the form of cross-health economy working and central support are likely to be required.

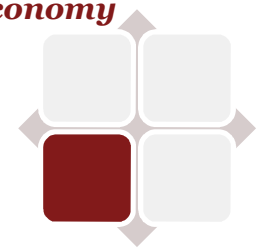
Boundaries of the tendering exercise

It is important to clarify that the boundaries of the tendering cover the Trust's estate and its services. Any other services that are provided locally are not part of this tendering exercise.

Specifically, the Older People procurement that spans different types of healthcare and a much broader region is underway. The vast majority of the services are not provided by the Trust – they are provided by dozens of other organisations across the Cambridgeshire and Peterborough health economy.

There is an opportunity for one or more providers to be successful in the Older People procurement and provide more integrated healthcare with the management team of the Trust, which is in place after the tender exercise.

Options for improving integration across the local health economy



Any solution to address the deficit at the Trust would require support and buy-in across the local health economy.

CPT View

To minimise this risk, the CPT has considered mechanisms that could be adopted that would create more stability, align incentives, and make it easier for all organisations to work in ways that deliver better value to the local health economy.

Opportunities to develop effective cross-health economy working

The CPT's wide-reaching discussions make it very clear that any sustainable solution to address the deficit at the Trust and deliver quality services to local patients would require support and buy-in across the local health economy. Without this, there is a real risk that the sustainability of the Trust could be undermined.

To minimise this risk and to optimise the value associated with all of the options considered in this report, the CPT has outlined actions that would create stability, align incentives and make it easier to work in ways that deliver better value to the local health economy:

- Collaboration on care pathways, with special attention on urgent care and long term conditions;
- New, collaborative and longer-term approaches to contracting;
- Exploring flexibilities around Payment by Results, creating incentives to integrate care and manage patient pathways coherently;
- Looking at synergies with commissioners' plans around frail and elderly care; and
- Considering models that allow staff to be deployed more flexibly across the local health economy.

A number of initiatives are underway or are being discussed to address some of these issues, (e.g. the Older People procurement covers a number of these aspects). However, the CPT believes that a comprehensive and focused workstream encapsulating each of these issues is required in order to create a sustainable solution for patient services.

A failure to make progress on these issues will reduce the likelihood of success of the other workstreams and therefore increase the financial contribution required of taxpayers.

Collaboration on care pathways, including urgent care and long term conditions

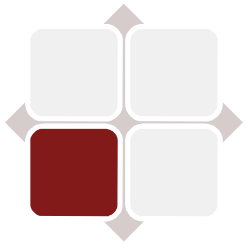
The CPT has identified opportunities for better collaboration on care pathways, especially for urgent care and long term conditions. It recommends commencing a programme of pathway and disease area redesign and taking immediate steps to reduce urgent care back to agreed baseline levels. Both issues will require commitment and leadership from the CCGs to work with the Trust to develop action plans with clear accountability, key performance indicators and outcomes.

Collaborative and long-term approaches to contracting

Many of the options the CPT has evaluated will take some time to implement and fully bed in. These options may require up-front investment and working with new partners. Current 12-month acute service contracting cycles may work against this approach. This is because they create inherent uncertainty – particularly in a situation where commissioners have stated their intentions to shift activity into the community.

There are opportunities to specify contracts in new ways – for instance, encouraging organisations to work together (e.g. alliance contracts) and to look at how risk and reward is shared across contracting parties. Such approaches could provide stability and promote collaborative working.

Options for improving integration across the local health economy



Cross-health economy support is required and, in many cases, joint working will be necessary.

CPT View

Key actions would need to include addressing the current short-term nature of contracting, exploring alternative payment structures and cross-health economy working to support the care of frail and elderly people.

Exploring flexibilities around 'Payment by Results'

A large portion of the Trust's income is delivered under Payment by Results (PbR), where the Trust is paid according to the units of activity delivered. Conversely, many non-acute providers are reimbursed on a block contract basis, where overall reimbursement is less dependent on the level of activity delivered. Together, these systems of reimbursement, particularly where they interact, are increasingly seen as blocking the delivery of integrated care (*Evaluation of the reimbursement system for NHS-funded care, PwC, 2012*). Acute trusts are incentivised to grow activity to cover fixed costs, whereas non-acute providers may not be reimbursed in-year for taking on additional activity. This could hamper the movement of patients between acute and non-acute settings.

In addition, contracts tend to be focused on units of activity delivered (in the case of PbR) or inputs (in the case of block contracts).

In the future, the CPT expects contracts to become much more outcomes-based, with commissioners focused on contracting for pathways of care that transcend current administrative lines between primary, acute, community and social care. A proactive approach between commissioners and providers in the local health economy now could help to drive organisations, including the Trust, to focus on delivering the right activity and outcomes. It would also facilitate the re-location of patients between acute and community-based care, allowing the Trust to free-up capacity for alternative uses. Through this approach, the CPT would expect to see providers in the local health economy working together to deliver a pathways-based approach to care, and to allocate risk and reward in contracts, contingent on outcomes.

Based on discussions with the CAG and OFG, the appetite for this type of approach exists within the local health economy. It would require commissioners and providers to operate outside the current PbR rules, which would need further dialogue with the Department of Health, NHS England and Monitor.

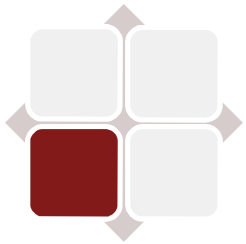
Aligning with the commissioning agenda

Much of what is described above has parallels with C&P CCG's tender for Older People services. The CCG is currently at PQQ (pre qualification questionnaire) stage in the procurement to deliver care for this group. The goal is to move to a capitation-based contract, where service providers assume risk and become responsible for delivering services to this group across the local health economy.

This exercise provides potential opportunities for the Trust. It is already delivering a significant amount of services to this group of patients, and the tendering exercise could result in serious efforts to move patients out of acute beds, where appropriate. The Trust could play an active role in re-shaping care and, along with other partners, developing a model that could be replicated across other service areas.

The CPT also recognises the risks arising from this process – particularly if the Trust is not successful in tendering to play a full part in the future delivery of frail and elderly care.

Options for improving integration across the health economy



New models of care will require different ways of staff working.

CPT View

There is merit in exploring how additional flexibilities could be built into staff terms and conditions in order to align incentives and enhance productivity.

Exploring how staff terms and conditions could support integrated working

In the future, the delivery of care is likely to be focused on a single provider and more likely to be driven by the location of care (closer to home), with a focus on patient experience and outcomes. This will mean that staff have to work in different ways. In many cases, staff will be working in different locations, with different teams, and delivering different services. While a wholesale shift in patterns of working is some way off, there is merit in exploring ways in which staff could be deployed more flexibly.

Nearly 70% of the Trust's cost base is staff-related. Commissioners are signalling that they want services delivered in different ways across the local health economy, indicating a need for providers to consider more flexible staffing models.

Examining models that give the Trust greater workforce flexibilities seems an essential step to preparing for future demands. Many community trusts are already moving towards the provision of 24/7 care, for example, among district nursing and community-based palliative care, and a number of local authorities are developing integrated care models with local CCGs.

Therefore, models already exist or are in development that can be considered or adopted for all workforce groups and across a range of providers in the local health economy.

The creation of a more agile and flexible workforce would need to take into consideration:

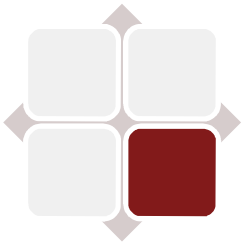
- Structural and contractual changes to ways of working (e.g. terms and conditions, pay and reward, hours of work/working week, mobility across working locations and teams);
- A range of enablers (e.g. mobile/remote working technology, outcome-based performance management, cultural shift);
- An investment in local health economy-wide workforce planning to ensure that each provider has the right skills mix to meet future demand;
- A joint approach to recruitment and retention among all providers in order to avoid competing for skills within the locality (which could drive up costs and negatively impact patient outcomes);
- A joint approach amongst all providers to local human resources (HR) policies, procedures and protocols to ensure equity and flexibility within joint/integrated teams; and
- Opportunities for more integrated (and lower cost) support functions across the local health economy, e.g. learning and development.

