

# *Peterborough and Stamford Hospitals NHS Foundation Trust*

## Assessment of sustainability

7 June 2013





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Dear Sirs,

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

## CPT view

*The scope of work to assess sustainability requires a detailed and comprehensive report. To help you navigate through the report, here is some guidance on which sections of the report you should read depending on the time you have available.*

## Reading this report

If you have 15 mins

'At a glance'- pages 5 to 7

If you have 30 mins

'At a glance' and the conclusions for operational, clinical and financial sustainability - page 43, page 58, page 90

If you have 3 hours

All of the report

# At a glance

## CPT view

*Whilst the Trust is operationally and clinically sustainable, it is not financially sustainable.*

*The Trust is operationally sustainable and continues to make positive progress regarding new management structures and processes to better govern and manage the services it provides.*

*The Trust is clinically sustainable and has improved clinical performance in the last 12 months.*

*The Trust is not financially sustainable. Even if it achieved cost improvement plans (CIPs) and delivered best in class efficiency it would have a sizeable deficit each year for the next five years.*

## 1 Background

Peterborough and Stamford Hospitals NHS Foundation Trust is an acute services provider with two sites and a total of 612 beds. The Trust moved into a new site, Peterborough City Hospital, in December 2010 which was funded through the PFI scheme. Since then, the Trust has consistently made losses and reported the highest proportional deficit in the NHS in the financial year ended 31 March 2012.

The local health economy in which the Trust operates serves a population of over 3 million with 8,458 acute beds provided by two major teaching and research hospitals and a range of district general hospitals.

The Contingency Planning Team (CPT) has been appointed by Monitor to review the sustainability of Peterborough and Stamford Hospitals NHS Foundation Trust from three perspectives:

- 1) Operational sustainability- does the Trust have the necessary organisational management structures, operating model, governance, risk management procedures and operational processes to deliver its immediate corporate objectives and longer term strategy?
- 2) Clinical sustainability- is the Trust delivering acceptable levels of clinical performance for the patients that it serves?
- 3) Financial sustainability- can the Trust return to surplus, maintain a surplus year on year, and generate cash in order to pay its debts as they fall due?

## 2 Operational sustainability

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

The Trust is in the process of implementing a number of changes that will further enhance its operational sustainability, including revised performance reporting, service line reporting and a comprehensive Trust board development programme.

However, progress in implementing some of these changes has been slow. There are concerns, shared by the Trust's commissioners and the Trust, that the large agenda facing the Trust, and certain residual weaknesses in performance management, may have an impact on performance if not carefully managed.

## 3 Clinical sustainability

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

The clinical Key Performance Indicators (KPIs) reviewed by the CPT indicate that clinical quality is appropriate and the performance of the Trust is, on the whole, within expected performance levels.

In some areas the Trust's performance is better than the national standard, such as the number of patient incidents that result in harm, severe harm or death.

There are specific areas of concern that the Trust is currently focused on, such as the national four hour A&E wait time target, where the Trust has achieved below expected performance for three of the last four quarters.

Overall, the Trust has shown an improvement in clinical performance in the last 12 months.

# At a glance

## CPT view

*Whilst the Trust is operationally and clinically sustainable, it is not financially sustainable without significant financial support.*

*The lack of a financial surplus is driven by a combination of operational issues - £18m and estate issues - £22m.*

## 4 Financial sustainability

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

The Trust has incurred an underlying c.£37m deficit in Financial Year (FY) 13 compared to an income of c.£223m. In addition, like other foundation trusts, the Trust is faced with the on-going challenge of being c.4.5% more efficient in future years.

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, upside and downside scenarios have been prepared by the Trust to illustrate the range of potential outcomes. The upside scenario does not bring the Trust back to surplus and the CPT concludes that none of the tests for financial sustainability have been passed.

## 5 Financially unsustainable: causes

The Trust had an underlying deficit in FY13 of £37m. To match a normal surplus it would have to 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 sections:

### Operational issues - £18m

- The CPT has identified that improving performance across a set of operational measures would reduce the deficit by £10m when comparing the Trust against average performance;
- The Trust was not paid for £5m of activity which was undertaken in FY13; and
- There are £3m of additional operational improvement opportunities which include reducing outsourcing of elective activity.

### Estate issues - £22m

- The CPT has considered a number of factors related to the causes of the deficit/ that may present opportunities for the Trust:
- Space utilisation - the Trust has identified that an additional 3 wards could be accommodated on the 4th floor at Peterborough City Hospital. This could generate an additional £9m of contribution assuming paid activity. This is in line with an estimate of the saved unitary charge cost of having less space.
- Private Finance Initiative (PFI) cost - although a competitive deal was made at that time, the unitary charge of the PFI 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.
- Tariff is calculated as an average across a wide-range of trusts, and therefore does not compensate those trusts that have invested in new estates funded by a PFI. The value of this has been estimated at £10m.
- Looking at estate costs from other angles such as a comparison to the cost of the old estate to the current estate gives £21m and the current affordability criteria gives £22m. The NAO report estimate was £11m - £26m.

The CPT has considered the causes of the deficit and the Trust's ability to address them through actions which are in their control. Even if the Trust were to address all its operational issues and gain agreement to increase income by utilising its spare space it would remain unsustainable due to its excess estate costs.

# At a glance

## CPT view

*The range of options the CPT will consider as part of its next phase of work will seek to address the Trust's deficit.*

The causes of the deficit will move over time and will be impacted by factors including the level of operational efficiency in the Trust and the cost of the PFI which will rise with inflation. Since the cost of the PFI will inflate in line with RPI, the level of financial unsustainability that is attributed to estate costs is likely to grow over time.

### **6 Financially unsustainable: the current position on efficiency**

The Trust undertook a programme of efficiency improvements in FY13 that achieved c. £13.2m of cost improvement. There remain opportunities for the Trust to catch up with other comparable foundation trusts that are more efficient in a number of areas. The Trust is targeting a level of efficiency in future years, £57m, that is greater than the average percentage efficiencies foundation trusts are seeking to achieve.

The CPT considers that, whilst possible, this degree of efficiency improvement will be significantly challenging for the Trust to achieve on its own. Furthermore, a cost reduction programme aimed at complete closure of the Trust's deficit would seriously increase the risk of an adverse impact on the quality of care provided to patients.

### **7 Financially unsustainable: the PFI**

The Trust entered into PFI arrangement in 2007 to build the 611 bed Peterborough City Hospital. It opened in December 2010.

The annual cost for the PFI was £40.4m in FY13 and there are 31 years of the commitment remaining. Each year the commitment increases by inflation based on the retail prices index, that is greater than the typical level of inflation over the remainder of a trust's cost base. As a result, the PFI is likely to represent a greater proportion of the Trust's costs in future years.

For the purposes of this report, the CPT has assumed that ending the PFI arrangement early would require a very substantial one-off payment and not represent value for money.

Looking at estate costs from other angles such as a comparison to the cost of the old estate to the current estate amounts to £21m more cost.

### **8 Financially unsustainable: cash**

In FY13 the Trust received one-off cash support from the Department of Health (DH) of £44.1m.

Even after delivering the challenging level of cost improvement plans already outlined, the Trust is forecasting a cash shortfall of at least £40m per annum over the next five years. In the absence of further support from national stakeholders, the Trust would not be able to pay its obligations, such as wages and suppliers, as they fall due.

### **9 CPT work on options**

The CPT is undertaking work to identify a number of options for addressing the unsustainable position the Trust finds itself in.

This process will involve engagement and close working with clinical, financial and operational stakeholder groups made up of organisations in the local area.

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# *Background to the Trust and the work of the CPT*

## **Background**

The Trust's main site is a 611 bed hospital in Peterborough. It also has a 22 bed site in Stamford. It employs approximately 3,400 full time equivalent staff.

## **CPT view**

*The Trust's financial projections have deviated dramatically from those on which the PFI was predicated.*

## **Overview of the Trust**

The Trust became a foundation trust in 2004 and provides acute health services to a population of c350,000 residents of Peterborough, Cambridgeshire and South Lincolnshire.

The PFI funded City Hospital on the outskirts of Peterborough became fully operational in December 2010. The new facility replaced three sites and had a total cost of £411m, including financing. It includes smaller facilities for Cambridgeshire and Peterborough Mental Health Partnership NHS Trust and Greater Peterborough Primary Care Partnership.

In the four years prior to the start of the transfer to the PFI site, the Trust made surpluses. In the last audited financial year to 31 March 2012, the Trust had a turnover of £208m and had an underlying deficit of £46m. The Trust reduced its deficit in FY13 to £39.6m but deficits of this magnitude are forecast for the foreseeable future.

Monitor has therefore appointed a contingency planning team to consider the sustainability of the Trust and recommend options to resolve the issues identified.

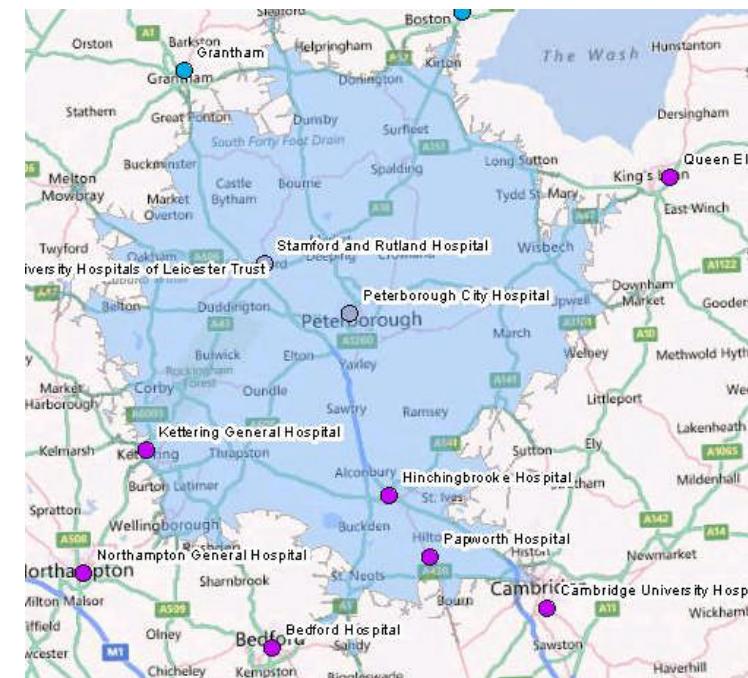
## **The local health economy**

The local health economy is a term used to describe an area in which health services are commissioned and provided.

The local health economy in which the Trust operates is shown on the map opposite. It includes two major teaching and research hospitals, each offering District General Hospital (DGH) type services, network services for the whole of the East of England and East Midlands respectively, and specialist services. In addition, there are a range of other DGHs – also shown on the map.

There are a total of 8,458 acute beds to support a population of over 3 million people.

More details on the Trust's catchment area can be found in the clinical sustainability section of this report.



## **Background**

A review by the National Audit Office (NAO) in November 2012 concluded on the circumstances of the Trust's financial difficulties.

## **CPT view**

*The NAO concluded that the Trust's board failed to recognise that the PFI scheme would place considerable strain on the Trust's finances for many years to come.*

*The CPT's report does not revisit the areas covered by the NAO in detail, but seeks to build on elements of this review to establish if the Trust is operationally, clinically and financially sustainable.*

## **National Audit Office review**

The Trust has been subject to a review by the National Audit Office (NAO) into the circumstances of the Trust's serious financial difficulties.<sup>1</sup> The NAO report includes an analysis of the PFI development, the financial crisis, delays in identifying the financial problem and the actions taken to address the problem. The NAO report concluded that:

- In 2007 the Trust's board failed to recognise that the PFI scheme would place considerable strain on the Trust's finances for many years to come;
- The Department of Health (DH) evaluated the scheme but was not sceptical enough about its affordability;
- The Trust's board and the DH failed to satisfy Monitor's concerns on affordability; and
- Monitor and the Trust's board did not adequately maintain focus on the Trust's financial performance between scheme approval and the opening of the new hospital.

## **Monitor's changing role as the sector regulator and the appointment of the CPT**

Under the Health and Social Care Act 2012, the role of Monitor is expanding. The legislation makes clear that the primary duty of the sector regulator is to protect and promote the interests of people who use healthcare services. As part of this revised role, Monitor has acquired new powers to ensure the continuity of services for patients if a provider's financial viability puts them at risk.

Since entering into a PFI scheme under which it developed the new hospital in Peterborough, the Trust has been under considerable financial strain. 10 months after the hospital opened in December 2010, it was placed in significant breach of the Trust's terms of authorisation for financial reasons.

The Trust, Monitor and commissioners have been working to address the financial performance. Whilst the Trust has been delivering cost efficiencies, a way of providing financially sustainable services has not been identified.

Monitor has appointed PwC to act as a Contingency Planning Team (CPT) to develop a plan for the long-term to ensure services are provided for local patients on a sustainable basis.

<sup>1</sup> [http://www.nao.org.uk/publications/1213/peterborough\\_and\\_stamford\\_nhs.aspx](http://www.nao.org.uk/publications/1213/peterborough_and_stamford_nhs.aspx)

## **Background**

The CPT was appointed by Monitor in February 2013 and has a number of objectives that underpin its work.

## **CPT view**

*This report covers the first of the CPT's core objectives: to make an independent assessment of the financial, clinical and operational sustainability of the Trust in its current form.*

## **Objectives of the Contingency Planning Team**

Monitor's press release regarding the appointment of the CPT can be found on their website<sup>2</sup>.

The core objectives for the CPT are to:

- Make an independent assessment of 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 PFI;
- Work with commissioners to identify those services that need to be maintained in the event of provider failure in order to ensure there is no significant adverse impact on local health or health inequalities;
- Establish wide ranging options for reducing the deficit at the Trust;
- Make recommendations on the future configuration of the services currently supplied by the Trust to ensure that they are delivered on a sustainable basis for the benefit of the local population; and
- Evaluate whether proposed changes should be delivered through consensual restructuring or as part of Monitor's Trust Special Administration framework.

This report addresses the first of these objectives.

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<sup>2</sup> <http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/latest-press-releases/monitor-response-the-house-commons-public-ac>

## **About sustainability**

### **CPT view**

*The assessment of sustainability is the first phase of the CPT's work and will provide the foundation for future phases.*

### **The purpose of assessing sustainability**

Under the Health and Social Care Act 2012, Monitor has a duty to support commissioners to ensure that, in the event of a failure of a healthcare provider, patients can continue to access the care that they need.

Monitor proposes to establish a Risk Assessment Framework (RAF) to assess the financial performance and governance of healthcare providers. This will assign one of four financial ratings to a provider: 'Normal', 'Concern', 'Distress' and 'Failure'.

If a provider is rated in 'Distress', Monitor may appoint a CPT to determine whether there is a feasible turnaround plan for that provider. If there is no feasible plan the appointed CPT will identify a plan of actions that could be taken if that provider were to fail.

The first step for the CPT is, therefore, to conduct an independent assessment of the provider to determine whether there is a plan that, if successfully implemented, would sustain the delivery of services over the short, medium and long term. The focus of this assessment is on the actions that the provider can take that are within their own control.

In other words, the CPT will assess whether there is a credible plan for the Trust to reach sustainability in its current configuration.

### **Why are operational, clinical and financial sustainability important?**

If a trust is not able to operate services in a sustainable manner then there may be a range of potential consequences. These include:

- The Department of Health and/or local commissioners may need to provide additional funding to enable the trust to keep operating – at a time when the NHS budget is static year on year;
- The trust's operations may be less efficient than they could be, which means that performance (clinical and financial) may be below the optimal level;
- The trust may not be able to:
  - Effectively deliver tactical or strategic change as and when required;
  - Manage crises as and when they occur; or
  - Identify in a timely manner that performance is falling below acceptable standards.
- The trust may deliver clinical outcomes that are below expected standards; and
- The trust may not be able to invest in the latest health technologies or medicines available.

This is by no means an exhaustive list and not all of the above have been noted at the Trust. However, the sustainability of service delivery is essential in order for Monitor to deliver its mandate to protect patient interests.

## **About sustainability**

### **CPT view**

*Whilst there are clear relationships between the three areas of sustainability, the CPT has assessed them separately but kept in mind their inter-relationships.*

### **How assessing sustainability fits into the CPT's overall programme of work**

The information and evidence that is gathered provides the foundation for the CPT's remaining work, regardless of the conclusion about whether the Trust is sustainable or not.

- If the CPT concludes that the Trust is sustainable in its current form, then the next task would be to develop a recovery plan, including the governance, resources and funding that would be required to deliver the plan.
- If the CPT concludes that the Trust is NOT sustainable in its current form, then the next task would be to develop a Contingency Plan that the CPT would recommend to Monitor. This would need to identify options for the changes required, either to the Trust and/or to the services that it currently delivers, to ensure these services are delivered in a sustainable way into the future.

### **How is the CPT assessing sustainability?**

The CPT has assessed sustainability from three perspectives – operational, clinical and financial. Whilst there are clear relationships between the three, the CPT has assessed each in isolation and presented separate conclusions for each perspective. This will directly inform the nature of the solutions that will be explored in the next phase of work. For example, the solution required for a trust judged to be clinically sustainable but not financially sustainable would be very different from those required if that judgement were reversed

### **What is 'operational sustainability'?**

Operational sustainability is determined by the extent to which the Trust has the necessary organisational structure, operating model, governance, risk management procedures and operational processes in place to deliver its immediate corporate objectives and longer term strategy. To inform the conclusions on operational sustainability, the CPT reviewed:

- The Trust's current performance;
- The alignment of the Trust's governance and operations with its strategy;
- The people, processes and systems in place; and
- The impact of recent changes to the operating model on clinical performance.

### **What is 'clinical sustainability'?**

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).

The CPT has assessed the Trust against a number of recognised clinical performance indicators and drawn conclusions where these can be drawn.

There is a clear overlap between the assessment of clinical sustainability and operational sustainability, so the primary focus of the review has been to look at the long term viability of services. However, current clinical performance has also been assessed in order to determine whether there are any immediate issues that need to be addressed.

## **About sustainability**

### **CPT view**

*Whilst there are clear relationships between the three areas of sustainability, the CPT has assessed them separately but kept in mind their inter-relationships.*

### **What is ‘clinical sustainability’? (continued)**

In order to assess future clinical sustainability, current performance has been compared against the latest external standards set by the medical Royal Colleges, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), and other professional bodies where appropriate.

The key questions considered when assessing clinical sustainability are:

- Is current clinical performance of an acceptable standard when compared with standard performance metrics?
- Is the Trust serving a catchment population that is in line with national guidelines for a hospital that delivers the full range of acute services?
- Does the Trust have sufficient consultant staffing levels across all services to maintain a 24/7 service based on national requirements or guidance?
- Is the Trust able to recruit and retain appropriate clinical staffing levels?

### **What is ‘financial sustainability’?**

Financial sustainability is determined by a robust demonstration that the Trust is:

- Forecast to deliver a surplus for the current financial year and for each of the following five years;
- Able to generate cash; and
- Able to pay its debts as they fall due without financial support.

This report now describes the operational, clinical and financial sustainability of the Trust.

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# *Operational sustainability*



## **Methodology**

The CPT's approach, based on Monitor's Quality Governance Framework, is designed to provide an independent assessment of the operational sustainability of the Trust.

### **Operational sustainability**

Operational sustainability considers the extent to which the Trust has the necessary and appropriate organisational structure, operating model, governance, risk management procedures and operational processes in place to deliver its immediate corporate objectives as well as its longer term strategy.

#### **Methodology**

Based on the CPT's experience of working with other NHS organisations across the United Kingdom, and in line with current best practice guidelines, the CPT has structured its review using the four domains of Monitor's Quality Governance Framework<sup>3</sup>. This structure enables a complete review of governance, risk management and operational structures in the Trust.

The CPT has considered the Trust's governance arrangements in respect of quality, performance, workforce and finance. It has also considered how these arrangements have impacted on operational performance in the Trust, and the future sustainability of these arrangements.

The CPT's findings on operational sustainability are set out under these headings:

- Strategy;
- Capability and culture;
- Structures and processes;
- Measurement;
- Impact on operational performance; and
- Conclusions on operational sustainability.

The review has been supported by evidence drawn from:



<sup>3</sup> Quality Governance Framework, Monitor, July 2010.



## **Strategy**

The Trust's overall strategy sets out its strategic direction for the next five years.

### **CPT view**

*The Trust has a consistent vision and strategy set out in both its annual plan and its five year business plan. This strategy contains a limited number of key objectives which, if achieved, will have a significant and beneficial impact on the Trust as a whole.*

*The Trust's strategy has a realistic prospect of supporting the operational sustainability of the Trust.*

## **Strategy**

This section considers the Trust's current strategy, including:

- The quality of the strategy;
- How the strategy is reflected throughout the Trust (including within the directorates);
- How performance against the strategy is monitored; and
- Progress against the strategy.