Conclusion

The CPT believes that a local health economy alignment exercise, encompassing the options described, should commence to address the issues raised in this section of the report. This process should involve local CCGs, the Trust, NHS England Area Teams and representatives from community and social care.

Following an alignment exercise, the CPT believes that the local health economy would need to deliver on a programme of activities to drive progress in this area. The implementation chapter that follows discusses the ways in which such a programme could be structured.

Options for supporting the high costs of the estate



A significant portion of the Trust's ongoing financial deficit is due to the cost of the PFI contract used to fund the construction of PCH.

CPT View

A key part of any solution will be support to providers operating from PCH. The CPT has explored four ways in which support could be derived.

Opportunity to address the high costs of the estate

As set out in the Sustainability Report, a significant portion of the Trust's ongoing financial deficit can be attributed to the cost of the PFI at PCH. The PFI cost for FY13 was £40.4m and this will inflate in line with the RPI. As a percentage of turnover, the Trust's estate costs are high (at 22%) and £22.2m above the DH's current 'approval threshold' benchmark.

It is worth noting that the Trust's ongoing financial deficits do not place the payments for the PFI hospital at risk; the DH is currently providing cash to the Trust to enable it to continue to provide services while a solution is found and has agreed to act as the guarantor of last resort for the PFI contract payments (through a Deed of Safeguard) should the Trust be unable to meet the full costs of the PFI estate.

The CPT has evaluated four possible options by which the financial burden of the Trust's facilities could be reduced. The table on the following page shows the CPT's rating of each option against core evaluation criteria.

Options for reducing the burden of the Trust's estate costs

Restructuring the PFI debt

The CPT considered options for restructuring the outstanding PFI debt, including private or public sector refinancing, a voluntary termination of the contract, or the buy-back of bonds by the Trust or the government.

Reducing facilities management costs

Approximately 50% of the ongoing costs of the PFI contract relate to the construction of PCH, with part of the remainder accounted for by the cost of facilities management by the PFI contractor.

As part of the review of the PFI contract, the CPT considered whether there was scope to reduce these costs by altering the services obtained from the contractor and/or putting the existing provision out to the market when the contract permits.

Commissioner support

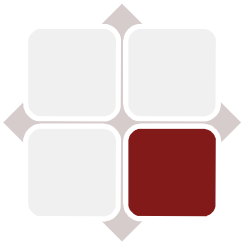
The CPT considered whether the Trust's commissioners might be prepared to make contributions to cover the disproportionately high estate costs, given the benefits to local patients of the high-quality facilities provided in Peterborough through the PFI build.

Department of Health support

The CPT considered the likelihood of the Trust receiving support for the high costs of its estate, according to the DH's current criteria for these payments, and the issues involved for the Department in implementing such a solution.

The CPT notes that the level of PFI support provided will reflect the methodology the DH has used for other Trusts. This will contribute to the overall solution for the Trust, but as highlighted elsewhere in this report, the Trust may still need to negotiate recurrent support from national stakeholders to cover any remaining shortfall and mitigate the high cost of the estate. This will be after all other actions identified as part of the CPT's recommendations have been taken to minimize the ongoing burden to the taxpayer.

Evaluation of options to support high costs of the estate



CPT View

The most feasible source of support is the DH or other national stakeholders. In deciding whether and how such support might be offered, the DH may wish to consider how it can be aligned most effectively to incentives that drive the Trust to increase efficiency across the organisation.

KEY

◔◑◕●

Greater shading indicates a greater positive impact or likelihood of successful delivery (see page 30)

	Impact on the Trust	Impact on patients	Impact on local health economy	Delivery	Overall	Commentary
Restructuring the PFI	◔	●	●	◔	◔	The PFI financial review concluded that all forms of refinancing the PFI are unfeasible due to current financial market conditions and the prohibitively expensive costs of restructuring.
Reducing facilities management costs	◔	●	●	◑	◔	The PFI services review identified some limited opportunity to reduce costs based on peer benchmarks.
DH support	●	◔	◔	◕	◕	A framework for granting DH support to trusts with legacy PFIs exists. Initial calculations suggest that the Trust could be entitled to support from this fund, with the amount dependent on the contribution of other workstreams. If successful in negotiating a settlement, these payments would have a limited impact on patients and local health economy participants.
Commissioner support	◕	◔	◔	◔	◔	While commissioners are well placed to ensure efficient use of any funds, absent of support from NHS England a commissioner funded payment diverts funds from local health services, to the detriment of patients and the other parts of the local health economy.

Conclusion

The relatively high costs of the estate as a result of the PFI contract account for a significant proportion of the Trust's deficit. This, combined with the likely range of financial contributions from the options described in this report, mean that some form of top-up is likely to be required. The CPT has not sought to provide clarity on the mechanism for allocation of these funds, although it recognises that funding is currently received by the Trust through an existing mechanism. The most feasible source is the DH support fund established to compensate hospitals for unaffordable legacy PFI schemes. The DH may wish to consider how any support can be aligned effectively to incentivise the Trust to increase efficiency across the organisation. One method of doing this would be to peg DH support to the RPI minus an efficiency factor (RPI-x), such that the real value of support decreases over time. Support could also be routed through the Trust's principal commissioners in order to incentivise them to maximise the use of the building.

Delivering sustainable services for patients and taxpayers – the CPT's recommendation

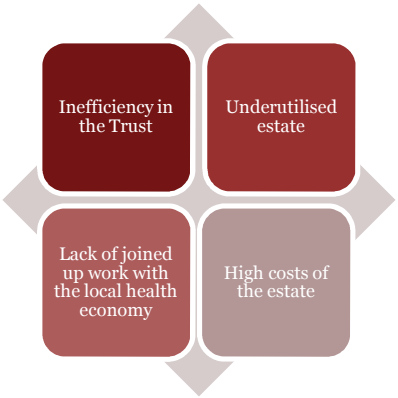
CPT View

No one single approach will address the financial deficit at the Trust.

The CPT has identified four streams of work needed to deliver a sustainable solution for patient services.

The CPT's approach requires action within the Trust, across the local health economy and from the DH or other national stakeholders.

Recommended approach



The size of the financial problem at the Trust is such that no one single solution is likely to generate a sufficient contribution to address the Trust's financial deficit. The financial potential of each area is different, as is the risk of delivery.

The CPT's recommended approach for a sustainable solution for the delivery of quality services to local patients involves four parallel workstreams, requiring contributions from all parts of the local health economy.

If one element were to fail to deliver, the contribution from the DH (which would ultimately come from the wider NHS budget) or other national stakeholders would need to increase.

The following chapter discusses how such a solution could be implemented and the potential risks involved in the approach that could lead to a higher contribution from the taxpayer.

Addressing the causes of inefficiency

An extensive efficiency programme should be implemented at the Trust in order to address the gap in CIP delivery identified in the Sustainability Report. This programme should make progress in:

a) Improving efficiency to top quartile performance;
b) Repatriating work outsourced to private providers;
c) Implementing the proposed Stamford Business Case;
d) Driving a number of business development opportunities; and
e) Further integrating health and social care service for patients to ensure that they are treated in the right place at the right time.

Making better use of the estate

A competitive tender should be commenced to offer the additional clinical space at PCH to interested parties. It should seek innovative solutions from interested parties, including solutions that support the delivery of the efficiency workstream (e.g. merger with another NHS organisation and/or working with an external operator). Interested parties could include existing NHS providers and commercial organisations (e.g. a private hospital).