A strong strategy and consistent sense of direction across the Trust will enhance organisational effectiveness<sup>4</sup> and, consequently, the likelihood of the operational sustainability of the Trust.

### **Overview of the Trust's strategy**

The Trust's vision, as set out in its 'Forward Plan Strategy Document for 2012-13' and in its 'FY12/13 to FY16/17 business plan' is:

*'Delivering excellence in care; in the most efficient way; in hospitals where it is great to work.'*

This vision is underpinned by three strategic elements:

- Doing the very best inside our hospitals (delivering high quality patient care, our top priority, supported by a high performing organisation);
- Getting value for money from our hospitals (creating a financially sustainable organisation, driving efficiencies by reducing our costs and growing our income through working with our stakeholders); and

- Making the most of our hospitals (working with patients, staff, commissioners and our wider health economy partners to make the most of our hospitals).

### **Strategic objectives**

The table in Appendix B sets out the strategic objectives underlying these elements of the strategy.

Each of these strategic objectives is underpinned by a number of more specific measures, for example, the Trust has established measures for quality and clinical performance under the three Darzi domains: patient safety, patient experience and clinical effectiveness.

### **The CPT's view of the Trust's strategy**

The Trust's strategy is designed to provide strategic direction for the next five years and covers quality, performance, workforce, finance, infrastructure and the wider health economy. It sets out a small number of objectives, each of which - if implemented - would have a positive impact across the Trust as a whole.

However, many of these strategic objectives will take a significant length of time to achieve and will require the involvement and support of a number of stakeholders (for example, public sector partners in Peterborough). More specific measures underpinning these objectives set out shorter term goals and a method by which to measure progress.

As part of the annual planning process, the Trust develops an updated plan, closely linked to its five year strategy. Constructively, this planning process is used by the board as an opportunity to revisit the strategy of the Trust.

<sup>4</sup> Measuring organisational effectiveness in the NHS: Management style and structure best practices, Zairi and Jarrar, 2001.



## **Strategy**

All Board members are familiar with the Trust's strategy, and there are processes in place to monitor performance against the strategy.

### **CPT view**

*Whilst well embedded at board level, at a directorate level, the link between day-to-day operations and the strategy is less clear.*

*To enhance the long term delivery of its objectives, the Trust should do more to ensure that the strategy is embedded in the directorates.*

## **Embedding the strategy**

At board level the strategy is well embedded; based on interviews, board members are familiar with the vision, strategy and strategic objectives. Furthermore, the front sheet of board papers link each discussion item to strategic objectives.

The strategy appears to be less well embedded within the directorates. Clinical directors were aware of the strategy and how their directorates delivered some of the strategic objectives (in particular those relating to quality and to finance).

Key messages relating to the strategy have been communicated to staff using the 'Team Brief' cascade, but it is less clear how well the day-to-day operations of the directorates are linked to strategic objectives, and how well staff understand their role in achieving those objectives. For example, papers presented at directorate management team meetings or governance meetings are not formally linked to the strategic objectives.

## **Monitoring performance against strategy**

The Trust has recently redeveloped its Board Assurance Framework (BAF) to link it to the strategy. The current BAF sets out the accountable director, risk rating and review dates for each of the strategic objectives. Each objective also has a risk card, which provides further details on:

- Outcomes;
- National and local drivers;
- Enablers;
- Impact and consequence of non-delivery;
- Controls in place (including frequency of review);

- Assurances in place;

- Gaps (in controls or assurances, including a link to principal risks on the risk register); and
- Actions.

These risk cards demonstrate how the Trust monitors performance against the outcome measures associated with each strategic objective. At the board meeting observed in March 2013, the Trust Secretary ran through each of the objectives on the BAF and gave an update against each of these measures.

## **Performance against strategy**

In Appendix C the CPT assess the Trust's performance against each of its strategic objectives and illustrates that the Trust can demonstrate some progress against each. This indicates that it has the ability to achieve its objectives in the long run, however, there is a risk that the large agenda the Trust faces reduces focus on these objectives and slows progress.

## **Quality strategy**

The Trust's quality strategy covers the areas outlined in Monitor's Quality Governance Framework. It is clearly linked to the Trust's overall strategy document.

The appendices to the quality strategy include an example of how progress against quality has been measured in FY13 (being an extract from the 2012 Quality Account), however they do not explicitly state how the Trust will monitor progress against the quality strategy in the future. The CPT understands that the Trust sets this out in its annual Quality Account, however, it should also consider including this in the overarching strategy.



## **Strategy**

The Trust is in the process of revisiting its Workforce Strategy, which ran from 2009 – 2013.

### **CPT view**

*The Trust acknowledges the current workforce efficiency challenge of providing high quality care whilst delivering pay cost reductions. Whilst a workforce strategy was in place from 2009 to 2013, this is currently being updated to reflect the challenges faced by the organisation and will be developed over the next three months. The strategy will cover the overall approach to all workforce and organisational development matters including CIPS and efficiency.*

*The Trust is committed to increasing productivity through a process of redesigning the workforce and changing working practices.*

## **Workforce strategy**

The Trust's workforce strategy ran from 2009 to 2013. An update against the strategy was provided to the board in December 2012, signposting the board to the ongoing workforce challenge and the need to refresh the strategy in light of the Trust's current financial challenge.

At the board meeting on 26 March 2013, the Director of Workforce and Organisation Development presented an update on the current workforce challenge and it was noted that the Trust has made significant progress in:

- Aligning workforce requirements to budgets based on business needs and safe staffing levels (for example, ward nursing levels);
- Developing workforce performance dashboards and measures; and
- Building the capacity and capability of the HR team to support organisational transformation;

While progress has been made, a new workforce strategy is required to address the workforce challenge going forward. At the 26 March meeting, the board gave a commitment to the development of a new combined Workforce and Organisational Development Strategy. This will underpin the Trust's five year plan with organisational development (OD) activities, such as communication, training and development, and talent management.

A board workshop has been designed to get agreement on the strategic workforce and OD objectives (and associated performance measures) that the board will sign up to and own. The workshop should also address reporting and measurement frameworks to track performance against objectives. It is expected that the new strategy will be drafted following this workshop.

A central list of cost reduction initiatives exists which includes transactional type schemes to reduce workforce costs and cross cutting transformational schemes, based on pathway redesign. In addition, some OD initiatives are already underway and others are planned.

Examples of initiatives underway include a review of the nursing recruitment and selection process which will include an assessment of candidates' values and compassion in care delivery. This initiative responds to the Francis Report into Mid Staffordshire NHS FT and is aimed at increasing the conversion rate of candidates to new hires in order to reduce the Trust's reliance on expensive bank and agency staff.

The CPT has been informed that both the workforce and OD plans will be developed more fully; these will be documented in the new strategy document and will underpin cost reduction plans.



## **Capability and culture**

There have been significant changes to the Trust board over the past two years.

### **CPT view**

*The significant recent changes to the board have allowed the recruitment of certain skills suited to an organisation in financial crisis, but have also constrained opportunities for board members to develop individually and as a team.*

*As a result of recent changes to the leadership of the Trust from a structural and Board perspective, the Trust has not had time to build a fuller track record of delivery and improvement.*

## **Capability and culture**

An open culture which encourages the reporting of concerns is essential to maintain high standards of patient care<sup>5</sup> and ensure the operational sustainability of the Trust in the future.

This section assesses the capability and culture within the Trust, including:

- Board of directors;
- Directorate leadership;
- Training and development;
- Appraisals; and
- Staff engagement.

### **Board of directors**

#### *Changes to the board*

From FY11 there have been significant and regular changes to the board, including changes to the individuals holding the positions of Chief Executive, Director of Finance, Chief Operating Officer, Director of Workforce and Organisational Development, and five non-executive director posts. At the time of writing, the chief executive role is interim, and a new chairman joined the Trust in April 2013.

The significant changes to the Trust's board over this period have presented both opportunities and risks. Whilst the process of recruiting new board members was used to identify and address potential skill gaps, the board has not undertaken formal self-assessments.

The board developed and introduced a board development programme in April 2013, however, this has not been an area of focus for the board over the past two years. The CPT's observation of the board has not identified any significant areas of concern, however, the lack of formal board development programme may mean that there are weaknesses that the board is not fully aware of, that the CPT has not observed, and for which appropriate actions have not been implemented.

### **Board capabilities**

The Trust has sought to use the changes in board members as an opportunity to recruit individuals with skills suited to an organisation experiencing financial distress. The non-executive team has a strong collective business background, providing both the commercial and financial acumen essential for the Trust.

The Trust has recently appointed a non-executive director with clinical experience. The appointment to this role will further improve the skill mix of the non-executive team and will enhance the ability of the non-executive team to challenge, in particular on matters of quality and performance.

<sup>5</sup> Letter ensuring an open NHS culture, Secretary of State for Health, February 2013.



## **Capability and culture**

The Trust has developed the role of clinical leaders over the past two years.

### **CPT view**

*To increase clinical engagement, the Trust has created the role of clinical director, of which there are six in the Trust.*

*Whilst the creation of this role is in line with best practice, it was introduced by the Trust later than many other trusts and it remains in development. It will require further embedding, particularly to ensure full engagement with the cost improvement plans and any options taken forward to reduce the Trust's deficit.*

### **Board challenge**

There was strong and relevant challenge from all non-executive directors at both board meetings observed by the CPT. The executive directors' response to this challenge was not defensive, and they either provided an immediate response or raised an action to address at a future board meeting.

The structure and agenda of these board meetings is considered in the 'Structures and processes' section.

### **Direktorate leadership**

#### *The role of the clinical director*

Following a review by the Interim Chief Executive in April 2012, the Trust moved from a clinical business unit (CBU) model to a directorate structure. This move included the creation of the clinical director role, designed to:

- Engage clinicians and, in particular, senior medical staff in running the hospitals;
- Create a strong, effective and accountable cohort of clinical leaders across the Trust;
- Simplify and clarify the lines of accountability within the Trust;
- Place managerial decision-making as close to the clinical service as possible, and make more of it clinician-led;
- Align authority more closely with responsibility, through full engagement of clinicians in management, tapping fully the clinical pool of potential leadership and strengthening the accountability of clinicians; and

- Align clinical leadership with budgets, so as to create incentives to drive transformational improvements in quality and productivity.

Based on the CPT's experience of high performing trusts and typical operating models, the design principals behind the clinical director role are sound.

The position of clinical director was introduced relatively recently in comparison to many other trusts and, as such, requires further time to embed. Consequently, some areas are less well developed, in particular in relation to engagement with the CIP process and with budgeting.

A leadership development programme for the clinical directors will include links with high performing trusts and external organisations for mentoring programmes.

The Trust is also in the process of developing an associate clinical director role, designed to develop future leaders. This will help to increase the capacity and capability to manage change but is at different stages of being embedded across the directorates.

### **Supporting tools**

The tools necessary to support the clinical directors in their roles, including service line reporting (SLR) and performance scorecards, remain under development.

Clinical directors have noted that they have not received the training and development required to support their new roles including, for example, training on how to understand and interpret financial information. Such training is essential to ensure that the clinical directors are fully engaged, and that the role is embedded as quickly as necessary given the current financial pressures on the Trust. The Trust recognise this as an issue and are in the process of addressing the problem.



## **Capability and culture**

The NHS staff survey has been reviewed in relation to the Trust's capability and culture.

### **CPT view**

*The NHS staff survey shows lower than average staff engagement.*

*However there is an improving trend in key areas such as staff receiving relevant training and well structured appraisals.*

*Areas of deterioration in the survey results include staff working extra hours and experiencing work related stress. These scores may be attributed to a more robust approach to performance and absence management and reflect the workforce challenge described on page 19.*

*The action plan to address the issues raised by the survey should be developed and implemented without delay.*

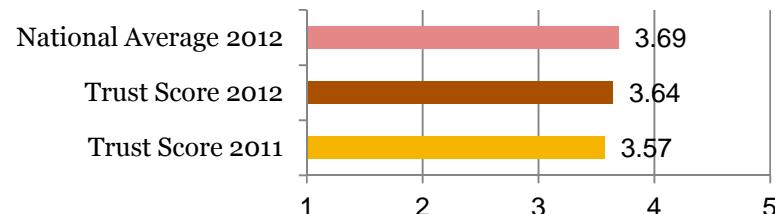
## **NHS staff survey**

In the following pages we consider the findings of the NHS staff survey 2012, historical trends and how the findings reflect the culture of the Trust. The survey is conducted annually in each NHS trust in England and provides a benchmark for comparison with other similar NHS organisations (for example, acute trusts, ambulance trusts, community trusts).

In order to ensure survey findings are comparable across all trusts (irrespective of size) the scores are weighted within staff groups and type of organisation. In this instance, the Trust scores are compared to those for other acute trusts with the weighting applied to ensure that the sample size of respondents in each staff group is consistent with the national picture.

When ranked against other similar trusts (i.e. acute trusts) the Trust's overall staff engagement score is below average. However, the trend is one of improvement and further analysis also shows an improving trend in key areas described in the following pages.

### **Overall Staff Engagement**



*Source: 2012 National NHS staff survey results for Peterborough and Stamford Hospitals NHS Foundation Trust.*

There are a number of areas where the Trust has scored better than the national average such as staff receiving training, having appraisals, and incident reporting.

There are also areas where the Trust has scored lower than the national average, such as staff feeling under pressure to attend work when feeling unwell, staff experiencing bullying or harassment from colleagues, work related stress, working extra hours, and equality and diversity training. Equality and diversity training is, however, the area showing the most improvement.

The Trust's scores on staff working extra hours reflect the workforce challenge described on page 19. Whilst, instances of bullying and harassment are not be condoned by CPT, scores in relation to bullying and harassment and work related stress may reflect a more robust approach to performance and absence management within the Trust. Notably, there has not been an increase in the volume of grievances being instigated in the last 12 months and the current caseload of formal and informal HR procedures represents less than 2% of the total workforce.

The Trust is in the process of developing an action plan to address the staff survey findings and these will be embedded within the Workforce and Organisation Development Strategy.

Further information on the NHS staff survey and the Trust's results can be found on the NHS Staff Survey Co-ordination Centre's website: <http://nhsstaffsurveys.com>.



## **Capability and culture**

Training and development indicators show that the Trust's performance is above the national average.

### **CPT view**

*Staff survey data shows an improving trend in staff receiving relevant on-the-job training. The Trust also performs above the national average for the percentage of staff receiving relevant training in the last 12 months. This is likely to make a positive contribution to future sustainability.*

## **Training and development**

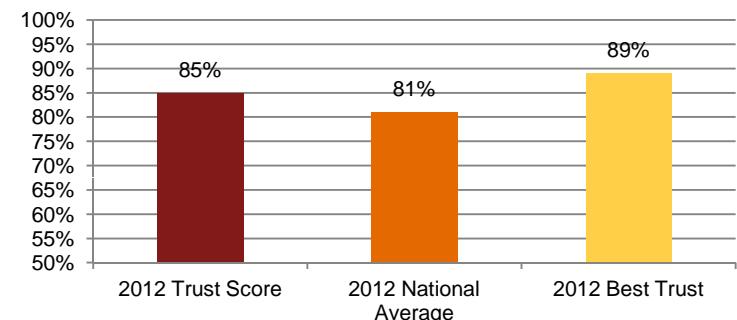
In order to deliver continuous improvement, collaboration and innovation in the NHS, investment in training and development is considered to be essential. Nationally, over three quarters (78%) of managers believe that patient care is at risk due to a lack of proper staff training and development<sup>6</sup>.

Within the Trust, the staff survey data shows an improving trend in the proportion of staff receiving relevant on-the-job training. While the Trust has some way to go to achieve performance comparable to the 'best Trust', it is above average when compared to the national picture.

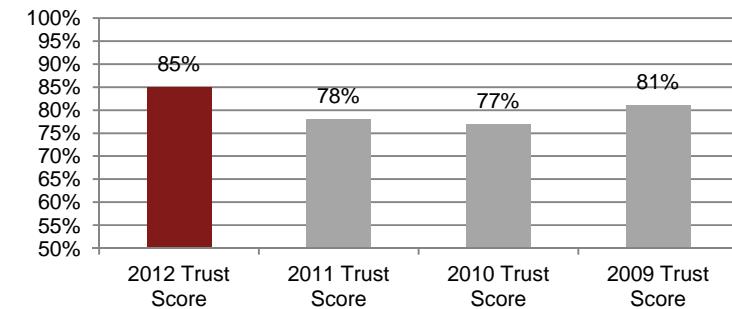
There has clearly been an investment in training and development, and the CPT has been provided with excellent examples of training taking place, including the Trust's commitment to apprenticeship and NVQ schemes.

However, continued focus to identify the key training requirements for both individuals and the Trust as a whole will be required. Targeted training needs to be rolled out in a structured plan, particularly in light of the recent changes to the organisation structure (for example, finance for non-financial managers to support the roll out of SLR).

### **Percentage receiving job-relevant training, learning or development in the last 12 months**



### **Percentage receiving job-relevant training, learning or development in the last 12 months**



*Source: 2012 National NHS staff survey results from Peterborough and Stamford Hospitals NHS Foundation Trust.*

<sup>6</sup> Why training and development should be at the heart of the NHS reform, Guardian Professional Health Network, June 2012.



## **Capability and culture**

Appraisal rates at the Trust are slightly above the national average.

### **CPT view**

*The staff survey indicates an improving trend in appraisal rates at the Trust.*

*These rates are monitored in a way which allows early identification of appraisal completion rates across the workforce.*

### **Appraisals**

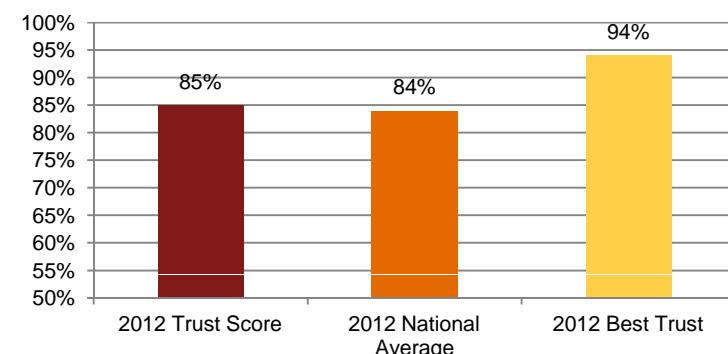
The staff survey shows above average completion of appraisals and an improving trend over recent years. This supports the staff survey results on training and development.

The Trust should ensure that appraisals provide a high quality discussion for all staff. The Trust score is in line with the national average for the key finding on well structured appraisals. This should be linked to the performance framework, used as a tool to target the development of skills the Trust needs in the current climate, and to support and recognise a high performance culture.

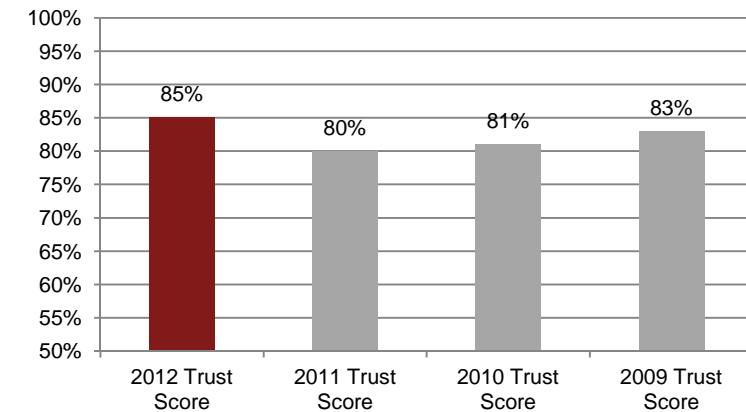
Appraisal rates are monitored on a monthly basis, using the HR key performance indicator (KPI) dashboard. This considers a rolling 12 month percentage completion rate at both a Trust-wide and a directorate level.

The improving trend in appraisal completion, coupled with the positive scores on training and development, show an investment in staff learning and development. Given that the board is relatively new, the Trust should ensure this investment is also applied at board level. The CPT has been informed that a number of leadership development programmes are either underway or being planned, including board development work.

### **Percentage appraised in the last 12 months**



### **Percentage appraised in the last 12 months**



*Source: 2012 National NHS staff survey results from Peterborough and Stamford Hospitals NHS Foundation Trust.*



## **Capability and culture**

The staff survey results for various measures of staff engagement indicate that the Trust is at or slightly below the national average.

### **CPT view**

*Whilst slightly below the national average, the measures are showing an improving trend in staff engagement.*

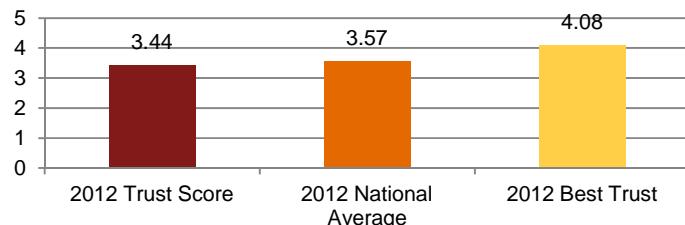
### **Staff engagement**

Staff engagement is seen as a critical component in delivering transformational change in public services, with particular reference to cultural change and leadership development<sup>7</sup>. Research also shows a strong correlation between high engagement levels and strong organisation performance<sup>8</sup>, demonstrated by the recent joint press release by the CIPD, HPMA and NHS Employers<sup>9</sup> commenting on the need to improve engagement in the NHS.