Supporting sustainability via local health economy working

To drive sustainability and to enhance the likelihood of options implementation, organisations from across the local health economy should work more collaboratively towards shared goals. Key activities would include:

a) Establishing appropriate governance arrangements to oversee local health economy change;
b) Making progress on pathway design in some key areas;
c) Making progress on longer-term contracts;
d) Considering economic incentives, including capitated budgets;
e) Reviewing how staff across the local health economy are incentivised to support the delivery of sustainable and integrated services; and
f) Progressing a joined-up approach to the transformation of services across the local health economy.

Addressing the high costs of the estate

There would be a need for recurrent support from DH or other national stakeholders for the transitional phase and possibly over a longer time period if the other actions taken to address the financial deficit are not sufficient to return the Trust to financial balance. A programme of work to agree and formalise this arrangement would be required.

Implementation of recommended approach

Introduction to implementation planning

This section explores how the recommended approach could be implemented. This includes evaluating different leadership models, key delivery activities and the costs and risks associated with the approach.

CPT View

The CPT has considered a wide range of factors, including the impact on business-as-usual activities, timescales, costs, and the impact of alternative solutions on the local health economy.

Purpose of this section

The CPT's recommendation to deliver a sustainable solution involves four parallel workstreams:

1. Implementing a comprehensive cost improvement programme within the Trust and the local health economy and working with providers of community and social care to free up capacity;
2. Redesigning an element of the physical estate at PCH to provide additional capacity and commencing a competitive tender to identify the optimal approach to maximising the use of the excellent facilities of the Trust;
3. Local health economy actions which will help to support the delivery of all aspects of the solution and ensure long-term stability for the local health economy; and
4. Once all other actions have been taken, negotiate recurrent support from national stakeholders to cover any remaining shortfall due to the high costs of the physical estate.

Considerations for implementation planning

In identifying and recommending an implementation plan for the recommended approach, the CPT has considered:

- The different leadership models that could deliver the recommended approach;
- The key building blocks required to implement each part of the solution;
- The timescales involved and likelihood of delivering a reduction to the deficit on a sustainable basis;
- The impact on the operational and clinical sustainability of services;
- The views of commissioners, NHS England and its Area Teams, and the Trust;
- Insight obtained from the CPT's advisory groups and one-to-one conversations with numerous stakeholders;
- The powers of a TSA, the Trust and commissioners to make changes at the Trust and local health economy level;
- Relevant laws and regulations, for example, in relation to competition and procurement;
- The risks and uncertainties around a particular method of restructuring;
- Whether different options require different implementation methods and, if so, whether they could effectively work together; and
- The potential costs associated with alternative approaches.

Leadership models
The CPT considered five leadership models

CPT View
All leadership models would require the involvement of the various stakeholders across the local health economy.

Choice of leadership model

With the Trust facing such a challenging financial deficit and the recommended approach being multi-faceted, it is critical that any implementation plan has clear leadership and a robust governance process.

The CPT believes that there are five alternative leadership models which could be used to implement the recommended approach:

1. Trust-led;
2. Trust-led supported by enforcement action by Monitor;
3. Commissioner-led;
4. TSA-led; and
5. A whole health economy-led solution.

Trust-led

In a Trust-led process, the current Trust Board would remain as the accountable body for driving progress on the efficiency programme, the competitive tender and negotiations to secure additional funding.

As the Trust cannot take decisions that bind other organisations within the wider health economy, a Peterborough Region Steering Group (PRSG) comprised of CCGs, the Trust and other local stakeholders, would need to be established, with support from regional and national bodies (e.g. the NHS Trust Development Authority, NHS England or its Area Teams) to drive progress on the health economy enablers.

The CPT is of the view that both the Trust and the PRSG would need to access additional capacity and skills in order to drive progress on each of the recommended workstreams.

Trust-led supported by enforcement action by Monitor

This model is similar to the Trust-led approach, with the addition that Monitor would use its enforcement powers as set out in sections 105 and 106 of the Health and Social Care Act 2012, to ensure pace, urgency and transparency in the process, and to allow it a degree of influence. Under this approach, the Trust would enter into a series of binding undertakings, providing commitment to Monitor of its intention to support and deliver the CPT's recommendations.

Enforcement actions could include requirements to:

- Appoint two new directors to the Board to lead the CIPs and competitive tender activities;
- Establish a cost improvement programme to achieve the stretch savings targets;
- Establish and run a competitive tender process;
- Secure external resources to support the recommended approach; and
- Cooperate with the Peterborough Region Steering Group.

Commissioner-led

In a commissioner-led process, local CCGs would be accountable for driving change across all four aspects of the solution. In this capacity, the CCGs would appoint a programme delivery team which would require external support and resources to deliver the work.

The current Trust Board would be retained and would have responsibility to deliver changes under the direction of CCGs and their programme team. This would require the Trust Board's consent and subsequently, very close working between the Trust, its commissioners and NHS England.

Leadership models

Of primary concern are the risks in delivering the solution. The need for objectivity in driving the solutions will be paramount.

CPT View

The CPT's initial appraisal of leadership models discounted the Trust-led and Commissioner-led models, as neither provided sufficient assurance over the delivery of the recommended approach.

TSA-led

In a TSA-led process, an independent, appropriately qualified individual (the Trust Special Administrator) would assume the role of the Board, the chief executive and the accounting office holder for the Trust. The Trust's Board would be suspended, and the TSA (or TSAs if there was a joint appointment) would become the ultimate decision maker.

The TSA would take the lead in driving progress on the efficiency programme, the tender and negotiations to secure additional funding, while delivering high quality services to local patients.

Under the terms of the Act, a TSA's remit is constrained to the Trust, and it cannot take decisions that bind other organisations within the wider health economy.

In order to support the TSA, a Peterborough Region Steering Group (PRSG) – as outlined previously - would need to be established to drive progress on the health economy enablers.

Any TSA would draw upon external support and resources to deliver the programme which could be procured by Monitor alongside the appointment of the TSA. These resources could also be accessed by the PRSG.

Whole health economy approach

Under this leadership model a Chief Restructuring Officer (CRO) supported by an expert team could be appointed by Monitor, NHS England and the Secretary of State for Health, to oversee the implementation of the recommended approach across all parts of the health economy.

The CRO would be empowered to lead on the necessary changes within the Trust through Monitor's enforcement regime (sections 105 and 106 of the Health & Social Care Act 2012) and would be supported in delivering change outside the Trust by NHS England and its powers over CCGs as set out in section 14Z21 of the National Health Service Act 2006 (as amended).

Initial appraisal of leadership models

Having conducted an initial appraisal of the various leadership models, the CPT believes that a commissioner-led process is unlikely to generate an optimal solution, given that a number of the key issues lie within the control of the Trust. Furthermore, the local CCGs are likely to have limited appetite for running a programme of work that is seen to affect a single provider in their respective areas. As a result, the CPT has discounted this option.

Equally, given the scale of the challenges facing the Trust, the CPT has discounted a Trust-led solution that is not supported by enforcement action by Monitor.

Detailed appraisal of leadership models

In order to determine the most appropriate way to implement the recommended approach, the CPT considered the advantages and disadvantages of each leadership model against three criteria:

1. The impact on business as usual;
2. The ability to deliver the proposed reforms in the Trust; and
3. The ability to deliver the proposed reforms in the local health economy.

Leadership models

The CPT has considered the advantages and disadvantages of each leadership model.

	Trust-led with enforcement action		Health economy-led		TSA-led	
	Advantages	**Disadvantages**	**Advantages**	**Disadvantages**	**Advantages**	**Disadvantages**
1) Delivery of business as usual	Preferable for retention of leadership, clinicians and staff and therefore most likely to retain or improve current performance.	Preserves the status quo. Use of enforcement powers may create temporary confusion as to who is responsible for patient care.	Likely to result in good retention of leadership and clinical staff at the Trust, as compared to a TSA-led solution. Changes would not take up as much capacity in Trust management, allowing them to focus on Trust performance.	Potential to create confusion over day to day responsibilities between the Trust Board, and the CRO. Does not fit with the NHS strategy of commissioner and provider roles. Lack of clarity over reporting lines for CRO.	Could bring greater pace and discipline into the CIP process. Provides a single focus for all issues affecting the Trust. Provides additional capability and capacity.	Appointing a TSA could see staff leave, undermining service delivery. There could be an impact on ownership of CIPs in the Trust. CIPs would need to continue after the TSA has left the Trust.
2) Delivery of the proposed changes at the Trust	The Trust has the levers by which to drive through the CIPs. The Trust has the potential to tender to operate the Trust's services and make the most of the space in its estate.	Despite improving performance in FY13, the Trust does not have a strong record in delivering cost savings. There is a threat of self interest in the outcome of a tender process which could limit third party participation and taxpayer value. Additional capacity and skills would be required to run a tender process and secure funding.	Health economy model has the potential to bind both the Trust and commissioners to delivering changes that support the delivery of efficiencies at the Trust. The CRO could align a tender for the additional space at the Trust with commissioners' intentions.	It is questionable whether an FT can surrender decision making powers over its future organisational form to an external agent, and Monitor does not have the powers to instruct it to do so. Complex governance arrangements may result in delays and could dilute the strength of actions taken. The CRO would be likely to require independent external support to deliver, which would need to be funded centrally.	Would provide access to additional capacity and capability. Bidders would have greater confidence about the transparency and independence of the tender process.	A TSA would need additional time to form his/her own view on the best course of action as they would be independent of the CPT.

Leadership models

The CPT has considered the advantages and disadvantages of each leadership model.

CPT View

The evaluation demonstrates that the structure of the local health economy is such that none of the leadership models is able to 'lock in' all of the parties who are integral to the recommended approach.

	Trust-led with enforcement action		Health economy-led		TSA-led	
	Advantages	**Disadvantages**	**Advantages**	**Disadvantages**	**Advantages**	**Disadvantages**
3) Delivery of changes in the wider health economy	The Trust's board would be likely to take decisions in support of the best outcome for patients	The Trust has no powers over commissioners or other providers.	Potential for strong alignment with commissioning intentions, increasing the chances of creating a sustainable solution. The direction of travel among CCGs is towards outcome based contracting and capitated budgets.	The remit of the CRO over the CCG's activities would need to be tightly defined such that it does not raise competition concerns or conflict with the intentions of GP-led commissioning. Complex governance arrangements could result in delays and could dilute the strength of actions taken.	There is strong support for a comprehensive and radical approach to the Trust's issues. A TSA would be most likely to take decisions in support of the best outcome for patients, regardless of how radical the changes were.	A TSA would need to work with the local health economy and the Trust to deliver change, as it has no direct power over commissioners or local providers.

Recommended leadership model

There are advantages and disadvantages to each leadership model.

CPT View

There is strong momentum and support within the local health economy for the current players to be the key drivers of the changes required. This has led the CPT to conclude that a Trust-led leadership model, backed by enforcement actions from Monitor and overseen by a Peterborough Region Steering Group, is likely to provide a more consensual route to driving change.

There is sufficient justification for the appointment of a Trust Special Administrator to drive the necessary changes, but this is not the leadership model most likely to maximise the benefits that are being sought.

Recommended leadership model

The evaluation of the different leadership models reveals that there are advantages and disadvantages associated with each, with no clear winner. Importantly, the evaluation demonstrates that the structure of the local health economy is such that none of the leadership models would be able to lock in all the parties who are integral to the recommended approach.

The findings of the sustainability review support the appointment of a TSA, as the Trust has been found to be financially unsustainable and unable to pay its debts. This approach has advantages, including creating a break from the past, an injection of pace and the creation of a clearly independent process to drive implementation of the TSA's chosen options.

However, it is the CPT's view that the key players in this local health economy, including local commissioners and the current Board of the Trust, are motivated to deliver these recommendations. The CPT is therefore suggesting an alternative solution, which includes:

- The implementation of an enhanced cost improvement plan, led by the Trust and supported by the actions of others from across the local health economy, including commissioners and social care providers;
- A programme of work led by the Trust to redesign elements of the estate at PCH to add clinical capacity;
- A competitive tender exercise led by the Trust to source potential bidders and solutions that make the best use of the world class assets of the Trust;
- The establishment of an independently chaired Peterborough Region Steering Group (PRSG), comprising local CCGs, the Trust, community services and social care providers, Healthwatch and other local stakeholders, to drive progress where parties need to work together. The PRSG would be overseen by NHS England, Monitor and the DH; and
- Additional and recurrent financial support from DH.

Providing assurance and pace to delivery

To provide assurance to patients and taxpayers as to the Trust's commitment to delivering a sustainable solution within reasonable timescales, the CPT recommends that Monitor seek a range of undertakings from the Trust using its powers under section 106 of the Act. These undertakings should include:

- The appointment of a director and a team to deliver the proposed cost improvement workstream;
- The appointment of director-level capacity and appropriate resources to lead the proposed competitive tender exercise and negotiations with potential bidders;
- Commitment to cooperate with the PRSG; and
- Regular progress updates to Monitor against a set of pre-agreed milestones for each workstream.

In addition to these undertakings, NHS England and Monitor should review whether extra measures, such as those provided by section 14Z21 of the National Health Service Act 2006 (as amended) should be used to secure the support of commissioners in addressing the challenges faced by the Trust

Should the Trust, working with other stakeholders, either be unable to deliver the proposed solution through these agreed undertakings or be unable to deliver against the agreed milestones in the undertakings - the CPT believes Monitor should seek to understand the reasons for non-delivery and consider alternative options, including, if necessary, the option of appointing a TSA should this be appropriate at that time.

Building blocks for implementing the solution

The underlying building blocks required to deliver each element of the solution will be similar, regardless of the leadership model chosen.

CPT View

Delivery of operational efficiency and cross-health economy working will require engagement with the whole health economy, supported by robust governance.

Key building blocks for implementing the solution

While the leadership model is essential to drive the implementation of the recommended approach, it does not directly impact the underlying building blocks required to deliver each element of the solution. It may, however, affect the timescales involved.

In this section of the report the CPT identifies the key building blocks required to implement the proposed solution and the costs and risks involved in each.

Delivering operational efficiency and cross-health economy working

Two areas of the recommended approach - delivering on operational efficiency and cross-health economy working - are only partially within the gift of the proposed Trust delivery team and cannot be fully resolved without fundamental changes in the way services are provided across the local health economy.

For example, the Trust could make some progress in reducing length of stay by addressing gaps in the discharge process (e.g. delays in pharmacy or patient transport), but further improvements would require additional community care provision to allow patients with a low acuity or in rehabilitation to be moved to a more fitting setting.

Fundamentally, it would be difficult for the management team to deliver on longer contracts and capitated budgets without the support of local commissioners.

As a result, there is a clear need to align the work of the Trust with that of the local health economy.

The CPT's discussions with the relevant parties have not identified any existing arrangements that could deliver on this requirement. Therefore, the CPT has identified a number of actions it believes are necessary to deliver a sustainable solution for patients, including:

1. Establishing a national group made up of NHS England, Monitor and the DH to provide guidance and oversee change in Peterborough;
2. Establishing an independently chaired PRSG to oversee the implementation of actions requiring commissioner, Trust and other stakeholder action;
3. A dedicated programme management office (PMO) to drive progress;
4. Clearly defined workstream activities and ownership from workstream leads;
5. Effective communications and stakeholder management; and
6. Consideration of the use of powers under sections 105 and 106 of the Health & Social Care Act 2012 and Section 14Z21 of the National Health Service Act 2006 (as amended) to drive the pace and change being overseen by the PRSG.

This approach should be considered by Monitor, NHS England and local commissioners, taking into account the revised landscape of the NHS as established by the Act.