The staff survey shows that staff engagement is increasing when measured against key engagement metrics. Although the scores are at or slightly below the national average, the general trend is of improving engagement levels over the last three years.

The scores suggest the Trust is moving in the right direction but has a way to go to bring levels to 'best in class'.

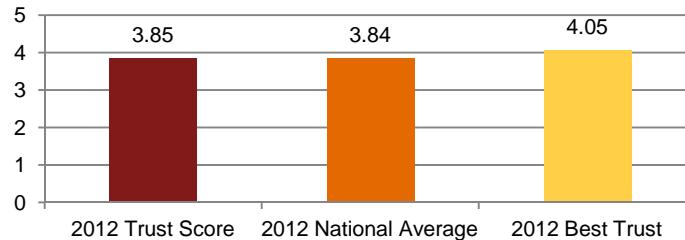
### **Staff recommendation of the Trust as a place to work or receive treatment**



### **Staff recommendation of the Trust as a place to work or receive treatment**



### **Staff motivation at work**



### **Staff motivation at work**



7 Leading Culture Change, Employee Engagement and Public Sector Transformation, CIPD in collaboration with PPMA, November 2012.

8 Locus of Engagement, Understanding What Employees Connect With At Work, CIPD Research Insight, May 2011.

9 NHS is taking steps in the right direction to improve staff engagement and patient care but employee consultation and communication remains a challenge, CIPD Press Release, February 2013.



## **Structures and processes**

The board manages a large agenda and is supported by five diverse and active subcommittees.

### **CPT view**

*In one of the board meetings observed there were a large number of one-off items that reduced focus from the 'business as usual' items. This wasn't the case in the second meeting observed.*

*Board members are conscious of the risk that the significant number of one-off items currently being tabled may distract from the scrutiny and challenge of business as usual matters.*

## **Structure and processes**

This section addresses the structure and processes within the Trust, including:

- The Trust board and its subcommittees;
- The directorate structure;
- Patient engagement;
- Performance, change and risk management;
- Corporate support; and
- The Programme Management Office (PMO).

These structures and processes are essential to ensure that there are clear roles and responsibilities in relation to governance, and that issues are appropriately escalated and resolved<sup>10</sup>.

### **The Trust board**

The structure in Appendix D sets out the committees supporting the Board of Directors and Council of Governors, as well as key operational committees.

The board meets on a monthly basis and holds both a public and a private session. In addition to a number of one-off items, on a monthly basis the board has a number of standing agenda items, including the:

- Quality report;
- Finance report;
- Operational performance report and performance scorecard;
- Regulatory and committee report;
- Board assurance framework; and

- Minutes from board subcommittees.

The board uses an action tracker; this was employed effectively in the board meetings that the CPT observed and is a useful tool to ensure that directors are held to account for the completion of actions, and that these matters remain on the agenda where appropriate.

At the February 2013 board meeting observed, there were a large number of one-off items at both public and private sessions.

As a result of the number of 'one off' items on the agenda, less time was spent discussing the standing agenda items. Were this to occur regularly, there is a risk that these items would receive insufficient scrutiny.

At the March 2013 board meeting there was a greater focus on 'business-as-usual'. There was a good level of discussion and debate about all key areas. In addition, there was an in-depth discussion on the issues relating to non-elective admissions, which provided the board with assurance as to the actions being taken. The CPT's review of minutes indicates that the March 2013 board meeting was more representative of the normal board processes.

As the Trust is likely to be managing a large agenda for the foreseeable future, there must be a focus to ensure that 'business-as-usual' matters receive the necessary level of discussion and scrutiny so that potential risks to quality and performance are identified and mitigated in a proactive manner.

<sup>10</sup> Quality Governance Framework, Monitor, July 2010.



## **Structures and processes**

The Trust has recently evolved the role of the Quality Assurance Committee.

### **CPT view**

*The membership, frequency of meetings and agendas of the board subcommittees are appropriate for the Trust.*

*The recent changes made to the Quality Assurance Committee provide added assurance to the board, but require further embedding.*

### **Trust committee structure**

The board has five subcommittees (as set out in Appendix D): the Quality Assurance Committee (QAC), the Audit Committee, the Finance and Investment Committee (F&IC), the Remuneration Committee and the Charitable Funds Committee. The roles of the QAC, the Audit Committee and the F&IC below are considered below.

#### *Quality Assurance Committee*

In FY13 the Trust revisited the role of the board subcommittees, in particular the role performed by the QAC.

Following an external review, the role of the QAC has been revised to act as an assurance committee. This has included a non-executive Chair and two other non-executive members (the subcommittee was previously chaired by the Chief Nurse). The operational oversight of quality and performance is now performed by the Quality Governance Operational Committee (QGOC).

This revised structure represents an improvement to previous arrangements and will enhance the assurance that can be taken by the board in relation to quality.

These revised arrangements were established in November 2012 and, therefore, there have only been three meetings in the current format. Further time will be required for these revised arrangements to become fully embedded.

Each directorate provides a number of documents to the QAC on a monthly basis, including the Matron's Balanced Scorecard and the monthly Care Quality Commission (CQC) submission.

At each meeting, two of the six directorates are present for discussion and challenge associated with these documents. Whilst the CPT has not observed this process in action, it has been informed that this has enhanced the level of accountability and performance management within the Trust.

#### *Audit Committee*

The Audit Committee is comprised of three non-executive directors (not including the Trust Chairman). It is also regularly attended by the Director of Finance and the Trust Secretary.

The Audit Committee meets on a bimonthly basis and considers the following regular standing agenda items:

- Governance and risk management, including the BAF and the corporate risk register;
- Internal audit;
- External audit; and
- Information received from other assurance committees, including the QAC, F&IC and the Trust Management Board (TMB).

The membership, frequency and agenda of the Audit Committee are appropriate and in line with acceptable practice. The CPT has noted some examples of good practice, for example, in January 2013, the Audit Committee assessed its performance in a number of areas and has developed an action plan to improve its effectiveness.



## **Structures and processes**

The Trust has a separate subcommittee to provide assurance on finance and investment matters.

### **CPT view**

*Both the Audit Committee and the Finance and Investment Committee provide an appropriate degree of scrutiny for key items.*

## **Trust committee structure (continued)**

### *Finance and Investment Committee*

The F&IC meets monthly and is attended by three non-executive directors, including the Chair, and executive directors, including the Interim Finance Director and the Chief Operating Officer.

The meeting considers a number of standing items, including:

- Results from previous period and year to date;
- Forecast for upcoming period and year end;
- Capital expenditure and business cases;
- Finance and risk registers;
- Contract performance; and
- Financial and business plan development.

The CPT's review of the minutes of this subcommittee has indicated that it provides a high level of scrutiny to the monthly finance report.

The CPT understands that scrutiny of the CIP programme is performed by the CIP Board (considered further below).

Whilst not all foundation trusts of a similar size have a subcommittee dedicated to finance, given the size of the financial challenge facing the Trust a committee such as this is appropriate and necessary to provide additional scrutiny and assurance over finance and to support the board.

## **The directorate structure**

Following a review by the Interim Chief Executive in April 2012, the Trust moved from a clinical business unit ("CBU") model to a directorate structure. The Trust has established six directorates, as shown in Appendix E.

As noted previously, the change from CBU to directorates aimed to increase clinical leadership and to rationalise processes and structures within the Trust. Whilst this change has led to some improvements, progress has been slower than expected.

### *Governance arrangements in the directorates*

The governance arrangements that the CPT observed in the directorates were fit for purpose and provided an oversight on key matters including quality, performance and finance. However, there was a lack of consistency in these arrangements between the directorates.

Due to the different nature of the directorates, some variation is to be expected, however, it was clear that best practice was not always shared between the directorates and services.

The Trust should consider how best practice can be shared more systematically across the Trust. For example, once the new directorate arrangements have been in place for 12 months, the Trust should consider a workshop for the directorate management teams to discuss and share best practice.



## **Structures and processes**

The governance arrangements within the directorates have been developed following the change from CBUs.

### **CPT view**

*Governance arrangements within the directorates are fit for purpose, but there are inconsistencies and examples where best practice could be more systematically shared across the directorates.*

### **The directorate structure (continued)**

At a minimum, the CPT recommends that there are common agenda headings for the key governance meetings within each service and directorate to ensure that all key matters are discussed regularly (for example, quality, performance, finance, workforce and risk management).

As each service and directorate has differing roles and priorities, the matters discussed under these headings may differ.

Similarly, the CPT would expect each of the directorates and services to be reviewing key quality, performance, finance and workforce data in a similar format. This reporting function is currently under development (see the Measurement section below).

### *Non-executive director and governor support*

The CPT understands that each directorate within the Trust has been assigned a non-executive director and governor. Whilst the roles adopted by these individuals differ, they are able to obtain an oversight of the directorate, gain more in-depth assurance concerning the performance of the directorates, and provide an element of support and challenge.

This is an innovative approach and will help governors to understand the organisation they represent and to focus their efforts<sup>11</sup>. There is an associated risk that the non-executive directors and governors may become less independent as a result of these arrangements however, individuals were aware of this risk and were careful to avoid performing a management role.

### *Inter-directorate communication*

The CPT has been provided with a small number of examples of insufficient communication between the directorates.

The CPT has observed some evidence that the directorates are working independently. For example, on occasion decisions have been taken by one directorate without fully considering or communicating the impact on other directorates.

Communication between the directorates will be essential as the Trust increases its focus on the implementation of system wide cost improvement plans.

<sup>11</sup> Director-governor interactions in NHS foundation trusts, Monitor, June 2012.



## **Structures and processes**

The Trust has not altered the middle management structure as part of the change to the directorate structure.

### **CPT view**

*Many of the middle management roles within the directorates are filled by nursing, rather than administrative and clerical staff (a more common model).*

*Whilst this approach may be appropriate, the Trust should consider whether these staff have been equipped with the necessary skills.*

## **Middle management structure**

The middle management structure at the Trust has not been addressed as part of the recent directorate restructure that introduced Clinical Directors and General Managers.

The workforce benchmarking has shown that, relative to the peer group, the Trust has a lean structure among administrative and clerical staff, where it would be more typical to see middle management grades. Additionally, the review of organisational charts and interviews with general managers has identified inconsistent middle management structures across the directorates which could affect the consistency of the:

- Manager banding;
- Approach to managing capacity and performance; and
- Role expectations and accountabilities.

Further analysis has shown that a high proportion of senior nursing staff (among the 8a - 8c band) are in middle management roles where the CPT would typically see these roles being filled by administrative and clerical staff of the same band.

The national direction of travel in the acute setting is for more clinically led service delivery. The focus the Trust has given to delivering safe staffing levels could potentially account for the number of nursing staff in middle management roles (see the clinical sustainability section).



## ***Structures and processes***

The inpatient survey indicates that the Trust has achieved an average score in almost all areas in 2012.

### ***CPT view***

*The Trust has undertaken a number of initiatives to improve patient experience, the success of which is evidenced through the improving friends and family score.*

*The board receives monthly updates on patient experience, which is given a good level of focus in board meetings.*

*Response time to complaints remains above the target of 30 days, and is an ongoing area of focus for the Trust.*

## ***Patient experience***

### *National inpatient survey results*

The 2012 national inpatient survey; (a national survey of inpatients) was published in April 2013<sup>12</sup>. The results of this survey indicate that in almost all areas the Trust performance was “about the same” as other acute trusts (that is, within expected ranges). For three areas, the Trust received a “better” score (i.e. a statistically significant result that is better than the average acute trust). These were:

- Single sex bathroom areas;
- Noise from other patients; and
- Privacy for discussions.

The Trust’s performance in these areas may, in part, be a result of its high number of single rooms. There were no areas in this survey where the Trust performance was worse than average.

### *Patient engagement*

The Trust has taken a number of steps to engage patients and improve the overall patient experience. Patient experience forms part of the Trust’s overall strategy and is monitored monthly through the board assurance framework and the quality report. The Trust’s objectives in this area are:

- To continue to improve the friends and family / net promoter score achieved; and
- To improve the experience related to complaints by improving the turnaround time for responding to them.

The monthly quality report provides the board with an update on these two objectives, in addition to reporting on other patient experience initiatives.

This report indicates that the Trust’s results for the friends and family test have been on an upward trajectory in FY13. However, whilst there has been an improvement in the time taken to respond to complaints, it has remained below the Trust’s target of 30 days throughout FY13. This remains an area of focus for the Trust in FY14.

A group has been established by the Trust to provide the board with assurance that focus is being given to understanding and acting upon reported patient experiences. This group includes board members and the leads for patient experience in the Trust.

<sup>12</sup> <http://www.cqc.org.uk/survey/inpatient/RGN>



## **Structures and processes**

The Trust continues to develop its performance management processes. This is an area of focus for the executive team.

### **CPT view**

*The CPT has received mixed feedback about the level of challenge at conformance meetings; the Trust should ensure that these meetings are used effectively to performance manage the directorates and ensure that they are accountable for targets and actions.*

## **Performance management**

There are a number of performance management structures in place in the Trust, however, the primary methods by which performance within individual directorates is managed is through the QAC and through monthly conformance meetings.

Conformance meetings take place over two mornings each month. These are the primary vehicle for the executive leadership of the Trust to challenge the directorates within the formal committee structure.

The meetings are chaired by the chief operating officer, and are attended in the main by management teams of each directorate, including clinical director, general manager, matron, and finance and HR representatives. There is a separate meeting for each directorate, at which relevant performance, quality, workforce and finance indicators are presented.

Each directorate team is required to prepare a report in advance of this meeting, using a standard template which covers matters such as quality, performance, workforce and finance. The meetings are also designed to provide a forum for the directorates to raise issues.

The CPT has received variable feedback as to the level of challenge received by the directorates at these meetings.

The Trust should ensure that these meetings, whilst remaining an opportunity for open discussion between the directorates and the Trust board, provide sufficient challenge and performance management to ensure that the directorates are held to account for the delivery of actions and targets.

The CPT has received more consistent feedback in relation to the CIP Board, which has not historically proven a challenging environment. As a consequence, directorates have not always been held to account for the delivery of CIPs.

This is a matter that the Programme Management Office (PMO) and executive team are aware of. The Trust is currently refocusing the CIP Board to highlight best practice and to discuss cross-directorate schemes. Individual meetings have been established with the directorates on a three-weekly cycle to challenge individual CIP schemes. The CIP Board is attended by the executive team, the PMO along with the clinical directors and general managers of the Trust's directorates.

From interviews with executive directors, the CPT understands that the executive team is increasingly focused on enhancing the performance management culture within the Trust, however, this will require further embedding, particularly in relation to the delivery of CIPs.

As a result of the above and the status of the FY13/14 CIPs, the Trust will need to keep this as an area of focus and track delivery of CIPs closely, so it is confident the CIPs are being implemented and the its focus is delivering improvement.

How the Trust improves its capability and culture (page 20) and its performance management will be key to the delivery of clinical and financial performance. Whilst there are some promising signs, the Trust is at an early stage and has a limited track record of making improvements in this area.



## **Structure and processes**

Corporate functions have been benchmarked against a peer group.

### **CPT view**

*The Finance and HR functions have a higher ratio of qualified to unqualified staff, placing them at the lower end of performance against the benchmarked peer group.*

*The CPT would expect this to be a transitional phase with future plans in place to review the functions once the Trust is more stable.*

*Other corporate functions, such as IT and Procurement, are showing good levels of performance against peers.*

## **Corporate support to service delivery**

The CPT's review of operational sustainability has included benchmarking the corporate functions against a selected peer group<sup>13</sup> to assess whether they are structured in the right way to support the operational delivery of services. The benchmarking considers each function against a series of indicators relating to:

- Shape of the function in terms of the number of managers and professionals versus administrative and unqualified staff;
- Size of the function in terms of overall workforce size; and
- Cost of the function.

Performance against each indicator is measured on a scale from lower end to upper end performance, with lower being poor performance and upper being good performance relative to the peer group. The benchmarking does not measure the quality of service each function delivers to the Trust.

### **Finance**

The finance function benchmarking suggests that relative to the peer group there is a higher ratio of qualified to unqualified staff. The function has recently been restructured and a new Finance Director has joined the Trust. The existing structure of Finance may be appropriate to implement a robust financial framework to support the Trust's current challenges. However, in a more stable environment the CPT would anticipate a review of the function to bring it in line with peers.

## **Human Resources**

The shape of the Human Resources (HR) function is showing a higher ratio of qualified to unqualified staff. Once again, in the current climate this may be appropriate while the Trust is focused on workforce strategy and organisation development objectives.

The Trust has informed the CPT that there has been a deliberate strategy to increase the capability of both the Finance and HR functions by introducing a higher ratio of qualified staff. This reflects a recognition by the Trust of the scale of the work yet to be done to deliver transformation.

Other corporate functions benchmarked show that work has been completed to achieve an appropriate and cost effective model to deliver support to the organisation, for example IT and Procurement - which are comparable with the top quartile performance in the peer group.

Payroll, in particular, is showing as a top performer against the peer group following a recent retendering of the outsourced contract. The function is delivering a good level of service within a tight contract.

Further detail on the benchmarking of corporate functions is provided in Appendix T.

<sup>13</sup> Appendix A



## **Structures and processes**

There are a number of initiatives at the Trust that are in the early stages of development and have taken some time to progress.

### **CPT view**

*The Trust has historically demonstrated an ability to implement and sustain initiatives, however, in some cases the rate of change has been slower than initially planned.*

*The ability to implement and sustain new initiatives will be essential to the operational sustainability of the Trust.*

## **Change management**

In assessing the operational sustainability of the Trust, the CPT has noted some examples of initiatives which have been effectively implemented and have had a positive impact on the overall sustainability of the Trust.

However, the CPT has also identified a number of initiatives that are in the early stages of development and which have taken some time to progress. These include integrated performance scorecards, service line reporting and the board development programme - although the CPT notes that in many cases these projects have been put on hold until there is a greater degree of stability, or availability of resources. Similar concerns have also been raised by the commissioners, although the details of the extent to which the Trust could have done more are unclear.

The Trust is currently managing an extremely large agenda; the board and management teams have limited capacity to implement further programmes and schemes. Further resources may be required to ensure that change programmes can be implemented as required.

The capability and capacity to implement and sustain change rapidly will be essential to the operational sustainability of the Trust in the future, and should be carefully considered.

## **Risk management**

The Trust uses a consistent risk register format throughout the services, directorates and at a Trust-wide level. Risk action cards are also maintained for all significant risks, setting out the controls and actions relevant for each risk. The corporate risk register is considered by the Quality Assurance Committee and the Trust Management Board monthly; the minutes of these groups provide evidence that risks are challenged and assurance is provided to the board. In observing the board, there was evidence that risks discussed during the meeting were referenced back to the risk register, indicating that at a corporate level this document is actively used.

Within the directorates, risk registers are discussed as an agenda item at monthly directorate management meetings. In the meetings observed, there was discussion and challenge around some risks. The CPT received mixed feedback from the clinical directors; some stated that risk registers were used as a tool to manage risks and staff took ownership for the risks identified. Others were less confident about the use of the risk register, indicating that further work will be required to ensure the use of risk registers as a tool to manage risk.

National Patient Safety Agency (NPSA) incident reporting data (shown in Appendix F) indicates that the Trust has been consistently in the top quartile of incident reporters for medium sized acute hospitals, and that there is a high proportion of no harm incidents. This is indicative of a strong reporting culture within the Trust.



## **Structures and processes**

Various data sources indicate that the Trust has a high rate of incident reporting, indicating a strong reporting culture.

### **CPT view**

*The Trust is one of the highest incident reporters amongst its peers. This is indicative of a high reporting culture.*

*However, staff survey results also indicate a higher number of staff than average feeling under pressure to attend work when feeling unwell. The Trust has a sickness rate of 3.51%, indicating a drive by the Trust to reduce sickness absence and increase attendance; a potential reason for this survey result.*

## **Risk management (continued)**

The staff survey results show an above average percentage of staff witnessing potentially harmful errors, near misses or incidents. The Trust is clearly taking steps to manage risks, demonstrated by the improvements in this metric over the last three years and by the fact that the Trust performs in the top quartile for incident reporting, maintaining that position for the last two years. The high proportion of no harm incidents shown in the NPSA data supports the CPT's view that the Trust is a high reporter of incidents, rather than there simply being more incidents at this Trust.