It should be noted that these proposed arrangements would supplement the governance approach for the direct activities of the Trust. As regulator, the ultimate responsibility for governance of the Trust's activities falls to Monitor.

Proposed cross-health economy approach

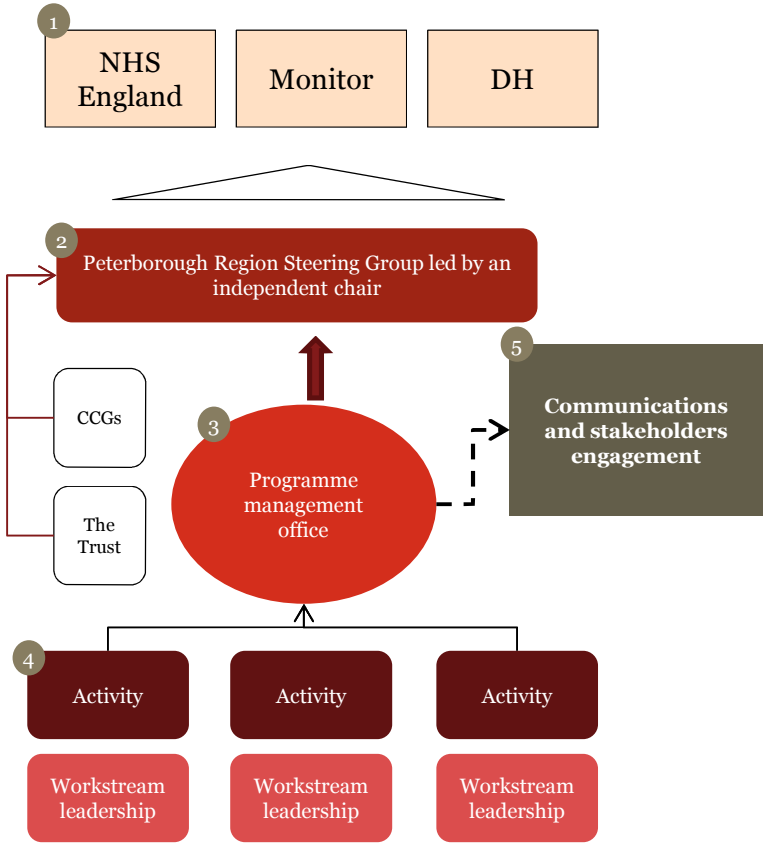
Alignment across the work of the Trust and the wider health economy will be essential.

CPT View

A Peterborough Region Steering Group should be formed to oversee activities requiring commissioner, Trust and other stakeholder input and action. This group would comprise representatives from NHS England and its Area Teams, the Trust's two main commissioners and the Trust's delivery team.

The approach opposite is illustrative and should be worked through in more detail under national leadership and to ensure that, locally, there is an effective connection with C&P CCG's Local Commissioning Group.

Suggested approach to cross health economy working



1- National level steering group

A national level steering group should be established to provide guidance and to overcome challenges associated with delivery of the options proposed in this report.

2- Peterborough Region Steering Group

A Peterborough Region Steering Group would help to drive alignment at the most senior level of the various agencies across the local health economy. This group should comprise:

1. Members of the Trust's two main commissioners;
2. Members of NHS England and its Area Teams;
3. Senior members of the restructuring team of the Trust;
4. An independent chair; and
5. National NHS bodies e.g. Monitor who would have a right to attend, but not an obligation.

The purpose of the group would be to:

1. Agree the options and the detail that underpins these, including a work programme to cover items like delayed transfers of care;
2. Set a strategy and a timeframe for the successful delivery of the options;
3. Ensure appropriate leadership is given to the workstreams;
4. Oversee the development of the workstreams that underpin the recommended activities; and
5. Report workstream progress to Monitor, NHS England and the DH.

Proposed cross-health economy approach

Progress and success will be driven by the right day-to-day working arrangements.

CPT View

A cross-health economy programme management office should be established with adequate experience and skills to deliver sustainable change of this scale.

This will need to be supported by effective communications and stakeholder management.

3- Programme management office

The role of a programme management office (PMO) in the set up and management of a programme of this change is significant. The key role of a PMO includes:

- Strong leadership across the workstreams of change;
- Development and implementation of robust tracking and reporting protocols and processes;
- Helping to make the change process as clear and smooth as possible for all the various stakeholders; and
- Holding to account the workstream leads and governance teams.

There is currently no system-wide PMO operating across the health economy. Recruiting adequate skills and resources into this governance structure will be important.

4- Workstreams and project leadership teams

Appropriate leadership for the workstreams will be critical to their success. The following leadership structure should be considered for each stream:

- Non-Executive Director ownership. In order to create a strong culture of integration each option should have a NED owner from both the Trust and its main commissioners;
- Executive level ownership. Further integration across the local health economy should be sought by the appointment of joint executive level owners;
- Clinical leadership. It will be important that the change is clinically led to ensure appropriate planning and delivery; and
- Support staff. The development and delivery of these programmes of change will require a significant commitment of time by the right staff.

Workstreams should be supported by robust project plans that detail:

- Leadership for each of the options;
- Project milestones, deliverables and dates;
- Financial implications;
- Other KPIs, including clinical quality metrics, which should be tracked by the PMO; and
- Risks and their mitigations.

5- Communications and stakeholder management

Central to the role of successful delivery is meaningful communication and engagement, and managing the involvement and expectations of stakeholders. A significant commitment has been given to the appropriate involvement and briefing of stakeholders affected by the work of the CPT to date. This level of commitment needs to continue to ensure that the approach is understood and owned by those involved.

It will be crucial that an effective communications strategy is developed to support planning development and delivery.

Methods for implementing the solution

The CPT has recommended that a competitive tender be undertaken to maximise the potential offered by the facilities of the Trust.

CPT View

The scope of the proposed tender will need detailed planning and consultation with a range of national and local stakeholders in order to maximise the potential value to patients and taxpayers.

Creating additional space and running a competitive tender

As described previously, the CPT has recommended that a competitive tender is undertaken which seeks to maximise the use of the Trust's excellent facilities.

Scope of the tender

As discussed in this report, there a number of options for the scope of the proposed tender. These range from a simple tender to lease the additional space identified within the Trust, to a tender that could consider the wider activities of the Trust.

The CPT's soft market testing has identified that the interest of participants is likely to increase in proportion to the breadth of opportunity being presented (utilisation of estate and operation of services), so the broader the opportunity, the more interest. Set against this is that a broader tender is likely to be more complex and this presents additional risk.

To reduce the contribution required of the taxpayer, the CPT is of the view that the scope of the tender should, at a minimum, include the broader activities of the Trust. In addition, NHS England and Monitor should consider whether aligning the proposed Trust tender with commissioning developments would be beneficial.

Structure and timetable of the tender

The tendering process would be subject to European competition legislation. While health services are usually considered Part B services for the purposes of the legislation, the size of the contracts under discussion may be large enough for the tender to fall under Part A regulations.

The key stages of the process to tender would be as follows:

- Agreement with the PFI contractor (Progress Health) regarding the use of the additional space at PCH;
- Preparation of tender documentation and issuing it through OJEU (Official Journal of the European Union);
- Initial responses from interested parties with invitations for further discussion to selected parties;
- Detailed responses received and bidders short-listed;
- Final round of submissions with preferred bidder chosen by the Trust Board;
- Competition commission merger clearance may be required should the preferred bidder propose a transaction; and
- Monitor clearance and final Trust Board approval.

On the following slide the CPT has modelled a timetable based on the assumption that the Trust leads the implementation of the solution and the planning can begin in September 2013.