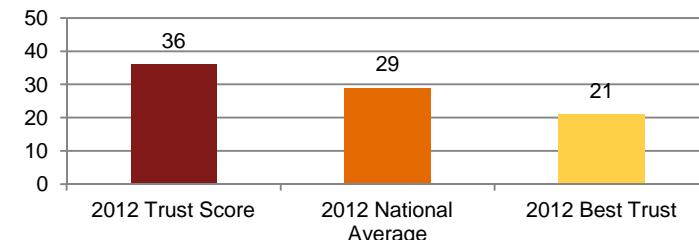
When triangulated against the staff engagement indicators, this suggests a culture of increasing openness and transparency.

### **Staff sickness**

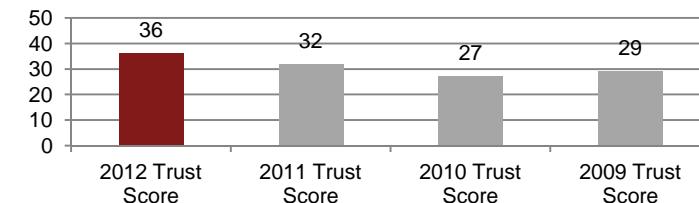
The staff survey also shows an increase in staff feeling under pressure to attend work when feeling unwell. The CPT notes that the Trust has consistently maintained a sickness level below 4% and is currently averaging 3.51%, which is below the national average for medium acute trusts and medium acute foundation trusts. The staff survey findings reflect the Trust's pro-active approach to short term sickness absence management with the majority of sickness absence related to long term absences.

*Source: 2012 National NHS staff survey results from Peterborough and Stamford Hospitals NHS Foundation Trust.*

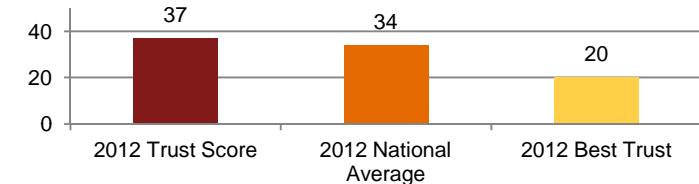
### **Percentage feeling pressure in the last three months to attend work when feeling unwell**



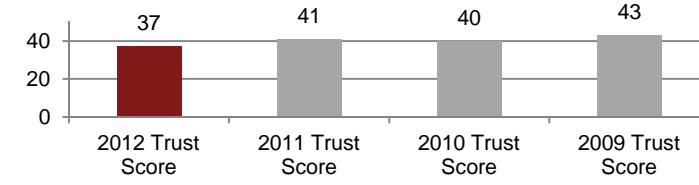
### **Percentage feeling pressure in the last three months to attend work when feeling unwell**



### **Percentage witnessing potentially harmful errors, near misses or incidents in the last month**



### **Percentage witnessing potentially harmful errors, near misses or incidents in the last month**





## **Structures and processes**

There have been significant changes to the PMO in the last 12 months.

### **CPT view**

*The PMO has identified that clinical engagement has historically been low and has taken steps to include clinicians at an earlier stage in the process.*

*Project documentation does not currently have the level of detail that would be expected from a robust PMO. The Trust is making changes in this regard.*

## **Programme management office**

A Programme Management Office (PMO) model provides the structure, governance, functions and services required for defining a balanced portfolio of change and ensuring consistent delivery of programmes and projects across an organisation or department<sup>14</sup>.

The PMO at the Trust has been through significant change in the last 12 months. In April 2012, a new programme manager was appointed to lead the PMO. Since then, further recruitment has been undertaken to fill supporting roles.

The structure of the PMO has changed for FY14, with the staff focussing on pathways rather than being split by directorate. This change is expected to improve efficiency and quality across overall pathways, which will often generate the largest savings.

In the last year, there has also been a drive to improve the level of engagement and involvement of clinicians (and the Trust staff as a whole) in the CIP programme. Historically, the CPT understands that clinical engagement has been low, but the PMO has made progress this year in seeking clinical buy-in at the early stages of the design of CIPs, and workshops have been run at various points in the year in an attempt to capture ideas.

The PMO will also have at least one full time individual (and perhaps up to three) to provide finance support for the tracking and reporting of CIP savings.

Historically, the PMO and finance team have struggled with the consistent reporting of savings. Furthermore, with patient activity being significantly in excess of plan for the current year, costs have generally risen above their budgeted level. This has made identifying efficiency savings difficult, as the work to split out a 'price variance' (showing an efficiency saving) and a 'volume variance' (showing additional activity) has only been performed at a high level. The Trust is in the process of strengthening programme governance to provide better evidence of efficiency savings.

### **Project documentation and process**

The Monitor guidance for sustainable CIPs highlights the need for detailed milestones to track the work performed and to show how savings will be driven out<sup>15</sup>. These have been absent from project documentation.

Historically, the level of project documentation used by the PMO has not been to the standard expected from a trust with a significant efficiency challenge. Project documentation has not been used consistently across the various CIPs and the level of detail included within the documentation is not in line with best practice.

Additionally, the project documentation reviewed does not have key performance indicators identified and tracked as part of the process - another critical part of a quality plan.

The CPT has been unable to review the quality of the new approach to documentation as it has not been fully implemented at the time of writing, so there is limited evidence of any recent track record in this area.

<sup>14</sup> Portfolio, programme and project management offices, Connecting for Health, June 2008.

<sup>15</sup> Delivering sustainable cost improvement programmes, Monitor, January 2012.



## **Structures and processes**

The Trust is in the process of developing its reporting processes for its CIPs.

### **CPT view**

*Ownership for the delivery of CIPs sits with the directorates, which is in line with best practice.*

*The CPT is concerned about the level of robust challenge of directorates who are not delivering against target.*

*Given the details opposite, the Trust's track record of CIP delivery (page 67), the changes to the Trust board (page 20), the Trust has not yet demonstrated it can deliver its planned CIPs.*

## **Programme management office (continued)**

### **Quality impact assessments**

The Trust has a standardised quality impact assessment (QIA) template which should be completed by the directorate/individual with responsibility for each CIP and is then reviewed by the Medical Director and Director of Care Quality and Chief Nurse.

The CPT understands that the QIA is revisited prior to any fundamental milestone of a project, for example closing beds, to ensure that nothing has changed since the QIA was first written that could affect safety and quality.

In reviewing the FY13 CIPs, the CPT found that some that had been identified retrospectively didn't have completed QIAs to support them (for example, where the Trust has performed additional work with the same staffing levels). This raises the risk that the impact of those savings on quality and safety hasn't been assessed.

### **Ownership of CIPs**

The ownership of the delivery of CIPs sits with the directorates, with the PMO providing support and facilitation. This is in line with best practice.

However, the CPT has received a number of comments regarding a lack of clarity about this. Setting out clear roles and responsibilities for the PMO and for the directorates would help to ensure that there is no uncertainty about the accountability for delivery.

Likewise, project documentation has not been approved in final version by the key staff involved. The PMO has identified this as an issue and is implementing physical sign off processes for FY14, which will help drive accountability.

### **Reporting**

Currently, the PMO reports progress against CIPs to the monthly CIP board and the CIP report is also included in the Trust Management Board (TMB) pack.

The report shows progress against target at a directorate level, but does not detail individual plans that are not delivering. Having reviewed the minutes of the most recent CIP board, the CPT would have expected to see far greater challenge of the directorates that have not delivered against plans.

Strong performance management is essential to the delivery of a cash-releasing CIP and is not currently evident.

The CIP board should be a forum where work stream leads can raise risks and issues and gain support from the CIP board. The CIP board should give robust challenge to directorates that are not delivering against their targets for the year.

As noted previously, the executive team recognised that this process requires strengthening. The CIP board has been refocused as a forum to share best practice, and three-weekly meetings with the individual directorates have been set up to provide challenge on CIPs.

The executive team has identified that the level of reporting should be improved to allow better tracking and the Trust is in the process of implementing these changes with a new set of reporting being developed for FY14.



## **Measurement**

The Trust is continuing to develop its performance reporting framework.

### **CPT view**

*The board receive a number of reports monthly. The format of these reports is not consistent, and the user is likely to need to spend a significant period of time reviewing the reports to triangulate issues.*

*The Trust is introducing an integrated performance scorecard which will address these concerns.*

## **Measurement**

This section concerns the measurement and use of non-financial data within the Trust, and the assurances concerning the robustness of this data, including:

- Key board reports;
- Integrated performance scorecards; and
- Data quality.

This data is essential for appropriate decision making and the identification and mitigation of issues and risks.

### **Monthly board reports**

On a monthly basis the board receive a number of monthly reports, including the Quality Report, the Finance Report, the Chief Operating Officer's Report and the performance scorecard. Elsewhere in the Trust there are various directorate level reports and scorecards, such as the Matron's Scorecard.

Individually these reports contain a good level of information and highlight potential risks, however, there are significant variations in the format of the reports.

Given the sheer number of reports and scorecards it is difficult to form a comprehensive view of performance, or to triangulate multiple measures to understand key trends in quality or performance. In observing the board, the CPT did note examples of triangulation made by board members, but in order to reach these conclusions it is likely that extensive review and familiarisation with these reports would be required.

A more consistent, comprehensive dashboard and report would increase accountability and would allow an assessment of the underlying trends and impacts of specific issues on all key areas of performance.

### **Integrated performance scorecards**

The Trust is in the process of implementing a revised integrated performance scorecard, which was presented to the TMB in April. The current board performance scorecard focuses on reporting against key targets and indicators. Each indicator is Red, Amber, Green (RAG) rated against the quarterly, monthly and year to date (YTD) targets, and supported by a short commentary. This is in line with best practice.

The Trust has begun to make some improvements in this area, for example, reordering the measures within the performance scorecard to focus the discussion on those with the most significant consequences for the Trust. Further development is required.

The Deputy Director of Performance Information and Contracting is in the process of developing a revised performance scorecard which aims to summarise on a single page the Trust's performance, quality, finance and workforce measures. This will be supported by a detailed exception report for each measure that is red, or in a declining position.

However, whilst the data for the report at a directorate and service level does exist, investment in systems to consolidate and analyse this data is required, and therefore directorate and service level reporting is not expected to be in place until at least mid FY14.



## **Measurement**

The Trust is introducing an integrated performance scorecard.

### **CPT view**

*The integrated performance scorecard will provide a 'Report summary' snapshot of the performance of the Trust, and will allow more effective triangulation of measures.*

## **Integrated performance scorecards (continued)**

The diagram opposite sets out the anticipated inclusions to the integrated performance scorecard.

Other trusts use a similar report; the format provides a good snapshot of performance in a particular month, and highlights any declining measures. Once in place within the wards, services, directorates and at a Trust level, the report should improve the identification and triangulation of performance measures.

The proposed exception report that will support this scorecard has a standard format that will include:

- A description and definition of the target;
- The issue(s) occurring;
- The actions that have been taken;
- The planned further actions (including lead and impact date);
- A trajectory for improvement; and
- Approval from the relevant clinical and executive directors.

This is a well formatted exception report and includes all the expected areas. The use of a report of this nature should allow users to challenge effectively and obtain the assurance they require.

## **Outcomes**

- Clinical outcomes
- Internal financial measures

## **Quality**

- Infection prevention and control
- CQUIN
- Clinical quality
- Trust patient satisfaction survey

## **Process / Governance**

- Department of Health operational standards
- Clinical efficiency
- Governance and regulation
- Financial indicators

## **Workforce**

- Workforce efficiency
- Workforce cultural index

*Areas for inclusion in the Trust's integrated performance scorecard (Floodlight Report) as set out in proposal to the April 2013 Trust Management Board.*



## **Measurement**

The Trust has a number of process in place to provide assurance around data quality.

### **CPT view**

*The processes in place to provide assurance around data quality are in line with expectations.*

*However, better use could be made of internal audit to provide specific assurance on measures of concern.*

### **Data quality**

The Trust has an established team responsible for the quality of data throughout the Trust. This team is part of the Information Technology department and assesses data quality in a number of ways, including:

- Addressing, on a real-time basis, invalid entries made into systems by staff;
- Reviewing weekly reports on missing items; and
- Proactively using the information services website to review reports and identify potential errors.

This team provides a report to the quarterly Data Quality Steering Group. Each directorate is represented at this meeting and provides various assurances to the Steering Group over the checks performed on data quality.

Staff at the Trust are able to access the information services website, which provides a number of real-time reports for various performance measures. This gives staff the ability to use data to manage areas of the Trust, and also increases the level of challenge that the Trust's data is subject to.

In 2011, the Trust commissioned an internal audit review to examine data quality governance arrangements. This reviewed governance and leadership, policies, systems and processes, people and skills, and data use and reporting. Overall the report noted 71.1% compliance, and did not flag any areas as 'red'. However, there were a number of areas identified for improvement, including the need for:

- The data quality implementation plan to be updated;
- Formal testing of the patient administration system;
- Performance to be included in appraisals;
- A fully documented committee structure to be put in place; and
- The documentation of the business cycles of subcommittees.

The Trust has provided evidence to support progress made against each of these areas.

There have been limited internal audits conducted on specific measures reviewed as part of the performance scorecard. The Trust should ensure that the Data Quality Steering Group feeds into the internal audit design process, to identify key audits required to provide greater assurance around measures of concern.

At the board meetings observed, the CPT did not note any significant challenge to the data quality behind the board reports. When developing the board development programme, the Trust should ensure that sessions on data quality are included to equip board members with the necessary knowledge to challenge the information that they receive, and to be assured of its quality.



## **Impact on operational performance**

The Trust has maintained its performance against key targets from Monitor's Compliance Framework in FY 12/13, with the exception of C difficile and A&E targets.

### **CPT view**

*The Trust's operational arrangements are reflected in improved performance in some areas, but access targets are at risk. In particular, the current high level of emergency admissions has led to a significant number of cancelled operations which will, in turn, impact the Trust's ability to meet its referral to treatment target in FY14.*

## **Impact on operational performance**

This section considers whether the Trust's operational arrangements are appropriate to address its current challenges, and how the Trust has historically addressed issues.

### **Assessment of operational performance**

In general, in FY13 the Trust has performed well against Monitor's Compliance Framework measures, however, it has breached two targets.

### **Clostridium difficile (C. difficile)**

The Trust experienced C. difficile cases above its planned trajectory in Q2 and Q3, which led to a breach of the annual target. The total number of cases in FY13 were 34, compared to 33 in the prior year.

As a result of enhanced infection control procedures, the trajectory appears to indicate a reduction of cases in 2013 (5 cases in Q4 FY13 compared to 15 in Q2 FY13). There will need to be an ongoing focus in FY14 to ensure continued improvement.

### **A&E four hour target**

The Trust breached this target in Q1, Q2 and Q4 of FY13 but met the target in Q3. There has been a significant increase in the number of patients attending A&E in Q1 to Q3 (an average increase of 5.1% on the prior year), however, there was a reduction in the number of patients attending in Q4 FY13 (down 3.4% on the prior year). More detail on A&E performance in the Trust can be found on page 55.

This pattern of higher attendances has been seen at a number of foundation trusts in Q3 and Q4 2012/13<sup>16</sup>. A significant impact of this increase in non-elective admissions is that there are a large number of medical outliers on surgical wards. This has, in turn, resulted in the cancellation of a large number of elective procedures.

These cancellations are expected to have a significant impact on the Trust's compliance with a number of access targets over the coming months, including referral to treatment (RTT) targets.

The Trust is taking a number of actions to address these issues, including:

- Holding capacity meetings three times daily to assess the availability of beds;
- Holding weekly access meetings to review waiting lists and compliance with targets;
- Converting a surgical ward into a medical ward to enhance patient safety and experience; and
- Holding regular meetings with key stakeholders in the health economy to attempt to address the factors leading to higher rates of admissions and delayed transfers of care.

The CPT attended one of the capacity meetings held. This was a well attended meeting with the Executive sponsorship. The CPT has not reviewed the non-elective pathway in full.

<sup>16</sup> NHS foundation trusts - review of nine months to 31 December 2012, Monitor.



## ***Impact on operational performance***

In FY13 the Trust has breached infection control and A&E targets.

### ***CPT view***

*The Trust has demonstrated progress in improving infection control rates in Q4, indicating its ability to implement effective actions to address risks.*

*The continued breach of the A&E target is symptomatic of the high number of non-elective referrals and lack of capacity at the Trust. This will require a whole health economy approach to resolve.*

## **Assessment of operational performance (continued)**

Performance against these key metrics, and clinical quality data indicates that, overall, the structures and processes in place provide a framework for operational performance in line with expected standards.

The Trust is facing a number of issues, in particular with access and capacity, that will require a whole health economy approach to address.

The CPT has not identified any evidence to suggest that the governance and operational arrangements in the Trust are inadequate to maintain an expected level of performance. However, the ongoing achievement of targets, such as the A&E four hour target and RTT targets, will require significant management time and focus and support from the whole health economy, in particular the local CCGs. Without this support, the Trust will breach these key access measures.

The CPT has been provided with a business case for a multi-agency team of professionals from community, primary care, social care and acute services that provide a community based, highly reactive service to help avoid admissions and to support early discharge in Peterborough for elderly patients. This service, called 'The Firm' is currently running as a six month pilot from February 2013. If successful, this service will reduce unnecessary admissions to Peterborough City Hospital by 3 - 6 patients per day, and in conjunction with other planned interventions should reduce the pressure on beds in the Trust. The plans will require the ongoing support of all partners to be successful. The Firm will be subject to an interim evaluation against planned outcomes in May 2013.



## **Conclusions**

Conclusions on the operational sustainability of the Trust.

### **CPT view**

*The Trust is operationally sustainable in its current form and has demonstrated some examples of good practice.*

*The Trust is in the process of implementing a number of schemes that will further improve its operational sustainability.*

*However, progress in implementing some of these schemes has been slow. There are concerns, shared with commissioners, that the large agenda facing the Trust and weaknesses in performance management may have a negative impact on operational performance.*

## **Conclusions on operational sustainability**

The review of operational sustainability has identified some notable strengths in the operational arrangements within the Trust, which provide a sound basis for operational sustainability. These include, but are not limited to:

- A comprehensive strategy that is well embedded at board level;
- Board members with the background and experience suited to an organisation in financial distress;
- A desire to continue to focus on providing high quality care; and
- Evidence of a transparent culture in relation to high levels of incident reporting.

These strengths are reflected in the quality and performance of the Trust, including the lower than average HSMR and SHMI (considered further in Clinical Sustainability below), low rates of avoidable MRSA infection, and compliance with a number of key targets, including stroke and cancer waiting times.

There are, however, a number of challenges facing the Trust that could affect this quality and performance. In particular, the high number of non-elective admissions and subsequent impact on elective pathways could significantly affect the Trust's access and performance, patient safety and experience. The Trust is working with the commissioners and other key stakeholders to resolve these issues, but continued cooperation between all parties will be required.

Historically, the Trust's governance arrangements relating to CIPS have been weaker than expected. The Trust has begun to implement a number of actions

aimed to strengthen this process in FY14.

The Trust is in the process of implementing several programmes that will further improve operational sustainability. These include:

- A comprehensive board development programme;
- Revised integrated performance scorecards from ward to board level; and
- Service line reporting.

Progress in implementing some of these programmes has been slower than expected. Similarly, concerns have been expressed by commissioners that the Trust does not have the capacity to change at the speed required. Given the large agenda facing the Trust, there is a risk that slow progress against key operational plans will have a negative impact on the performance of the Trust.

This review has also identified some inconsistencies and limited sharing of best practice between the directorates, and some examples of directorates working in silos. Continued focus on creating a culture of sharing and communication will be required to ensure that transformational changes can be made.

The systems and processes are sound in design, but some are at a relatively early stage of development and there is a risk that the large agenda of the Trust reduces focus on the 'business as usual' processes and slows progress.

Assuming that the Trust was able to achieve financial and maintain clinical sustainability, the CPT believes that the Trust is operationally sustainable in its current form. Continued sustainability will, however, be dependent on a whole health economy approach to ease the current capacity issues at the Trust.

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# *Clinical sustainability*



## **Methodology**

The CPT's approach draws recognised lines of enquiry that together allow a conclusion to be drawn on clinical sustainability.

## **Clinical sustainability**

Clinical sustainability considers the extent to which the Trust is currently delivering acceptable levels of clinical performance, and whether this level of performance is likely to be maintained over a three to five year period.