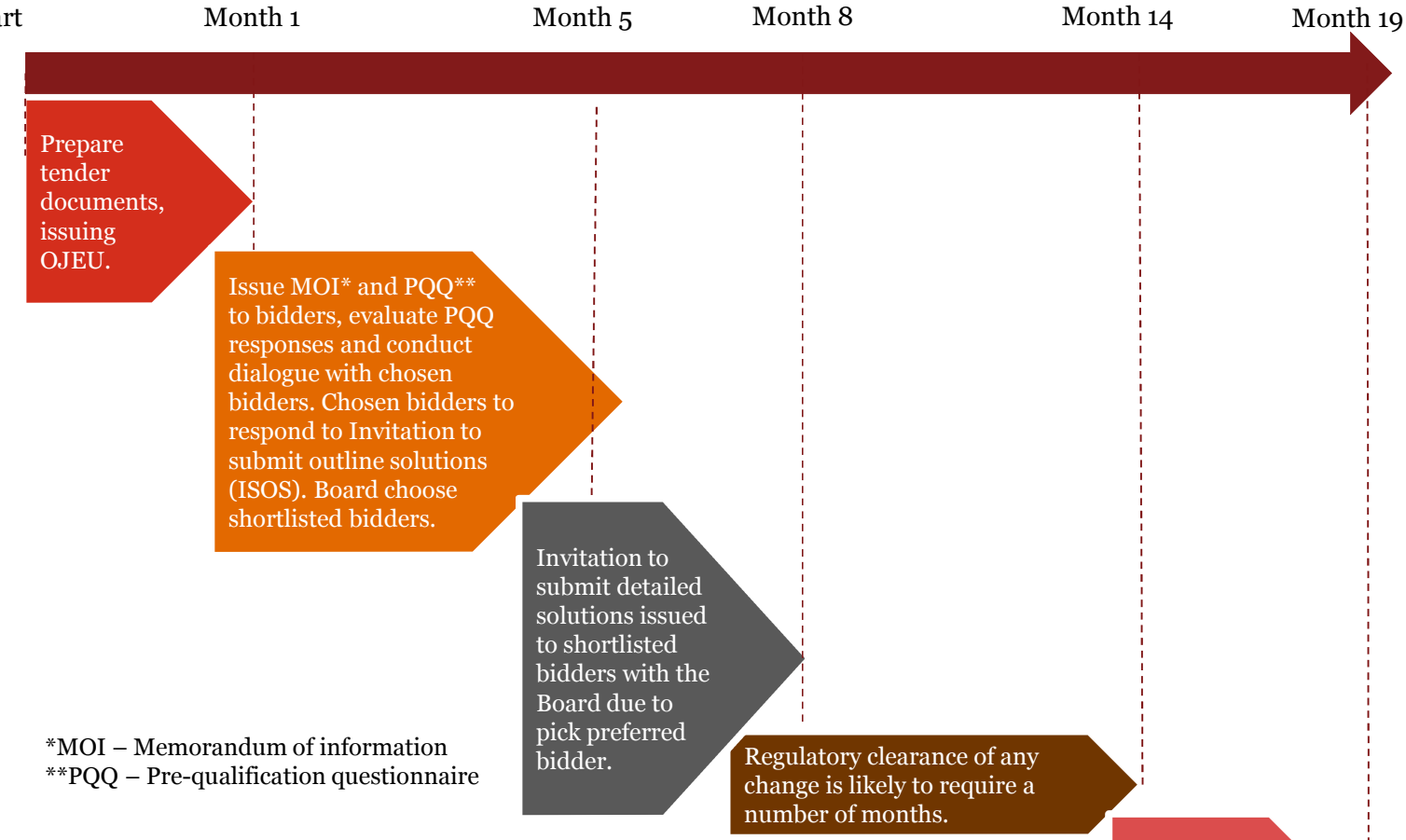
Methods for implementing the solution

The CPT has produced an indicative timeline for the competitive tender process to find the most appropriate party or parties to operate the Trust's services and make the most of the space in its estate.

It is anticipated that the process will begin before the end of 2013.

CPT View

The process is forecast to take up to 90 weeks.



*MOI – Memorandum of information
**PQQ – Pre-qualification questionnaire

Based on the CPT's experience of other such competitions, this is an outline timetable for the competitive tender to operate the Trust's services and make the most of the space in its estate. Experience shows that attempts to run rapid tender processes often result in sub-optimal outcomes and increase the risk of challenge. Additionally, it should be noted that elapsed time for processes outside the control of the Trust (e.g. external approvals) can extend considerably beyond the time indicated and introduce substantial delay.

The CPT is aware of a number of policy debates around tendering simultaneously for NHS and private providers. It has not sought to pre-empt the outcomes of any decision relating to this and, therefore, this page illustrates the process it believes necessary to maximise the value associated with this competitive process.

Methods for implementing the solution

The Trust must satisfy a number of regulatory and legal conditions in order to implement the proposed solution.

CPT View

The tendering process would be subject to European competition legislation and Competition Commission merger clearance would be needed once the preferred bidder had been identified.

A robust case would need to be developed to support negotiations with the DH. The value of the subsidy would be dependent on the contribution that the other elements of the recommended approach can make to the financial deficit. Since the cost of the PFI inflates over time, it is likely that the level of support required would also increase with time.

Legality of the potential end states models for the Trust

The CPT has sought independent legal advice as to the consistency of each of the potential end state models with the legal requirements of the Foundation Trust model and broader legislation governing the healthcare sector. It is confident that each of the potential end states could be achieved, though further legal advice would be required on specific proposals.

Competition and consultation considerations

The outcomes of the tender could be a merger or business arrangement that requires approval from the relevant competition authorities. The parties involved would have to obtain approval by demonstrating the benefits of the change to patients.

Service changes also require the normal consultation procedures. It would be the responsibility of the parties involved to coordinate this consultation.

Other considerations

The tender and bidding process would also need to consider:

- Models for capital funding;
- The role of private providers; and
- How to achieve value for money.

Addressing high estate costs

Securing additional support from the Department of Health

If the financial contribution generated by the enablers, operational efficiencies and the tender were not sufficient to close the deficit, the Trust would need to access additional support from national stakeholders.

The DH has established a support fund to compensate hospitals for unaffordable legacy PFI schemes. In order to access this fund, a trust must prove that:

1. The problems it faces are exceptional and beyond those faced by other organisations;
2. The problems are historic and there is a clear plan to manage resources in the future;
3. It is delivering high annual productivity savings; and
4. It is delivering high quality services that are clinically viable.

The CPT notes that the level of PFI support provided will reflect the methodology the DH has used across other health economies with high cost PFIs. This will contribute to the overall solution for the Trust, but as highlighted elsewhere in this report, the Trust may still need to negotiate recurrent support from national stakeholders to cover any remaining shortfall and mitigate the high cost of the estate. This will be after all other actions identified as part of the CPT's proposed solution have been taken which, together, are expected to minimize the ongoing burden on the taxpayer

All other things being equal, since the cost of the PFI inflates over time it is likely that the level of support required would also increase with time.

Coming to an agreement with the DH will require the Trust to develop a clear business case that sets out the requirement for funding and details actions that the Trust (or new organisation, depending on the result of the competitive tender) would take in order to manage the requirement down over time and mitigate the risks of additional expenditure in the future.

Costs and risks associated with the recommended approach

Implementation risks

The CPT has considered the risks arising from the implementation of the solution.

CPT View

Any restructuring in the health sector brings risks and challenges. These may be difficult to manage, but the success of a programme depends upon the ability to mitigate risks where possible.

Management of risks and challenges

The implementation of the CPT's recommendations will not be straightforward, and the CPT has identified several risks and challenges which will need to be taken into consideration. Main risks include:

- The efficiency challenges to be addressed within the Trust will require strong leadership, detailed planning and programme management. There will need to be an increased focus on delivering these efficiencies across the whole Trust;
- Any competitive tender to find solutions to maximise value from the space at the Trust will need to be managed in an open and transparent manner and there will need to be an openness to consider alternative solutions and providers in order to make the best use of PCH;
- The solutions that require changes across the local health economy will be particularly difficult to deliver, requiring the commitment and joint working of a number of commissioners and providers, all of whom will have their own challenges and will not necessarily have the sustainability of the Trust as a key consideration; and
- Throughout the implementation of the recommendations there will be uncertainty and confusion for staff, patients and local stakeholders. It is key that the safety of patients remains the priority and that all stakeholders work together to ensure that standards of care are not adversely impacted.