## **Methodology**

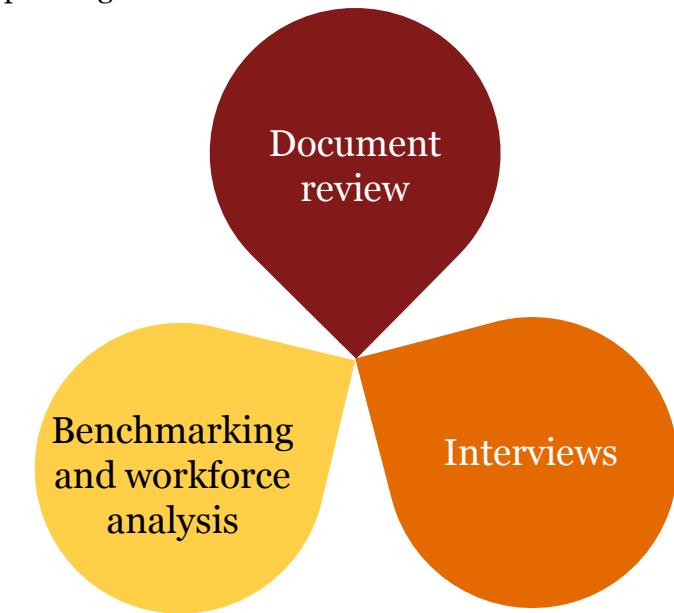
In order to draw conclusions about the Trust's clinical sustainability, the CPT investigated the following lines of enquiry, chosen because of the impact on the provision of continuity of services and based on experience of reviewing clinical quality. These include:

- An evaluation of the catchment population and services provided by the Trust to help understand if the Trust is sustained by appropriate number of patients;
- Consideration of the macro level challenges, local health needs and CCG commissioning intentions to assess the appropriateness of services provided to local population;
- NHS mortality indices to indicate clinical safety;
- An analysis of surgical outcomes and medical care to provide insight into quality of care;
- A review of regulatory reports to collate the Trust's performance against a number of quality standards;
- An investigation into A&E wait times and referral to treatment times;
- An investigation into workforce to understand whether the Trust has the appropriate staffing level to deliver sustainable and safe care.

## **Data sources**

The CPT has undertaken this review using data and indicators from the Healthcare Evaluation Database (HED)<sup>1</sup>, quality reports, interviews with key stakeholders, and in-depth analysis into a number of areas using the Trust's Secondary Usage Services (SUS) data.

The reports reviewed by the CPT focused on standards set out by the Care Quality Commission (CQC), the NHS Litigation Authority (NHSLA), the National Institute for Health and Care Excellence (NICE), Monitor, the Commissioning for Quality and Innovation (CQUIN) payment framework and the NHS operating framework.



<sup>1</sup> Healthcare Evaluation Database (HED) benchmarking system is developed by University Hospitals Birmingham which draws on Hospital Episode Statistics (HES) and other data sets.





## Catchment population

The Royal College of Surgeons recommends that the catchment population for an acute hospital should be 450,000-500,000<sup>2</sup>. However, given that approximately just 10 percent of trusts in England meet this criteria, a more realistic catchment population of 300,000 should still enable sustainability of services.

## CPT view

*The Trust's catchment is above the Royal College of Surgeons recommended minimum of 300,000, and it is likely that it approaches the ideal figure of 450,000-500,000.*

*The Trust therefore serves a catchment population that is sustainable for most of the acute hospital services.*

## Estimates of the catchment population

Obtaining an estimate for the catchment population of any NHS trust is highly complex. The Trust serves a wide geographical area that intersects the boundaries of six Clinical Commissioning Groups (CCGs). Outlined below are two approaches to estimating the Trust's population. This report uses both to provide a lower and upper level for the population.

**1) Travel times:** Populations within certain travel times from Peterborough City Hospital have been calculated based on Census 2011 population data and travel times from the Transport Direct Journey Planner. The table below indicates the total population of those areas within 15, 30, 45 and 60 minute travel times to the Trust.

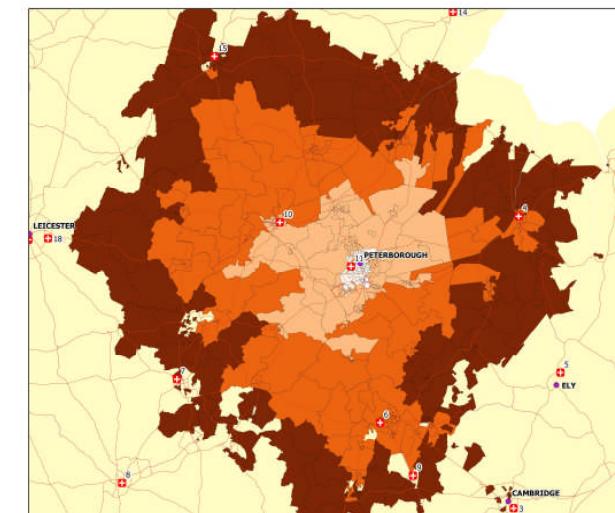
From this data it is clear that the Trust continues to serve a population that lives up to 45 minutes away. This corresponds to a catchment population of approximately 500,000. Whilst it is unlikely that the Trust will deliver services to 100% of this population, it demonstrably offers services to this area. As such, this provides an upper boundary for the catchment population used within this report.

	Total population	Proportion of the Trust's activity
<b>15 minutes or under</b>	92,316	26.4%
<b>30 minutes or under</b>	245,769	69.8%
<b>45 minutes or under</b>	500,596	90.7%
<b>60 minutes or under</b>	859,514	91.2%

**2) CCG population:** New CCG boundaries see the Trust providing services for the following six CCGs: Cambridgeshire & Peterborough CCG (851,200), Lincolnshire East CCG (240,000), South Lincolnshire CCG (154,900), Leicestershire & Rutland CCG (315,000), Nene CCG (625,000) and South West Lincolnshire CCG (128,300). Whilst the Trust does not draw 100% of the activity from these populations, it is a significant provider of acute hospital services to the population represented by these CCGs.

## Conclusion

Having considered estimates drawn from these two approaches, it would appear that the Trust's current population adequately supports the need for an acute hospital in the Peterborough area. Population growth and migration are not taken into account here, although they have been considered by the Trust in financial planning assumptions.



*Areas within 15, 30, 45 and 60 minute travel time zones.*

<sup>2</sup> Delivering High-Quality Surgical Services for the Future, Royal College of Surgeons of England, 2006



## ***Services provided by the Trust***

There are four specialties for which the Trust has less than 50% market share within 10 miles, all of which have low total activity. There are also three specialties for which the Trust has 50%-75% market share which indicate higher total activity.

### ***CPT view***

*The four specialties with low market activity are considered to be sustainable because they provide services in conjunction with other tertiary specialist centres.*

## **Current services provided by the Trust**

The Trust provides a full range of District General Hospital (DGH) services, and a small number of regional specialties. In FY13 the Trust delivered 85,983 inpatient spells, including 13,090 for General Medicine (the largest specialty by volume of activity). The Trust delivered more than 7,198 Trauma and Orthopaedic spells, 2,433 Gynaecology spells, and fewer than 250 spells of both Neonatology and Nephrology.

The Trust also served 85,503 A&E attendances and 390,473 outpatient attendances and procedures.

Some of the services currently delivered by the Trust are considered specialist rather than part of a core DGH offering. These include aspects of Critical Care and Respiratory Medicine.

## **Size of population served by the Trust's specialties**

This report has already indicated that the catchment population served by the Trust is sustainable at the Trust and organisational level. When reviewing the volume of activity at the Trust the Trust ranks 86th compared to all other 163 trusts in England. In the specialties where the Trust has lower volumes of activity, it ranks nationally as follows:

- Neurology 105th out of 132 trusts;
- Nephrology 79th out of 99 trusts;
- Paediatric surgery 59th out of 78 trusts; and
- Paediatric urology 24th out of 40 trusts.

Whilst the CPT has not assessed whether similar/smaller sized trusts are themselves sustainable, the Trust does not fall at the lowest end of the rankings by volume in these specialties, and in addition has partnerships with specialist centres to support delivery of the activity.

## **The Trust's specialties with low market activity**

Specialty	Market activity (Episodes)	Main specialist centres
Neurology	67	Addenbrookes
Nephrology	1,096	University Hospital of Leicester (UHL)
Paediatric Surgery	203	UHL
Paediatric Urology	84	UHL

## **Conclusion**

Most specialties provided by the Trust are currently sustained by a reasonable level of activity from a population living within 10 miles.

The Trust offers a number of specialties where there are lower volumes of activity. In these instances, the majority of activity is supported by tertiary specialist centres, with the Trust acting as a satellite service. The Trust maintained the provision of these specialties by having procedures or consultations performed by visiting specialists (see the table above). With this support the Trust has been able to achieve clinical sustainability for the low activity specialties as well.



## **Appropriateness of services**

Three factors have been considered to assess the appropriateness of the current services being delivered to the local population. This section provides an assessment of the first two factors.

### **CPT view**

*In addition to the challenges faced by all trusts within the NHS, deprivation, high population density and alcohol abuse also impact health needs in the local area of the Trust.*

## **Appropriateness of services**

Whilst the majority of this review, and this section in particular, focuses on the current performance of the Trust, in order to fully evaluate the clinical sustainability of its services it is necessary to consider the following factors:

- Macro level trends in healthcare are likely to impact on the services required by NHS acute hospitals;
- The health needs of the local population; and
- The buying or commissioning intentions of the local CCGs.

### **1) Challenging trends in healthcare**

The UK population is both growing and ageing, and increased demand is putting pressure on public services. By 2015, the UK population is expected to reach 65m, and by 2026 this number is predicted to reach 70m. This population increase will intensify the demand on NHS resources at a time of budgetary restraint and austerity.

The proportion of elderly people in the UK is also increasing. In 2010, over 65s made up 17% of the population, and by 2051 the Nuffield Trust estimates that elderly people will account for 24% of the population.

Life expectancy is longer, with poorer lifestyle choices – primarily excessive alcohol consumption, poor diets, and smoking. This means that people in the UK are increasingly likely to suffer from chronic conditions. The number of people with diabetes, for example, is growing rapidly, with an additional 140,000 people diagnosed with the disease each year. These long-term conditions place a constant strain on services; chronic disease accounts for 80% of GP consultations and 60% of

hospital bed days. The dual impact of behavioural and demographic trends will therefore influence future NHS budgets, and also the type of care that will need to be delivered in the next decade.

### **2) Health needs of the local population**

As part of the review of the catchment area of the Trust, the CPT has explored the characteristics and trends of the Trust's catchment population (Census 2011). These pose additional challenges to the Trust, as follows:

- Peterborough is more ethnically diverse than most areas in the East of England (EoE), where 1 in 14 people falls within an Asian ethnic group;
- The Office for National Statistics (ONS) categorises Peterborough as a 'new and growing town', along with several other local authority areas;
- At 5.3 people per hectare, Peterborough City has a higher population density than found on average in the EoE (3.1) and in England (4.1);
- Peterborough's population is generally younger than the regional and national averages;
- There is a relatively high level of deprivation and the area is ranked amongst the third of English local authorities with the greatest levels of deprivation;
- The rate of reported crime is higher than the national average (Public Health Observatories 2012);
- The rates of teenage pregnancy are higher than national average (Public Health Observatories 2012); and
- There is an increase in the use and abuse of alcohol over the past years (Peterborough Alcohol Health Needs Assessment 2011).



## ***Appropriateness of services***

The intentions of local commissioners are to relieve some of the pressure on the Trust's A&E department.

### ***CPT view***

*Local CCG intentions are aligned with the current health needs of the population and with hospital efficiency.*

*Services being provided by the Trust may well be fit for current purpose, but may be inappropriate for the needs of the local population in the next three to five years if there is not close working with the commissioners to evolve and adapt services accordingly.*

### **3) Commissioning intentions of the local CCGs**

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 the local commissioners: Cambridgeshire and Peterborough CCG and South Lincolnshire CCG. They are broadly:

- To reduce emergency bed days for unplanned admissions of older people;
- To increase as far as possible elderly patients receiving care at home or in the local community;
- Improving care for frail and elderly patients and improving end of life care;
- Tackling health inequalities across the CCG's catchment area;
- Reducing the percentage of mothers smoking at the time of delivery;
- Reducing the number of emergency bed days for patients over 75; and
- Improving primary prevention for cardiovascular disease (CVD).

The CPT also reviewed key schemes for the commissioning intentions, including:

- The provision of an upgraded GP led minor injury and illness unit at the City Care Centre in July 2013; and
- The commissioning of an Older People Programme , which includes a new elderly care service as part of

the future plans for community services in Cambridge and Peterborough.

The impact of these schemes is unclear as the activity reduction has yet to be realised at this time of investigation. The elderly care service is at an Invitation To Tender stage, and there are a number of variables which could impact the Trust, including success or failure in bidding for the tender, when the new service will impact on activity, and the identification of the benefits realisation plan by the commissioners. If attendances at A&E and 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).

### **Conclusion**

Whilst the Trust does consider the needs of the immediate population in the development of its services, there has been very little system wide planning of services across the local health economy aimed at meeting the needs of the catchment populations.

The services being provided by the Trust may be fit for purpose now, but there is every likelihood that without closer working with commissioners, the Trust may be unable to meet future demands in a sustainable manner.



## Hospital Standardised Mortality Rate overview

This section provides a summary of the Trust's HSMR and benchmarks the Trust against national peers.

### CPT view

*The Trust's overall HSMR indicates that it sits within expected levels of performance.*

## Mortality indicators

Mortality is an important clinical safety indicator. The CPT considered two types of index for mortality to give a balanced view of any mortality issues the Trust might have. The Hospital Standardised Mortality Rate (HSMR) index and the Summary Hospital Mortality Indicator (SHMI) index are explored below.

### Hospital Standardised Mortality Rate

The Hospital Standardised Mortality Rate (HSMR) is an index used to monitor death rates for a hospital. The ratio is a calculation of observed to expected deaths (multiplied conventionally by 100). Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100.

Between quarter 4 of FY11 and quarter 3 of FY12 the Trust's average HSMR score was 95. This lies within expected range, as seen in the funnel plot on the right. The funnel plot<sup>3</sup> uses the Poisson distribution model (a statistical test) to compare the Trust with its national peers, by calculating 95% (inner lines) and 99.9% (outer lines) confidence intervals. Any trust's HSMR within the funnel formed by the red and green lines is within the expected range.

The Trust's monthly HSMR maintained a steady trend within expected range in the 12 month period observed.

## The Trust: HSMR funnel plot



## Conclusion

During the period of FY11 Q4 to FY12 Q3, the Trust's HSMR falls within the expected range as per the graphs.

Whilst the overall HSMR performance is not an outlier, the Trust should continue to closely track performance of HSMR by diagnostic group.

<sup>3</sup> A funnel plot is a statistical analysis used to identify statistical outliers. Different trusts' HSMR are compared using this method to indicate the range of expected performance for mortality indices.



## **Summary Hospital Mortality Indicator overview**

This section provides a summary of the Trust's SHMI and benchmarks the Trust against national peers.

### **CPT view**

*The data indicates that the Trust's SHMI is at the national average and within the expected confidence intervals.*

Another mortality index will be discussed to indicate the Trust's patient safety in this section.

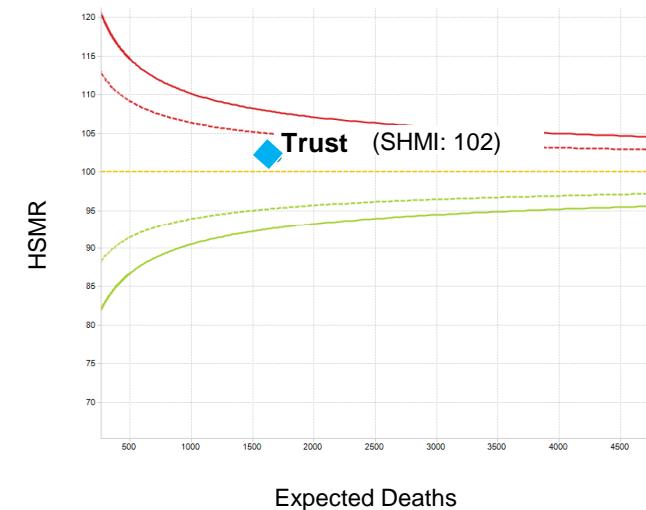
### **Summary Hospital Mortality Indicator**

The Summary Hospital Mortality Indicator (SHMI) is the ratio of the observed deaths in a trust to expected deaths over a period of time. Similar to HSMR, if a trust is observed to have mortalities in line with the rest of the country the SHMI will be 100. SHMI differs from HSMR by a number of criteria including counting all hospital deaths, excluding palliative care coding, and counting post discharge deaths outside the hospital within 30 days.

During the period of FY11 Q4 to FY12 Q3, the Trust's average SHMI scored 102, which lies within the expected range, as seen in the funnel plot on the right. The funnel plot uses the Poisson distribution model (a statistical test) to compare the Trust with its national peers, by calculating 95% (inner lines) and 99.9% (outer lines) confidence intervals. Any trust's SHMI within the funnel formed by the red and green lines are within the expected range.

The Trust's monthly SHMI was also within the expected range in the 12 month period observed.

### **The Trust: SHMI funnel plot**



### **Conclusion**

During the period of FY11 Q4 to FY12 Q3, the Trust's SHMI is within the expected range.

As with HSMR, the Trust should continue to track performance of SHMI closely by Hospital Mortality Group and Quality Governance Operational Group.



## **Surgical outcomes and medical care**

This section provides an introduction to the methodology used to conduct an in-depth analysis into surgical and medical care.

### **CPT view**

*The CPT developed an in-depth understanding of the clinical outcomes at the Trust by analysing inpatient activity. This is the area where the majority of clinical complications and preventable errors typically occur.*

## **Surgical outcomes and medical care**

Given the overall reassuring mortality indicators at the Trust, the CPT conducted a detailed review to assess the quality of care, by focusing on the surgical outcomes and acute medical activity across the Trust over a three year period to January 2013. The analysis draws from detailed clinical coding of individual patient episodes to produce the following assessment:

- Clinical case-mix adjusted surgical outcomes (taking into account risk and complexity of patients treated during the target period); and
- Incidence of avoidable harm, triangulated from recognised clinical trigger events<sup>4</sup>.

This analysis is provided by C-Ci, a specialist Healthcare IT company that has developed a solution for analysing acute care using detailed clinical coding. The system applies clinical formulae to assess specific outcomes by patient, rather than statistical aggregates.

### **Conclusion**

Based on the analysis conducted, the Trust appears to have maintained acceptable performance over the three year period observed, with no major anomalies. It also seems to have been improving moderately over time. Furthermore:

- Risk-adjusted surgical mortality is consistently within acceptable limits;
- The overall trigger rate is generally lower than expected, although an increasing trend is observed; and
- The only anomaly for the Trust appears to be driven by higher ratios of observed to expected death in General Surgery. Together with trigger rates, these are

concentrated specifically in non-colorectal gastrointestinal procedures in General Surgery. However, they are largely historical, occurring in early 2012.

This analysis has identified some areas that should be considered for action and require ongoing monitoring to maintain or improve upon current performance, notably:

- Management of patient transfers between medical and general surgical care;
- Rates of return to theatre for bleeding and anastomotic leakage; and
- Chest infection rates in orthopaedic patients.

There are also some clinical coding and recording issues to be addressed (particularly in relation to septicaemia, pressure ulcers and accidental injury). This will help improve the overall clarity of the picture for the future.

The Trust should be commended for establishing VTE and C-difficile review panels, and should continue to triangulate these with trigger events and mortality rates.

<sup>4</sup> Trigger events are indicative of harm caused by medical examination or treatment (iatrogenic harm).



## **Care Quality Commission review**

This section provides a summary of the CQC inspection in April 2013 and the Quality and Risk Profiles published in February 2013.

### **CPT view**

*Based on CQC inspections the Trust has no serious issues, with no high risk of non-compliance against any indicators in the QRPs. This provides further support to clinical sustainability. However, actions should be taken to improve assessment of patients' existing care needs and address issues quickly.*

## **Care Quality Commission**

Care Quality Commission (CQC) is the regulator of health and social care in England. They carry out unannounced inspections at least once a year and planned follow-up visits to check whether trusts meet the essential standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These include:

- Care and welfare of people who use services;
- Meeting nutritional needs;
- Staffing; and
- Assessing and monitoring the quality of service provision

During the CQC's inspection visit, they observe how people are cared for, and talk to people who use the service, to their carers and to staff. Checks are made to ensure the right systems and processes are in place and information such as service records and case notes are reviewed.

In the latest visit (April 2013), CQC made the following observations within the scope of inspection:

- Patients' existing care needs were not always assessed or adequately planned for to ensure they received the care they needed; and
- Issues identified were not always addressed quickly enough to reduce the risk to the health and safety of patients. They were judged as having a moderate and minor impact on people receiving the care.

The Trust has provided an action plan to the CQC on how it will address these issues.

Quality Risk Profiles (QRP) bring together information about a care provider and an estimate of risk of non-compliance against each of the 16 essential standards of quality and safety. In order to build each of the QRPs, CQC analyses a range of data sources, both qualitative and quantitative. These include national clinical audit datasets, routine data collections, information from people using services and data from other regulatory bodies. A summary of these profiles is regularly reported to the board of the care provider and an action plan is set out as a result.