Implementation risks

The CPT has considered how the implementation risks could be mitigated.

CPT View

There are ways to mitigate the potential impact of risks to implementation.

A strong and robust governance structure which draws on appropriate skills and resources will be essential in driving the programme of work.

And it will be critical that the tender for the additional space is run as openly and transparently as possible to encourage potential bidders.

Significant Risks	Mitigations
Inconsistency of the proposed approach with the legal framework	• The CPT has sought independent legal advice as to the consistency of each of the potential end state models with the legal requirements of the foundation trust model, and the broader legislation governing the healthcare sector. Having sought this advice, the CPT is confident that each of the potential end states could be achieved, though further legal advice will be required as specific proposals are made.
The Trust Board does not accept the enforcement undertakings	• Early drafts of Monitor's enforcement undertakings should be shared with the Trust as soon as possible. If agreement can't be reached with the Trust board on the enforcement undertakings, then Monitor would need to consider alternative methods of enforcement.
Staff will seek and find alternative employment during implementation of the recommendations, destabilising the Trust	• Communication to explain the consequences of restructuring for staff and reduce uncertainty - with HR support provided. • Understand the skills mix required to deliver the services required. • Trust Board must give strong messages that it is business as usual, with no loss of services .
The Trust fails to deliver its CIP programme.	• Development of the Trust PMO to identify efficiency opportunities and use high quality documentation to support a culture of accountability. • Use of the Monitor regulatory regime to drive delivery. • Trust undertakes to recruit additional Director and team to lead CIP and transformation programmes.
Capacity of leadership to deliver change.	• Development of a detailed plan to identify the capacity needed and actions that can be taken to develop that capacity. • Capital expenditure and/or external support may be required in some areas to support change. • Monitor to oversee progress against KPIs and take action if performance deteriorates.
Challenge to the process on competition grounds	• Fair and open tender process throughout. • Tender team supporting the Trust to include competition advisors. • Early engagement with the CCD.
The tender does not result in solutions that provide the financial benefits anticipated.	• The tender should be run as openly and transparently as possible, with potential bidders being encouraged to participate. • The Trust must be seen as impartial in any tender process. • The financial contribution from the proposed end states will need to be evaluated against specific value for money assessments. • NHS England and Monitor should seek assurances over the alignment of the proposed tender for the Trust and the current Older People's procurement being led by local commissioners.
Lack of engagement of Commissioners with the CIP (puts years 3-5 at risk)	• Communications at launch (see appendix). • Monitor and NHS England should explore whether powers under sections 105 and 106 of the Health & Social Care Act 2012 and section 14Z21 of the National Health Service Act 2006 (as amended) could be applied to generate alignment of all parties in the local health economy with the challenges faced by the Trust.
Patients choose to switch to other providers as a result of uncertainty.	• Clear communications to ensure that patient decisions are not impacted by the restructuring. • The Trust Board must give strong messages that it is business as usual from a patient perspective and that the Trust has been found to be clinically and operationally sustainable.

Costs of implementation

The CPT has considered the costs of implementing the solution.

CPT View

Any restructuring in the health sector would incur exceptional costs beyond normal Trust expenditure.

Transition costs

The proposed solution would require investment both in terms of management capacity and funding for some transitional expenditure. The key areas where funding would be required are:

1. *Estate costs*

   Any reconfiguration of the additional capacity at PCH would require capital expenditure to bring the accommodation to an acceptable level for clinical use. There may also be some capital expenditure required to relocate the administration functions, which currently fill the capacity that has been identified as more appropriate for clinical use.

2. *Tender costs*

   Running a competitive tender process to maximise the opportunity provided by the Trust's assets would require funding.

3. *Increasing capacity to deliver efficiencies at the Trust*

   It is likely that the Trust would need additional resources to deliver the ambitious CIP programme that will be required.

4. *Governance over local health economy changes*

   The CPT recommendation is that a governance structure is established to manage any changes required in the local health economy. This is likely to require an independent Chair and a programme management office to drive through the changes.

5. *Staff costs*

   Some of the changes proposed require the cooperation of staff at the Trust. Throughout this process, staff will need to be treated fairly and in compliance with HR policies. None of the options proposed in this report suggest the need for staff redundancies, although contractual arrangements should be considered as part of the solution.

Total transition costs

The CPT has made an initial assessment of the indicative transition costs which would be required to support the solution. These have been estimated at £27m, subject to more detailed costing and discussions with the PFI provider and surveyors.

These costs would need to be fully developed during a detailed design stage. This estimate excludes the costs of funding the Trust's deficit throughout the transition period and the costs of any ongoing subsidy that is agreed.

Costs of implementation	£millions
Capital costs of 4th floor conversion (four wards)	£16.5
Capital costs of increasing bed estate	£2.5
Costs of addressing inefficiencies at the Trust	~£3.5
Costs of local health economy governance structure	~£1.5
Cost of the tender process	~£2.5
Costs of accessing additional funding for any shortfall after all other actions are taken	~£0.5
Total implementation costs	~£27.0

Next steps

Conclusion and next steps

The CPT's principal objective was to develop an approach to secure the sustainable delivery of services for the population of Peterborough, Stamford and the surrounding areas.

CPT View

Having completed its work, the CPT believes a sustainable solution can only be achieved through the successful delivery of four parallel workstreams which, in turn, require contributions from all parts of the local health economy - including the taxpayer.

It is for Monitor to consider whether to proceed with the CPT's recommended approach. In the meantime, the Trust and the local health economy must continue to focus on delivering high quality services to patients.

Conclusion

The people of Peterborough, Stamford and the surrounding areas, rightly expect their local health services to be the very best, with the best standards of care, delivered efficiently and effectively and with compassion, by appropriately qualified staff.

The CPT's principal objective was to develop a set of options for the delivery of sustainable services to the local population that address the financial issues currently facing the Trust – but without damaging patient care or shifting the burden onto other organisations or local populations.

Having completed its work, the CPT believes a sustainable solution can only be achieved through the successful delivery of four parallel workstreams which, in turn, require contributions from all parts of the local health economy - including the taxpayer.

This approach, which requires the involvement of a large number of organisations within the vicinity of Peterborough and Stamford, is strongly aligned to the key recommendations of the recent Public Accounts Committee and their review of the Trust (http://www.publications.parliament.uk/pa/cm201213/cmselect/cmpubacc/789/78902.htm).

The CPT believes it has set out a compelling strategy for the future of the Trust that both protects the existing high quality services offered to the local population and makes the most of the excellent facilities at PCH.

Next steps

Monitor will now consider whether to proceed with the CPT's recommendations.

In the meantime, it is essential that the Trust, its commissioners and other local stakeholders continue on a "business as usual" basis. This includes the development and delivery of CIPs to support the Trust's forecasts in year 1 and year 2, most importantly, a continued focus on delivering a high quality service to patients.

Any decision that is taken in future to propose any changes to the current pattern of services would be subject to a statutory public consultation.

Appendices

Location specific services

The CPT has been supporting commissioners to identify services that must continue to be provided at the location of the Trust's sites in the event of its failure.

CPT View

Given the extent of the services provisionally identified as Location Specific Services at the Trust, it is clear that a major healthcare facility is likely to be required within the Peterborough area over the medium-term.

Location Specific Services

Should Monitor place a provider into Trust Special Administration, commissioners are required to identify the services currently delivered by the organisation for which there is no acceptable alternative provider. As part of the contingency planning process, the CPT has been supporting Cambridgeshire and Peterborough CCG and South Lincolnshire CCG to identify services, including specially commissioned services, that must continue to be provided from the Trust's sites (Peterborough City Hospital and Stamford and Rutland Hospital) in the event of failure of the Trust, due to the absence of suitable alternative provision. These are known as Location Specific Services (LSS).