The QRPs for the Trust published in February 2013 for the 16 standards indicate no signs of high risk of non-compliance. Most standards scored medium to low risks, which provide support to clinical sustainability. See appendix G for more details.

Overall, the Trust also has acceptable clinical quality indicators on the HED dataset. See appendix H for more details.



## **Regulatory reports**

This section provides the key findings of the latest papers published on the Trust's clinical quality performance.

### **CPT view**

*The Trust does not demonstrate any major areas for concern, and is accredited with NHS LA Level 1 and CNST Level 2 for maternity services.*

*Some performance related issues and targets are recognised by the Trust's QAC and regularly reviewed. The Trust is accredited with NHS LA Level 1 and CNST Level 2 for maternity services. The Trust also achieved most of the CQUIN targets and NICE status, except some areas lacked sufficient documented evidence.*

## **Review of regulatory reports**

The CPT has reviewed reports assessing the Trust's clinical quality based on a number of standards set out by the CQC, NHS LA, and NICE. Overall, the Trust demonstrated expected performance, with some developmental areas listed below.

### **Quality Assurance Committee Reviews (February 2013)**

The Trust has a Quality Assurance Committee (QAC) which holds quarterly board level review into the quality related performance against locally agreed standards/targets. As recognised by the Trust, there will be action plans and ongoing review of the below points:

- Reported falls failed to meet the target of 20% reduction in February and March 2013;
- The target to reduce pressure ulcers was not met;
- Six patients developed a hospital associated VTE (Venous Thrombus Embolism) in 2012. They were fully reviewed;
- 8 of the 31 C. difficile infection cases were deemed avoidable;
- Safety thermometer data suggests catheter-associated urinary tract infection requires improvement;
- 1,050 safety incidents were reported during January 2013: an increase of 66 against the 986 reported in December 2012;
- There were 46 serious incidents from April 2012 to March 2013 (including 26 pressure ulcers and 20 clinical incidents);
- Four hour Emergency Department wait times narrowly met threshold standards; and
- Drug errors - potential to cause harm/omissions/errors - were rated as red, as more than two incidents were reported in 2012 Q2.

## **NHS Litigation Authority**

The Trust was accredited with NHS LA level 1 in October 2012 (with a score of 48/50). Areas identified to be non-compliant during the inspection were in 'health records management' and 'moving and handling training'. The Trust's maternity service was previously accredited with CNST Level 2 in February 2010. This was re-assessed against new standards in March 2013 and a pass mark of 40/50 was achieved. Out of the 10 areas recommended for further improvement, continuous electronic foetal monitoring remained non-compliant since the last inspection despite the purchase of digital equipment. Shoulder dystocia is another area that remained non-compliant since the last inspection in 2010. (See Appendix J for a detailed review on the maternity service.)

### **Commissioning for Quality and Innovation (CQUIN)**

CQUIN is a payment scheme set out by Department of Health that makes a proportion of income conditional on quality and innovation.

- The Trust is expected to achieve an exceptional performance of 92.5% on CQUIN for FY13;
- There are some areas where the Trust did not meet the CQUIN targets. These include national patient survey (2.5%), and patient education for maternity services (2.25%). The other shortfalls were on partial achievements of relatively modest sums.

### **NICE status update (February 2013)**

The Trust met the majority of standards for NICE compliance, except there was insufficient documented evidence in some areas. In particular, the VTE prevention policy, technology appraisals for drugs and some clinical guidelines required attention.

## A&E wait times and Referral to treatment

Patient experience and clinical quality is impacted by the time taken to see patients both in an emergency and elective care setting. This page reviews the Trust's current performance in Emergency Department.

### CPT view

*The Trust and its commissioners should focus on managing A&E wait times, which is influenced by a combination of factors.*

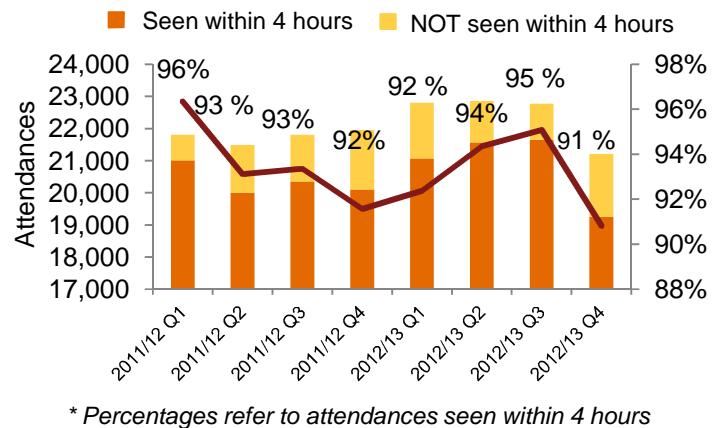
*Whilst further investigation is needed to understand the cause of long A&E wait times, the Trust should continue to engage with commissioners about improving support in the community.*

## A&E wait times and referral to treatment

The Trust has faced significant challenges in meeting the 'admitted transferred or discharged within 4 hours' A&E target. This has been the experience of 94 other trusts nationally in the last quarter of FY13.

The CPT has investigated the emergency pathway to explore performance within A&E. In addition, the CPT has explored the elective pathway and the 18 week RTT requirements.

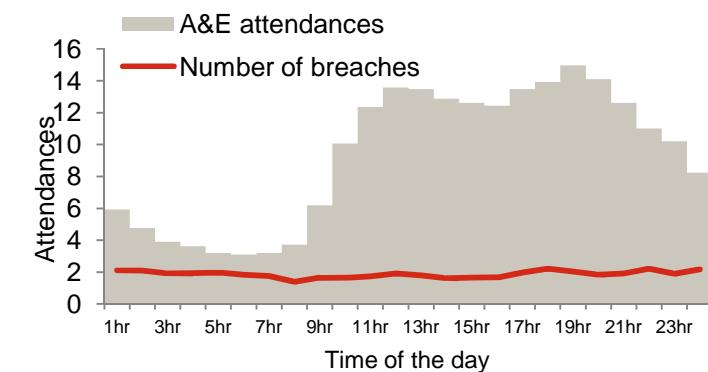
### The Trust: Four hour A&E wait times



The Trust's emergency model is viewed as best practice by the Urgent and Emergency Care Intensive Support Team (ECIST<sup>5</sup>), which allows all patients to access emergency services through A&E. Unlike some other trusts, the Trust does not have a 'Medical Assessment Unit' (MAU) that receives direct access GP referrals. If an MAU were in place, GP referrals (approximately 10% of A&E attendances)

would attend the MAU directly instead of A&E. In addition, patients that are waiting for further assessment or to see a subsequent specialist could also be admitted to the MAU if appropriate.

### The Trust: Comparison of A&E attendances and number of breaches



The Trust has an ambitious improvement programme underway to transform the unscheduled care pathway. It is recognised that there are actions that are within the Trust's control that will assist in improving patient flow. However, there is also recognition that a number of blockages within the current pathway are dependent on the implementation of commissioning intentions including those noted in the previous chapter of this report.

<sup>5</sup> ECIST is a national team set up to provide support to health and social care communities in reviewing their system for urgent and emergency care.



## A&E wait times and Referral to treatment

Patient experience and clinical quality is impacted by the time taken to see patients both in an emergency and elective care setting. This page reviews the Trust's current performance in referral to treatment times (RTT).

### CPT view

*Whilst the Trust is meeting RTT targets at the moment, it is at a financial cost by outsourcing to private providers. This is primarily caused by emergency bed pressures.*

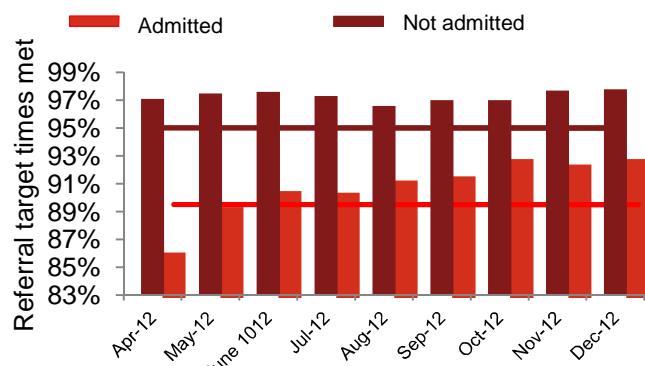
*The Trust should also continue to focus on meeting the RTT targets.*

### Referral to treatment (RTT)

CPT's analysis shows that the Trust is meeting its targets for referral times, with those being treated within 18 weeks increasing for both admitted and non-admitted patients.

During January and February 2013 the Trust cancelled a number of operations due to capacity issues and bed shortages; this may have an impact on future RTT reporting.

#### The Trust: Referral to treatment times



### Conclusion in relation to A&E and RTT

There is a trend of improvement in performance in RTT. However, these improvements have followed a significant period of investment in time, expenditure and resources by the Trust. This is at a financial cost as it requires outsourcing patients to private provider beds.

The Trust has been commended on its progress in implementing its improvement programme by ECIST, with evidence of significant improvement between visits, particularly A&E.

Whilst nationally half of all trusts are struggling to meet the target A&E wait times there are a number of actions the Trust can take to meet this target. This would require reducing breaches by an average of 3 per day. However, there should be a shared responsibility between the Trust and the CCGs, as recognised by the NHS England Gateway report (ref 00062). The CCGs' intentions are to improve the Elderly group admission pathways with an aim to alleviate the pressure on A&E.

The Trust must work with the health economy to eradicate delayed transfers of care, and improve access to intermediate care facilities.



## **Workforce sustainability**

The CPT has considered the Trust's workforce to assess the staffing required to deliver sustainable, safe levels of care.

### **CPT view**

*The Trust's clinical approach to workforce has been one of safety first, and this aligns to the Trust's clinical outcomes and the CPT's conclusions regarding clinical sustainability.*

## **Workforce considerations in relation to clinical sustainability**

With increases in activity levels, appropriate steps have been taken to ensure compliance with safe staffing levels as identified by the Royal Colleges. This is particularly evident in the Emergency Department and Maternity Services.

### **Approach to ensuring safe staffing levels – nursing and medical workforce**

The Trust has established its ward shift templates aligned to safe staffing level guidance ('green' levels) and resources these through a mixture of substantive and temporary staff, as required. In practice, this means that each shift is properly resourced with the safe level of staffing per shift, irrespective of the cost implication.

The benchmarking conducted as part of this review has found that the ratio of qualified to unqualified staff is 65:35, which is in line with the Trust's peer group and Royal College of Nursing guidance.

The Trust is in the process of confirming its nursing staffing levels following a review that identified appropriate staffing levels relative to patient dependency and acuity levels.

The Royal Colleges have published standards for the number of consultants required to deliver a 24/7 service across a number of specialties. The Trust is able to meet the Royal College standards in Paediatrics and Emergency Surgery and is working towards improving the staffing levels in A&E and Maternity Services.

However, a report published by the national Emergency Medicine Task Force in December 2012 identified lower than 50% fill rates into higher trainee posts, as well as

lower numbers of candidates opting for careers in emergency medicine. As less people opt for a career in this specialty, there is likely to be an ongoing impact on the ability of the Trust to fully meet its safe staffing levels.

Appendix L provides a breakdown of Trust staffing levels against specific Royal College standards. It should be noted that these standards are not mandatory and the Trust has taken steps to ensure rotas are established to provide appropriate consultant cover, supported by middle grade staff, on site presence when required. It is also increasing training amongst junior and middle grade doctors to 'grow their own' and counter national skill shortages in key specialties, such as Emergency Departments.

### **Recruiting a sustainable workforce**

Although the Trust has an ongoing recruitment campaign to fill current vacancies, it has a low rate of converting nursing recruits to permanent staff. While this may reflect high clinical standards being applied in the selection process, it means a continued reliance on temporary staff.

### **Conclusion**

The Trust's clinical approach to workforce has been one of safety first and this aligns to the Trust's clinical outcomes, contributing to the CPT's conclusions regarding clinical sustainability.



## **Conclusions**

Conclusions on the clinical sustainability of the Trust.

## **CPT view**

*Based on the evidence reviewed, the Trust is clinically sustainable but should continue to focus on areas for improvement*

## **Conclusions on clinical sustainability**

On the basis of the evidence reviewed and the interviews undertaken, overall the Trust is currently providing services that appear clinically safe and sustainable, and clinical performance is within expected ranges. However, there are still some areas for improvement, such as A&E wait times and the Trust is currently planning further improvements in some areas.

The findings of the review are summarised below:

- Whilst the Trust's catchment population lies within RCS recommended limits, where the current population is too small the Trust provides some services as part of a wider network. Therefore, the Trust may not be able to sustain particular services without support from other healthcare providers;
- Trust mortality indices indicate acceptable clinical safety in comparison to national peers. In-depth analysis into surgical outcomes and medical care again revealed overall acceptable clinical performance, with General Surgery being the main driver of mortality historically. However, some areas will require ongoing monitoring to maintain or improve upon current performance.
- The recent CQC inspection revealed areas for improvement in adequately assessing patients' existing needs and addressing issues quickly. The overall QRP indicated no high risks of non-compliance at the Trust.
- Historic reports assessing the Trust's clinical quality based on standards by CQC, NHSLA, CQUIN and NICE did not reveal major areas for concern. This is also supported by the majority of HED clinical quality and by safety indicators being within expected range;
- The Trust's Maternity service is demonstrating fair to good service and has seen improvement over the last two years. Where areas of concern have been highlighted previously and within recent analysis, the Trust appears to be responding to them (Appendix K);
- Although the Trust's RTT is better than the national target for both admitted and non-admitted patients, it is struggling to consistently meet the four hour A&E target. The Trust should work with external partners to ensure processes and facilities are provided to reduce attendances at the Trust, and expedite the discharge of patients into the most appropriate setting of care;
- The Trust's staffing levels are considered safe. However, the high number of temporary staff observed may impact the Trust's ability to sustain long term service delivery;
- Pathways of care have been designed based on significant clinical leadership and reflect the opportunities presented by a newly built facility. Both elective and emergency pathways within the control of the hospital were reviewed by the CPT as representing good practice; and
- Across both elective and non-elective pathways, the clinicians that were interviewed demonstrated a positive approach to patient care and proactive attitudes to delivering the best levels of care within the acute setting.

Based on the evidence reviewed the Trust is clinically sustainable but should continue to focus on areas identified for improvement. This sustainability is in part dependent on the CCG intentions and plans. If not carried through with a successful implementation, then the Trust could be clinically compromised in the future.

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# *Financial sustainability*



## ***Methodology***

The CPT's methodology is designed to provide an independent assessment of the financial sustainability of the Trust.

## ***Methodology***

The financial sustainability review of the Trust has focussed on three pillars which determine whether it can provide high quality affordable care to its patients in its current structure:

1. The Trust's ability to return to, and maintain, a surplus;
2. The Trust's ability to generate cash; and
3. The Trust's ability to pay its debts as they fall due.

This section considers whether the Trust will be able to move to a position where it can meet the above tests through actions which are largely within its gift. The CPT is therefore concluding on whether the Trust is financially sustainable in its current form, prior to the impact potential options for service reconfiguration may have.

This assessment has been undertaken through interviews with the Trust and its principal commissioners, and the analysis of reports.

In order to form a view on the above areas, the CPT has reviewed:

- The historical financial performance of the Trust insofar that this helps to support a view on the future of the Trust;
- The current performance of the Trust, using the outturn figures for FY13;
- The financial forecasts of the Trust, which are based on the long term financial model (LTFM) include income, costs and capital expenditure for the next five years;

- The recent cost improvement plan (CIP) performance and the Trust's future plans for further cost savings; and
- The opportunity for efficiency savings in the Trust based on benchmarking against other trusts and its own analysis.

The above has helped the CPT to form a view on the Trust's ability to improve its financial performance. It has then drawn on its review of the Trust's operational and clinical sustainability to further underpin its findings and conclusions.

The CPT has engaged with the Trust's principal commissioners in order to understand how their intentions (where available) will impact on the Trust's forecasts.

It has sought to minimise the repetition of the work that has already been undertaken by a number of other professional advisors, regulators and government bodies and references these reports where relevant.



## **Background**

The Trust began to incur significant deficits from the time it moved to its new facilities at Peterborough City Hospital.

### **CPT view**

*The Trust did not expect the size of the deficits that were incurred in FY11 and FY12.*

*The Trust received transitional income in excess of transitional costs in FY11, which reduced the reported deficit.*

## **Historical performance**

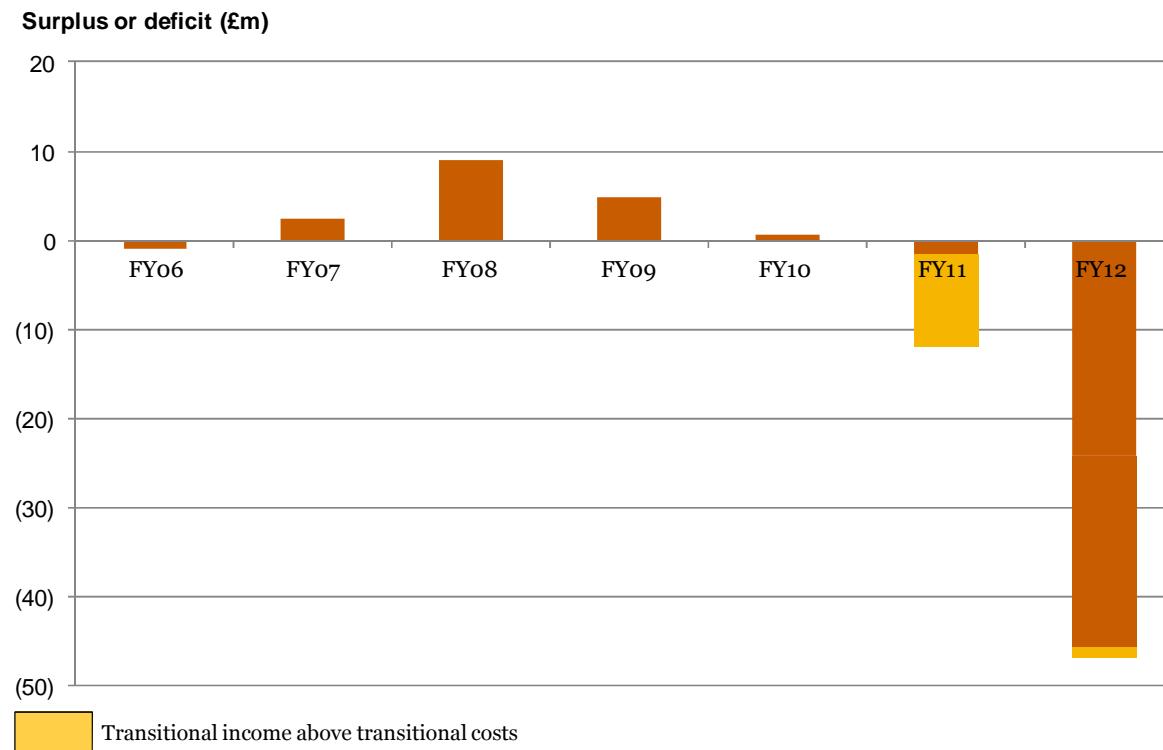
The table below summarises the financial performance of the Trust from FY06 to FY12.

The Trust's relocation from three sites across Peterborough to the single Peterborough City Hospital site was completed in December 2010. Stamford and Rutland Hospital has remained in place throughout.

In FY11 the Trust reported a loss of £1.5m. However, this was after the inclusion of c.£10m of transitional

funding above transitional costs. Therefore, the underlying deficit was £11.5m. These funds were received from the East of England Strategic Health Authority.

In FY12 the Trust incurred a deficit of £45.8m against a budgeted deficit of £21m. This was 22% of Trust turnover and was amongst the worst proportional deficits of any of the foundation trusts in the country. During this period, the level of deficit approached £900k per week.



Source: NAO report – *Peterborough and Stamford Hospitals NHS Foundation Trust*, November 2012

Note: FY11 deficit includes one-off support from the SHA of £20.5m and removing impairments of £1.68m relating to the old hospital site.

## Background

Expenditure growth in FY11 and FY12 significantly outstripped the increase in income.

## CPT view

*With the benefit of hindsight, it appears that the business case for the move to the new site was overly optimistic.*

## Historical performance (continued)

From FY06 to FY10 the Trust had a track record of either achieving a small surplus or breaking even.

The Trust moved into the new Peterborough City Hospital site in December 2010. The Trust has not been able to deliver against elements of the business case that the investment in the new facilities was predicated upon.

The National Audit Office recently reported that the key issues with the approval and implementation of the Trust's PFI were:

- The lack of recognition of the strain it would put on the Trust's finances in the future;
- The lack of scepticism shown to the affordability of the scheme; and
- The lack of focus on the financial position of the Trust between the approval of the scheme and the opening of the new hospital.