Defining a provisional view of Location Specific Services

Commissioners, supported by the CPT, have followed Monitor's guidance for identifying LSS, devised using insight from clinicians, commissioners and providers.

In addition to Monitor's guidance, commissioners used three guiding principles in deciding whether to designate a service as LSS:

1) Commissioners' wish to maintain the status of PCH as a category two trauma centre with the ability to admit patients with urgent care needs.
2) The need to retain services used by patients from more deprived backgrounds in order that the designation of services as LSS does not increase health inequalities.
3) Not to designate as LSS those services that could be re-commissioned in the short term from suitable alternative providers.

Provisional designation of LSS

Subject to market conditions, including Monitor's approach to tariff adjustments, commissioners have provisionally identified the following services delivered at PCH as LSS:

- Accident and Emergency services (major injuries);
- All associated support services required to run a level two trauma centre, including adult critical care;
- All paediatric and neo-natal critical care services;
- All emergency (unplanned) maternity and paediatric services with planned care where alternative local capacity does not exist;
- All emergency medical and surgical specialties with planned care where alternative local capacity does not exist;
- All geriatric services, driven by concerns over health inequalities should additional travel be required for this population cohort; and
- All support services, including diagnostics and therapies that are required to support ongoing provision of the LSS identified above.

Impact of commissioners' provisional designations on services provided at the Trust

The nature of commissioners' views on LSS means that the options developed by the CPT need to be consistent with the retention of a major healthcare facility within the Peterborough area to provide a wide range of acute and emergency services.

The CPT options are based on the provision of these services as a minimum.

Terms of reference

The terms of reference under which the CPT has conducted its work are set out opposite.

Terms Of Reference : Contingency Planning Team for Peterborough & Stamford Hospitals NHS Foundation Trust

Context and Purpose

Monitor has been working with Peterborough & Stamford Hospitals NHS Foundation Trust ('the Trust'), the Department of Health and local NHS commissioners on initiatives to bring down the Trust's significant deficit since the Trust was found in significant breach of its Authorisation in October 2011.

It is now clear that the existing initiatives will not be sufficient to return the Trust to financial sustainability. This is partly because of the ongoing costs of the PFI funded hospital scheme on which the Trust embarked in 2007 and other reasons, that are set out in the National Audit Office's report.

Monitor has therefore appointed a Contingency Planning Team ('CPT') to work in partnership with the Trust's Board and executive team to develop an agreed plan which ensures the sustainability of services for patients and minimises the need for ongoing funding of deficits by the taxpayer.

The CPT will be provided by PwC who were selected by Monitor through a competitive tender process and will comprise a team of experts with healthcare, restructuring and administration skills should a Trust Special Administration ('TSA') be needed. Work will commence in February 2013 and a final report and recommendation will be delivered to Monitor at the end of Summer 2013.

The CPT will work closely with stakeholders from the local health economy in developing its recommendations. This approach has been agreed with the Department of Health, the NHS England and the NHS Trust Development Authority.

Scope

As part of the review, the CPT will make an independent assessment as to the financial, clinical and operational sustainability of the Trust in its current form.

The CPT will look at the Trust's arrangements with the PFI, including facilities management arrangements, to identify opportunities to reduce the cost to the Trust.

The CPT will work with commissioners to agree the range and scale of services provided for local patients and identify those that should be classified as Locality Specific Services ('LSS') at the Trust. LSS are those services which would need to be kept in operation in the event of provider failure in order to ensure there is no significant adverse impact on local health or health inequalities.

Having established sustainability, opportunities to reduce cost at the PFI and LSS, the CPT will engage with the Trust, local commissioners and providers to identify and explore the options for the future provision of services at the Trust. The CPT will also seek to identify other ways in which the financial challenge can be reduced such as opportunities to improve the Trust's efficiency or be paid more fully for activity undertaken.

Terms of reference

The terms of reference under which the CPT has conducted its work are set out opposite.

Scope (continued)

As part of this exercise the CPT will consult key local organisations, including: Cambridge Community Services NHS Trust, Cambridge University Hospitals NHS Foundation Trust, East of England Multi-Professional Deanery, Hinchingbrooke Healthcare NHS Trust, Kettering General Hospital NHS Foundation Trust, Northampton General Hospital NHS Trust, Papworth Hospital NHS Foundation Trust, Queen Elizabeth Hospital NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust, University Hospitals of Leicester, the East of England Ambulance Trust and Cambridgeshire and Peterborough NHS Foundation Trust.

The CPT will engage with a wide range of other stakeholders either directly, or in support of Monitor, including representatives of the public, Members of Parliament, the Ministry of Defence, the Academic Health Science networks, patient advocacy groups and Local Authorities.

The final report will make a recommendation to Monitor for the future configuration of the services currently supplied by the Trust, and the mechanism most appropriate to ensure that they are delivered on a sustainable basis for the benefit of the local population.

Alongside the final report the CPT will be expected to provide support for the production of consultation and implementation plans.

CPT governance

The CPT will make its recommendations to the Monitor Board.

The progress of the CPT will be overseen by senior representatives of Monitor, the Department of Health, the NHS England and the NHS Trust Development Authority.

Glossary

The report includes a number of terms and short descriptions which are defined here.

Term	Definition
AfC	Agenda for Change
A&E	Accident and Emergency
BH	Bedford Hospital NHS Trust
Capex	Capital expenditure
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan/Programme
CPT	Contingency Planning Team
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSIP	Clinical Services Implementation Plan
CUHFT	Cambridge University Hospitals NHS Foundation Trust
C&P CCG	Cambridge and Peterborough Clinical Commissioning Group
DH	Department of Health
EBITDA	Earnings before Interest, Tax, Depreciation and Amortisation
EWTD	European Working Time Directive
FCE	Finished Consultant Episode
FM	Facilities Management
FRR	Financial Risk Rating

Term	Definition
FT	Foundation Trust
FTE	Full time equivalent
FY	Full Year Effect
FYXX	Financial year ended March 20XX
GRR	Governance Risk Rating
HCC	Healthcare Commission
HHFT	Hinchingbrooke Healthcare NHS Trust
HMRC	Her Majesty's Revenue and Customs
IBP	Integrated Business Plan
I&E	Income and Expenditure
KGFT	Kettering General Hospital NHS Foundation Trust
KPI	Key Performance Indicator
LTFM	Long Term Financial Model
m	Million
NCA	Non-contract activity
NHS	National Health Service
NICE	National Institute for Health and Clinical Experience
NRAF	Net Return After Financning
PBR	Payment By Results

Glossary

The report includes a number of terms and short descriptions which are defined here.

Term	Definition
PCT	Primary Care Trust
PDC	Public Dividend Capital
Peterborough	Peterborough City Hospital
PFI	Private Finance Initiative
PMO	Programme Management Office
PPE	Property, Plant and Equipment
QEFT	Queen Elizabeth King's Lynn NHS Foundation Trust
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
RCI	Reference Cost Index
RPI	Retail Price Index
SDP	Service Development Plan
SHA	Strategic Health Authority
SIFT	Service Increment for Teaching
SL CCG	South Lincolnshire Clinical Commissioning Group
SLA	Service Level Agreement
SLM	Service Line Management
SLR	Service Line Reporting

Term	Definition
Stamford	Stamford and Rutland Hospital
the Trust	Peterborough and Stamford Hospitals NHS Foundation Trust
TSA	Trust Special Administration or Administrator
UHL	University Hospitals Leicester NHS Trust
ULH	United Lincolnshire Hospitals NHS Trust
WCF	Working Capital Facility
WLI	Waiting List Initiative
WTE	Whole Time Equivalent
YoY	Year on year