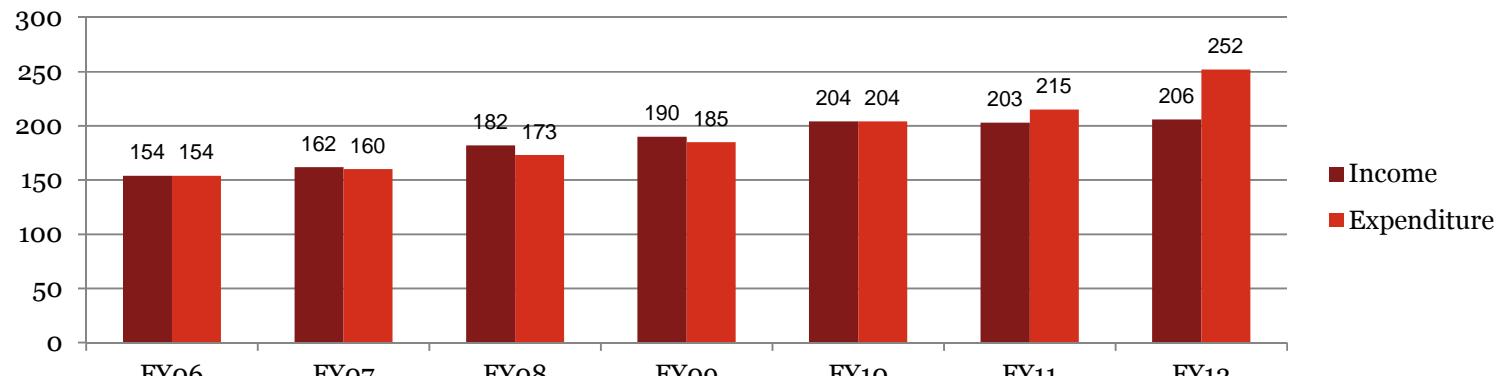
The NAO report attributed the deficit to a combination of:

- Excess costs of estate functions (PFI and non-PFI);
- Historical failure to achieve cost efficiencies; and
- Activity not funded by the commissioners.

The CPT has considered the causes of the deficit in order to inform its view of the Trust's financial sustainability.

The Trust has continued to incur a sizeable deficit in FY13. The most recent financial performance is discussed further on page 71.

## Trust income and expenditure from FY06 to FY12 (£m)



Source: NAO report – *Peterborough and Stamford Hospitals NHS Foundation Trust*, dated 22/11/12.

Note: The figures exclude impairments and transitional income/cost in each year.



## **Background**

The Trust's financial performance in FY13 has improved to a deficit of £39.4m.

The outturn position would have been further improved had the Trust been paid for all of the patient activity that it delivered.

## **CPT view**

*The Trust have delivered a slight improvement in financial performance in the last year.*

*However, the majority of the improvement has been based on increasing activity which is may not be sustainable in the long-term.*

The bridge, below, shows the causes of the movement of the Trust's deficit from £43m in FY12 (net of restructuring expenses) to £39m in FY13.

The Trust's CIP programme in FY 12 contained a number of savings which were considered to be "one-off" for that year only, or non-recurrent. These totalled £4.7m and would be costs the Trust expected to incur in FY13.

Although there was no cost of living increase paid to staff in FY13, pay costs rose by £2.3m (1.6%) as a result of staff moving up pay bandings, so called incremental drift.

Additionally non-pay costs, covering items like drugs and other clinical supplies, inflated by £2.2m (3.3%).

The Trust have delivered a higher level of activity this year than in FY12, performing an additional c£16m of work.

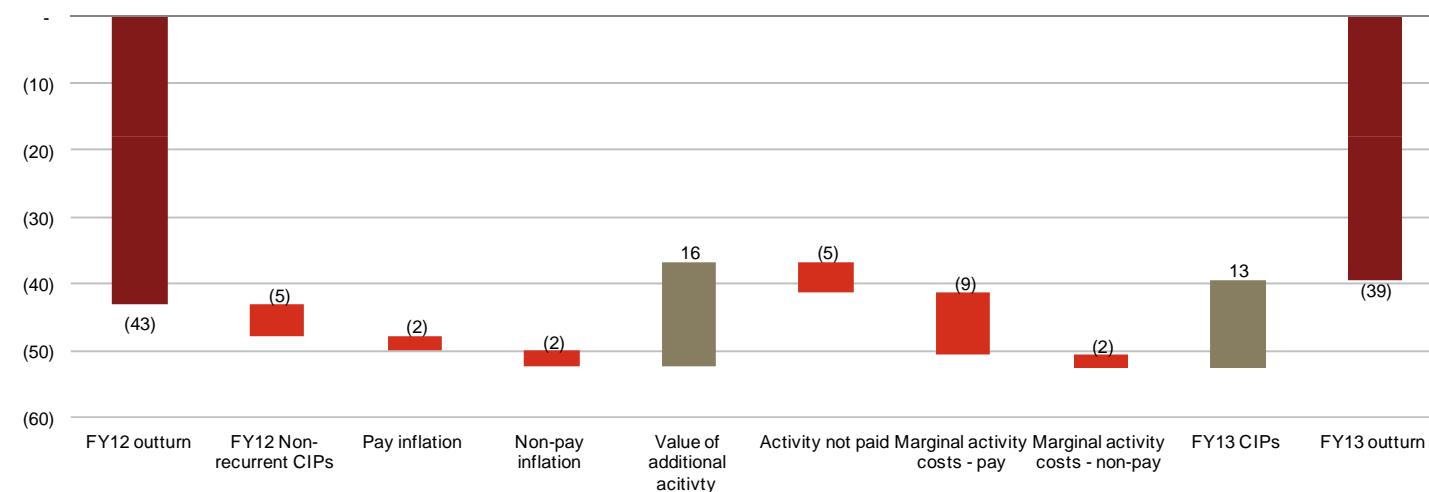
However the Trust have not been paid for all of the activity undertaken (c£5m) and this is discussed in greater detail later in the report.

There were additional costs attached to delivering the higher level of activity described, employing more staff to deliver the work (£9.4m) and purchasing more clinical and other supplies (£1.9m).

Against this, the Trust have delivered £13.2m of efficiency savings and productivity gains as part of their CIP programme which has resulted in their delivery of a deficit of £39.4m in FY13.

In the following slides, the CPT firstly sets out how the outturn position for FY13 differs from the business case prepared to support the PFI. Secondly, the CPT sets out the main causes of the deficit for FY13.

**Bridge of FY12 outturn to FY13 outturn**



## Causes of the deficit

The PFI business case forecasted a small surplus in FY13 compared to the actual performance of a £39.4m deficit.

The graph below outlines sources of the variance between the PFI business case and the actual outturn for FY13.

### CPT view

*In the following slides, the CPT firstly sets out how the outturn position for FY13 differs from the business case prepared to support the PFI. Secondly, the CPT attributes the deficit to its the main causes for FY13, albeit there is some overlap.*

*The level of variance to the income and costs in the PFI business case and FY13 show the business case assumptions have not materialised. However, the CPT believe the page overleaf is more informative in setting out why the Trust has a deficit in FY13.*

## Overview

As noted in the background section, the Trust had achieved financial balance up to the point that the PFI facilities opened. The CPT has therefore looked at the business case that supported the PFI and compared the financial forecast to the outturn for FY13.

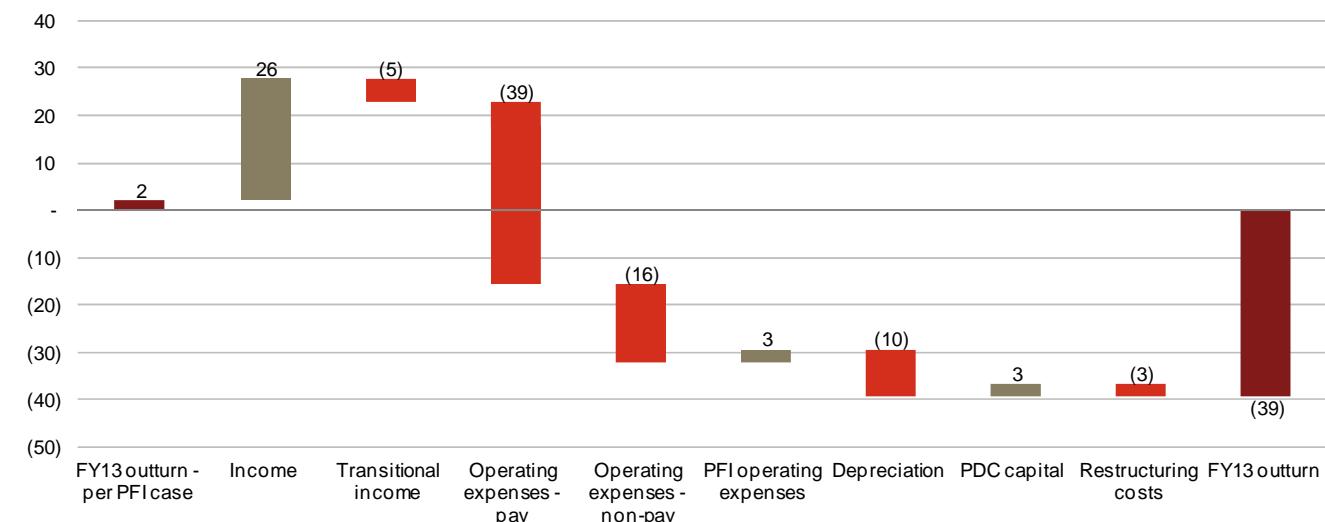
There is a variance of £42m in FY13 between the forecast in the PFI business case and how the Trust has actually performed in FY13.

This variance is explained by the following factors:

- The Trust has performed more patient care activity than was envisaged in the business case. Overall the Trust has received £26m of income over and above that in the business case. However, the Trust has not been paid for all of the work undertaken;
- Furthermore, the business case was written when the general expectation was that the prices paid to acute hospitals for work undertaken would rise rather than fall;

- The Trust has incurred c£55m additional pay and non-pay costs. This is only partly explained by the increased activity discussed previously (estimated at c£18m). The remaining difference is caused by a combination of savings included in the business case relating to moving to a single site not materialising (£18.2m) and the Trust's failure to achieve CIPs in FY11 and FY12; and
- The Trust also assumed that transitional income of £5m relating to the PFI would be received. The Trust received an increased level of transitional income, as described previously, but did not receive any in FY13.
- The variance in depreciation is partially due to a revaluation in the Trust's estate. Additionally some depreciation costs were classed as PFI operating expenses in the business case which have been separately identified as depreciation charges.

Bridge of PFI business case forecast for FY13 and expected outturn position (£m)





## Why does the Trust have such a large deficit?

The deficit is driven by a combination of operational and estate costs.

### CPT view

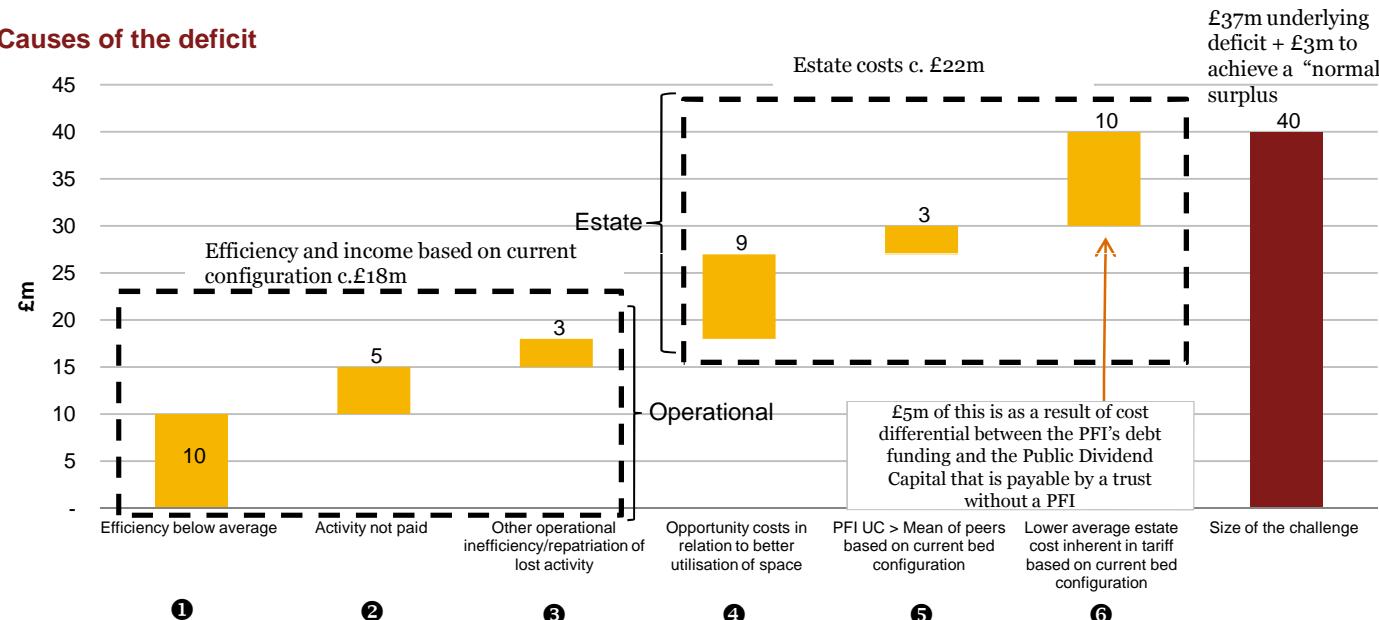
*Even if the Trust had been significantly more efficient and had been paid for all the activity it delivered, it would still have made a deficit due to the cost of its estate.*

*In FY13, the Trust estate contributed c. £22m to the causes of the deficit.*

*There are significant opportunities within the Trust to convert some of its office/meeting room accommodation to clinical areas and increase revenue to help service the estate costs. In itself this additional income would be insufficient to address the total deficit associated with the estate.*

The size of the Trust's challenge and the issues that would have had to have been addressed to recover to a surplus in FY13 are set out below:

### Causes of the deficit



At a summary level the causes are as follows:

- ① Compared to a broad set of peers the Trust is not as efficient.
- ② The Trust had a "block contract" with its largest commissioner in FY13, following years of contract disputes. The parties reached a commercial settlement that saw the Trust recover some of the over delivery of activity, leaving an unpaid balance of c£5m. In FY14, a PbR contract has been negotiated.
- ③ There are a number of further operational improvements to achieve a further £3m of contribution. Alternatively the efficiencies noted in ① could be driven harder with c.£5m additional savings achievable if the Trust were to get to upper quartile performance.

④ ⑤ ⑥ The additional costs that relate to the Trust's estate equate to c. £22m. In the bridge above, we have considered the income opportunity related to the utilisation of spare capacity currently not configured as bed space, and the slightly higher cost of the unitary charge than other trust's with comparable PFIs and the difference that a Trust with a mainly PFI estate has from trusts without (in relation to tariff). The latter point is partly driven by public dividend capital charges being lower than PFI financing charges (estimated at £5m).

The causes of the deficit will move over time and will be impacted by factors including the level of operational efficiency in the Trust and the cost of the PFI which will rise with inflation.

## **Why does the Trust have excess estate costs?**

There are a number of factors that contribute to the Trust having excess estate costs.

### **CPT view**

*The cost of the original build, the size of the estate including areas not utilised for clinical activity and tariff shortfalls associated with funding PFIs all contributed to the reasons for the deficit in FY13.*

### **Estate costs**

There are a number of corroborating pieces of evidence that support the conclusion that the estate cost is driving around £22m of the deficit.

1. Firstly the Trust moved from a position of a small surplus when operating at its legacy sites to a deficit in its current location. The additional estate cost is now £21m greater.
2. Secondly, the PFI business case had some major assumptions associated with it – cost reductions attributed to CIPs and single site working of £18.2m in FY13. It also had an assumption of £5m pa starting in FY14 from one of the legacy sites. Both of these assumptions have not materialised but the full anticipated cost of the PFI has.
3. Thirdly, the methodology employed by the National Audit Office indicated that the Trust has estate cost over the current affordability benchmark of 12.5%.

In hindsight, the PFI business case was approved on assumptions that have not materialised. Whilst the estate cost is broadly in line with the business case, the CPT has looked at the position that the Trust finds itself in now and considered whether the estate is too big, too expensive compared to other PFIs or too expensive compared to estate funded through PDC.

### **Was the estate built too big?**

If the Trust is compared to the three hospital PFIs built in 2007, it has the lowest m<sup>2</sup> per bed of this small sample and is not an outlier on this metric.

However, there is space on the 4th floor that is not used for clinical activity and the office accommodation and meeting room facilities are generous.

The Trust believe that an additional three wards could be accommodated on the 4th floor indicating that the build had a level of in built flexibility that has not been utilised by the Trust. The CPT has quantified the impact of this better utilisation to be £9m and note this as opportunity.

### **Is the Trust's PFI too expensive compared to other PFIs?**

The Unitary Charge per bed is slightly above the average (by 6%). Overall, the PFI unitary charge is £3m more expensive than its peers, on a per bed basis.

Again this is indicative given the small number of peers and the unique set of circumstances each Trust will have.

### **Lower average estate costs inherent in tariff**

The PbR tariff is derived by analysing the cost of delivering healthcare across a broad range of trusts and uses average cost as a proxy for a reasonably efficient trust. Being an average, it does not additionally compensate those trusts which have chosen to build new estate funded by PFI. There is a difference between the cost of PFIs that includes debt funding and the cost of Public Dividend Capital that is the source of capital funding of a Trust without a PFI.

Our analysis of the impact of this has concluded that the value of this difference in costs is in the region of £10m.

### **Conclusion on estate costs**

In broad terms, £22m of the causes of the deficit can be attributed to estate costs.

Whilst there are a number of reasons that underpin the causes of the deficit that relate to the Trust's estate, there exists flexibility in the original build not being utilised - £9m, a cost differential to peers of £3m and £10m as a result of the difference in estate costs for those trusts with and without a PFI.



## **Causes of the deficit – inability to forecast and control costs**

The Trust was unable to control costs in line with income in FY11 and FY12. Costs during this period grew to levels in excess of those estimated in the PFI business case.

### **CPT view**

*The combination of an over-optimistic PFI business case, major organisational change and a lack of continuity of key staff, led to a position whereby costs increased rapidly.*

*The Trust has improved its financial performance in FY13, but still has an unaffordable cost base.*

### **The Trust's historical inability to forecast and control costs**

There are several factors that have contributed to issues regarding the Trust's forecasting and cost control. This section should be read in conjunction with the CPT's commentary on governance arrangements for CIPs on pages 36-37. It is difficult to allocate the cost growth between increase driven by additional patient care activity, failure to forecast the cost base at the time that the PFI was approved, and under-delivery of CIPs. However, this page does set out the background to the increases.

### **Increases in costs due to additional activity**

Total income in FY13 was £26m (14.8%) higher than the business case forecast.

In order to deliver this higher level of activity the CPT would have expected to see an increase in the related pay and non-pay costs. However, both are significantly higher than the level of additional activity which has occurred. Specifically, pay costs were £39m (or 34%) above the PFI business case forecast for FY13 and the equivalent figure for non-pay costs was £16m.

In conclusion, it would appear that the growth in activity only partly explains the increased costs that have been incurred by the Trust.

### **Failure to forecast the cost base**

The PFI business case forecasted a number of cost reductions that would be delivered upon the consolidation of sites and the move to the new PFI building. These totalled £18.2m.

The CPT has not been provided with detailed plans to evidence where these savings were to be made, although it is clear that they have not been delivered.

### **Delivery of CIPs**

Further to the above issues, the Trust did not meet its planned CIP target in FY11 and FY12, achieving savings of £5.2m against a target of £9.3m in FY11 (56%) and £5.3m against a target of £12.0m in FY12 (44%). However, the Trust was able to make some additional one-off savings.

By FY12 the Trust had not kept pace with the cost improvements made by other trusts and needed to achieve higher than average savings to catch up (see efficiency opportunities on page 85).

In FY13 the Trust achieved a greater level of CIPs (£13.2m, c.6% of turnover and controllable cost) than the planning assumptions set for foundation trusts at the start of the year. This was partly due to working more efficiently against a backdrop of higher patient care activity, rather than through cost reduction.

In Appendix M this report provides more detail about how the Trust's pay costs, the largest driver of total costs, have increased in the recent past.

### **Conclusion on inability to control costs**

On page 85 the CPT has assessed the extent to which the Trust has fallen behind its peers to be some £10m. This is the amount that the inability to control costs has contributed to the deficit.

## **Causes of the deficit – PFI and estate costs**

The actual PFI cost has slightly exceeded the forecast in the business case.

### **CPT view**

*The variations in the PFI cost are typical of large projects of this nature. However, there has been a significant change in the national context which necessitates a revised benchmark for assessing the affordability of the PFI scheme.*

### **PFI summary**

Set out below is an outline of the PFI agreement. This is to provide context to the PFI assumptions and the latest thinking on PFI affordability.

The PFI transaction was signed on 4 July 2007 and Peterborough City Hospital opened in December 2010. The overall project included providing three new facilities on two sites:

- The new acute hospital built for the Trust;
- A new mental health unit for the Cambridge and Peterborough NHS Foundation Trust; and
- A new City Care Centre built for NHS Peterborough (the Primary Care Trust).

The PFI is paid for through a service payment (84% of which is paid by the Trust) and a fee for the managed equipment services (92% of which is paid by the Trust).

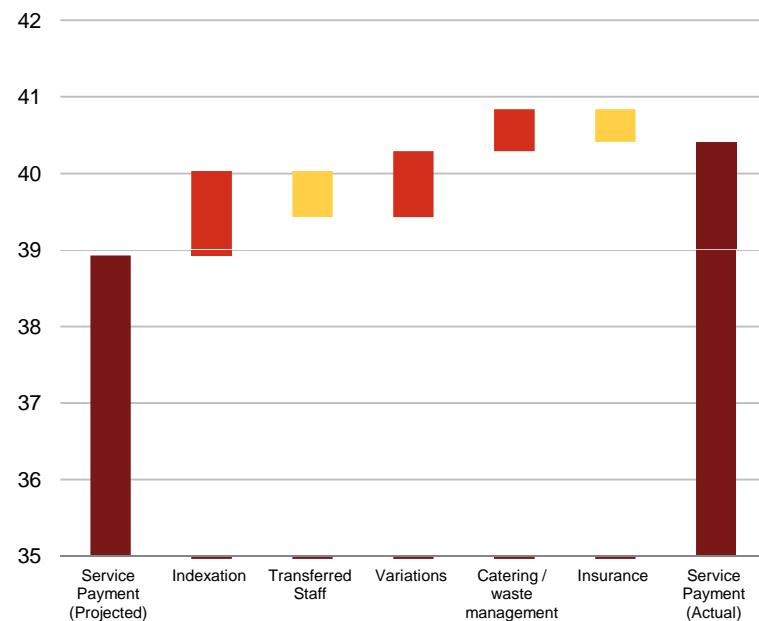
The contract lasts for 35 years, including the construction period.

The cash cost in FY13 of the PFI to the Trust was £40.4m. Future PFI payments increase by inflation based on the Retail Price Index and there is little flexibility to reduce this cost.

Compared to the original PFI business case forecast, the cash cost of the PFI has varied only slightly. This reflects actual inflation, small variations in the construction period, transferred staff costs and some adjustments for the level of catering, waste management and insurance.

There is potential in the usage of the space in the PFI (pages 65 and 66) to accommodate more beds/acute activity. This would involve reconfiguring the use of space including training and back office functions at the Trust, but allow for more acute activity.

### **PFI total cash cost compared to business case (£m)**



However, there has been a significant amount of change in the health sector between the approval of the PFI and now. A key example is that when the PFI was approved it was assumed that the tariff received by trusts for activity would increase year on year. The reality is that the tariff has reduced and in Monitor's implied efficiency requirements is forecast to continue falling in the next five years.

This has led to a change in the benchmark against which new business cases are assessed. The following page illustrates how the current PFI and estate costs would be assessed against the new benchmark.

## **Causes of the deficit**

### **– PFI and other estate costs**

The Department of Health benchmark at the time of signature was for PFI cost to be a maximum of 15% of a trust's turnover. Since then, the Department has changed the benchmark so that total estates cost (including PFI) should not be more than 12.5% of turnover. The Trust's PFI would not be considered to be affordable under current benchmarks.

### **CPT view**

*The change in the affordability benchmarks does not directly impact the PFI cost.*

*However, the total estates cost now makes up a greater proportion of Trust turnover than the current Department of Health benchmark would allow if the scheme were to be put forward for approval now.*

## **Affordability benchmarks**

When the contract was signed, the PFI was assessed as being affordable based on the Department of Health (DH) benchmark of the time. This page sets out how, despite limited cost movement, the PFI has moved from being affordable at the time the business case was drawn up, to the current position where it would not be considered viable if it were put forward for approval now.

The following reference numbers correspond to the chart set out below:

- (1) The forecast PFI cost was the highest level permitted by the benchmark at the time of approval. This is shown as £0 on the graph (i.e. it was just about affordable). The costs were mitigated by the inclusion of £5m of projected income from the Peterborough District Hospital (PDH) site;
- (2) The income from the PDH site has not been received, therefore the PFI cost would have been unaffordable to the tune of £5m;

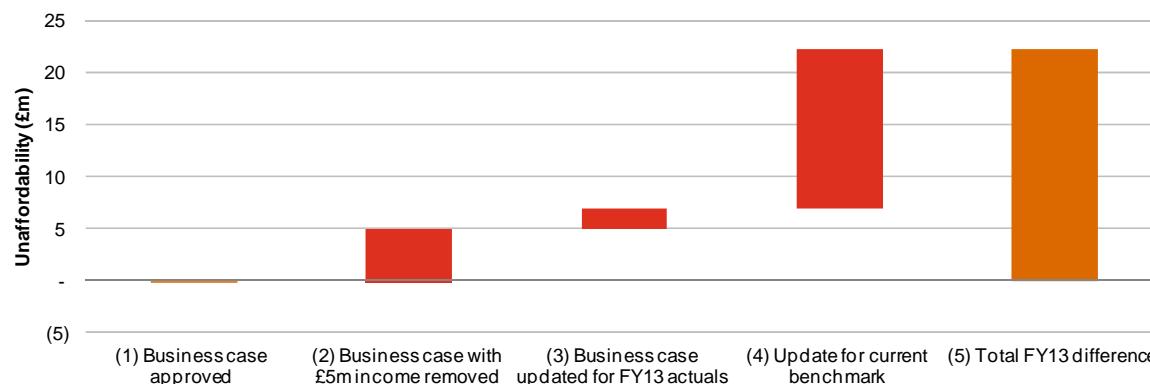
(3) The net of the positive impact of higher turnover less higher costs has added £2.1m to the level of un-affordability. The total un-affordability against the original benchmark has therefore turned out to be £7.1m;

(4) The benchmark for affordability has been lowered, and now includes the cost of non-PFI related estate costs. This means that if the project were to be assessed against the current benchmark it would be unaffordable by a further £15.2m.

(5) The total difference between the current benchmark and the total estates cost is £22.3m, despite there being no significant increase in the overall PFI cost. The difference is predominantly due to changes in the DH benchmark.

The PFI and estate costs themselves are not a cause of the deficit, as they are relatively unchanged. However, the difference between the original and current benchmark highlights the impact of the move to the new facilities on the Trust's financial performance.

**PFI and estate costs compared to Department of Health benchmarks (£m)**





## **Causes of the deficit – activity not funded**

The Trust was not paid for all of the activity that it undertook in both FY12 and FY13.

### **CPT view**

*The Trust and the commissioner responsible for the underpayment have differing views on why there is over activity but have reached a commercial settlement which left £4.5m unfunded in FY13.*

*There were additional local metrics which impacted on the level of income the Trust received for the work delivered, for example, marginal rate emergency tariff.*

*A baseline has been agreed with the main commissioner for FY14. The CPT understands that the agreement has been based on a logical, systematic approach and this should help to improve the quality of future forecasts for this commissioner.*

### **Activity not funded**

The NAO report explained that the Trust was not paid £9m in FY12 through the commissioner's application of contract penalties.

In FY13 the Trust entered a 'block contract' arrangement with its main commissioner with the potential for renegotiation in the event of a significant difference in activity from plan. The CPT understands that the aim of this arrangement was to provide stability and certainty for both parties. In FY14 the Trust have negotiated a PbR contract (see right).

The CPT's analysis of the FY13 contract performance shows that the Trust delivered an additional £7.7m worth of patient services to the main commissioner, even after penalties were applied. The final settlement for FY13 has been concluded and the commissioner in question has agreed to pay £3.2m (or £3.7m including additional funding for winter pressures) of the £7.7m.

### **Marginal rate emergency tariff**

Under the rules by which acute providers are paid, trusts only receive 30% of the tariff for increases in the value of emergency admissions. The increase is judged against a baseline of the actual value of activity in FY09.

This is important because the Trust believes that the baseline should be reset as a result of the opening of a local bypass. It believes this has significantly increased the level of A&E activity. The Trust is currently in negotiation with the relevant commissioner to have the baseline reset and believes that the lost income is estimated to be worth at least £750k. The parties are considering arbitration to resolve the issue. In the circumstances, it would be inappropriate for the CPT to comment on the likelihood that the Trust will be successful in having the baseline reset.

### **FY14 contract**

In principle, the Trust has agreed a payment by results (PbR) based contract with all of its commissioners, but has only signed with NHS Cambridgeshire and Peterborough. Negotiations are ongoing with the other main commissioner.

This agreement to follow PbR should help the Trust manage the financial risk of not being paid for activity undertaken in FY14.

### **Conclusion**

The recent NAO report states that the drivers of the deficit in FY12 were:

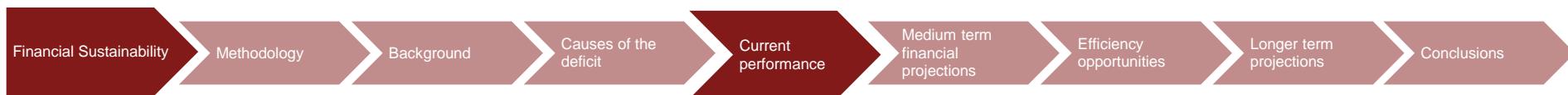
- PFI/estate costs – £11m to £26m;
- Failure to control costs – £11m to £14m; and
- Activity not funded – £9m.

Following the CPT's benchmarking, and the settlement of the FY13 contract, the CPT has set out its understanding of the drivers of the FY13 deficit. This is in the context of the deficit reducing from £45.8m in FY12 to £39.4m in FY13. The CPT has estimated the value of each driver, but notes that these are broad estimates and are provided to give an indication of their relative size.

For FY13, the CPT believes the underlying deficit (£37m) and additional contribution required to make a surplus equivalent to the an average foundation trust (1.5% or £3m) total £40m can be attributed to the following:

- High estate costs relative to turnover – £22m;
- Trust operational inefficiency – £10m to £13m; and
- Activity not funded – £5m.

The underlying deficit, and the reasons for it, will change in future years as the Trust switches to a PbR contract, improves efficiency and the PFI costs increase with inflation.



## **Current performance**

The Trust has recorded a deficit of £39.4m in FY13. This is £14.8m better than plan and £6m better than FY12.

### **CPT view**

*The increase in income would have been even larger if all of the patient care activity provided had been paid for.*

*A baseline has been agreed with the main commissioner for FY14 and this should help to improve the quality of future forecasts.*

### **Introduction**

In order to put its analysis of the projections in context, the CPT has reviewed the financial performance of the Trust in FY13. For reference, the FY12 analysis is set out in Appendix O.

### **FY13 performance**

The Trust has reported a deficit of £39.4m against a budgeted deficit of £54.2m. This represents a £14.8m positive variance for the year.

The improvement is driven by a £14.7m over-performance on income, offset by £7.6m of additional expenditure. Additionally, the Trust has not incurred the costs budgeted for restructuring and turnaround, and has not made planned impairments on the PDH site.

### **Income and expenditure account FY13**

	Budget	Outturn	Variance
<b>£m</b>			
<b>Income</b>			
Clinical income	189.2	200.2	11.0
Other income	19.2	22.9	3.7
<b>Total income</b>	<b>208.4</b>	<b>223.1</b>	<b>14.7</b>
<b>Expenditure</b>			
Pay	(143.0)	(150.1)	(7.1)
Non-pay	(64.8)	(65.1)	(0.3)
PFI service charge	(17.9)	(18.1)	(0.2)
<b>Total expenditure</b>	<b>(225.7)</b>	<b>(233.3)</b>	<b>(7.6)</b>
<b>EBITDA</b>	<b>(17.3)</b>	<b>(10.2)</b>	<b>7.1</b>
Depreciation	(14.2)	(13.9)	0.3
Impairment	(1.8)	(0.3)	1.5
Interest	(12.3)	(12.2)	0.1
<b>Recurring deficit</b>	<b>(45.6)</b>	<b>(36.6)</b>	<b>9.0</b>
Restructuring expenses	(5.0)	(0.5)	4.5
Turnaround costs	(3.6)	(2.3)	1.3
<b>Deficit</b>	<b>(54.2)</b>	<b>(39.4)</b>	<b>14.8</b>

*Source: Trust management information*

### **Income**

A large part of the income variance is driven by over-performance on the NHS Lincolnshire contract, amounting to £5.3m (after penalties), with other non-recurrent income also above budget.

The Trust has recently agreed a settlement with NHS Cambridgeshire and Peterborough for unpaid patient care activity in the year.

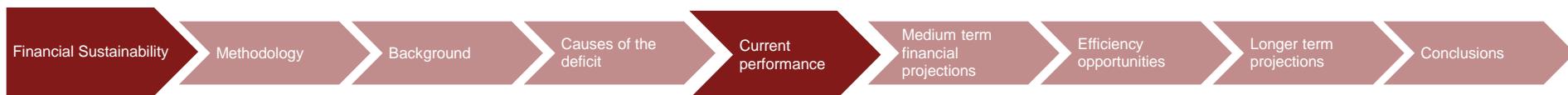
After penalties were applied per the contract, c£7.4m of activity remained unpaid. The Trust negotiated a settlement of £3.7m against this (including £500k of winter pressures funding) with the remainder added to contract deductions outlined in the table below.

Parties have differing views on the drivers of activity over-performance. The Trust points to the attractiveness of its new facilities, improved road links, and the difficulty of achieving demand management.

On the other hand, the commissioners perceive that there are a number of internal inefficiencies which they continue to discuss with Trust management.

### **Clinical income FY13**

	Activity variance	Contract deductions	Income variance
<b>£m</b>			
Cambridgeshire and Peterborough	11.2	(7.5)	3.7
NHS Lincolnshire	7.1	(1.8)	5.3
Leicestershire and Rutland	1.2	(0.4)	0.8
Other commissioners	1.2	0.0	1.2
<b>Total</b>	<b>20.7</b>	<b>(9.7)</b>	<b>11.0</b>



## **Current performance**

In FY13 the Trust's pay costs, non-pay costs and PFI service charges exceeded budget by £7.1m, £0.3m and £0.2m respectively.

### **CPT view**

*The Trust has over-spent on agency and locum staff costs by £9.3m.*

*The Trust rightly challenged itself to reduce temporary staffing. The overspend in FY13 was down to a combination of how budgets were prepared, additional patient care activity and difficulties recruiting in some areas.*

## **Pay and non-pay expenditure**

Expenditure has exceeded budget by £7.1m on pay, £0.3m on non-pay, and £0.2m on the PFI service charge.

### **Pay**

The £7.1m pay difference is driven by a £9.3m over-spend on agency and locum staff net of a £2.2m under-spend on substantive posts.

This over-spend is made up of three factors. Firstly, the higher than expected patient care activity during the year. Secondly, the Trust had difficulty in recruiting to substantive posts in some areas. Thirdly, the budget included an inherently challenging reduction in temporary staffing. This was designed to keep management focussed on reducing temporary staffing, not only because the Trust pays a premium for it, but because excessive temporary staffing has also been shown to reduce the quality of the patient experience.

### **Non-pay**

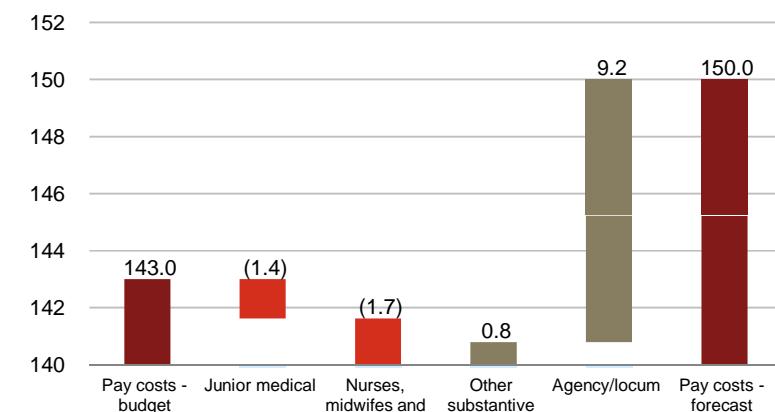
The non-pay expenditure over-spend results from a net adverse variance of £1.2m for drugs and an overspend of £2.5m on external healthcare providers. Much of this outsourcing relates to activity to ensure the 18 week referral to treatment (RTT) target was met.

### **Exceptional items**

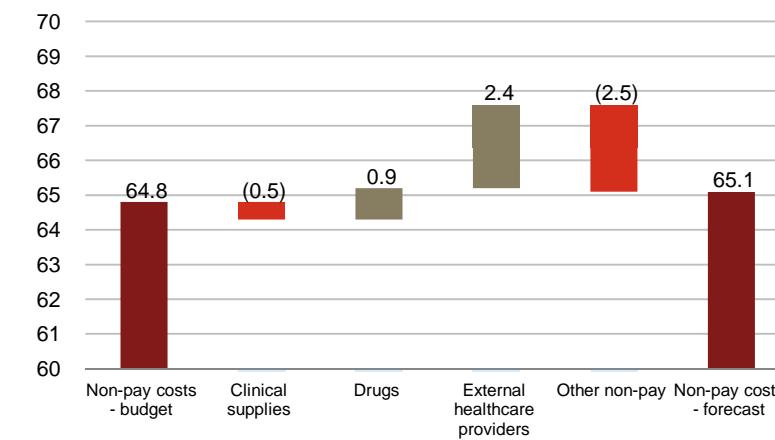
The Trust did not revalue the Peterborough District Hospital site in FY13 due to the sales process not being as advanced as expected. This generated a £1.5m positive variance in impairment charges.

Restructuring costs were £4.5m lower than budget. The additional patient care activity did not allow the Trust to restructure its workforce as it had intended.

### **Pay variance analysis FY13 (£m)**



### **Non-pay variance analysis FY13 (£m)**



## Current performance

The Trust achieved its CIP target of £13.2m in FY13.

### CPT view

*At the start of FY13, there were £5.3m of CIPs that had not been identified. It is not clear whether these would have been achieved if activity had been relatively flat, as forecast.*

*Whilst the Trust did meet its CIP target for FY13, this was done through productivity efficiency savings rather than cost reductions.*

*The level of rigour and corporate mindset required to deliver CIPs in a flat activity environment are not yet fully evident. This is an issue that the Trust is addressing.*

### CIPs – FY13

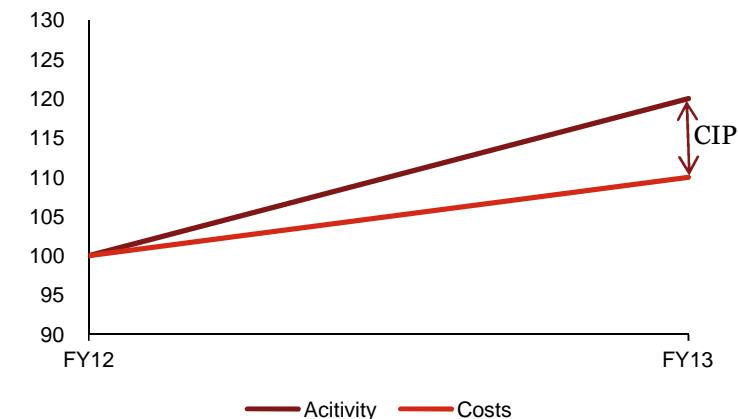
The CIP target for the year was to achieve a recurrent full year effect saving of £13.2m. Of this target, £5.3m had not been identified at the beginning of the year.

Since the Trust experienced growing patient care activity levels throughout FY13, it has been unable to reduce its cost base in line with its budget.

However, the Trust successfully delivered this increased activity whilst controlling the corresponding growth in costs, giving rise to an efficiency gain during the year.

The graph below illustrates this dynamic.

Illustrative productivity efficiency CIP



### Conclusion

The Trust has seen major upheaval in its recent past. The move to the new facilities, increasing activity and the lack of senior management continuity have led to the Trust significantly underestimating its cost base in FY12.

The Trust approved what has turned out to be a prudent budget for FY13, against which it has over-performed. Whilst budgets have historically been inaccurate, the Trust has now been in occupation of the new facilities for two and half years and, therefore, has a better understanding of the cost base. This gives the CPT some confidence that the starting position for the coming year can be relied upon to a greater extent than in previous years.

That said, the Trust will have to demonstrate a change in mindset in order to deliver a CIP rather than rely upon cost efficiencies driven by higher activity. The CPT discusses this dynamic further in the following section, which reviews the Trust's medium term projections.



## Projections

The Trust has presented a long term financial model to the board, showing the expected financial performance for the next five years.

The Trust's five year financial projections show a net deficit of between £38.5m and £41.4m each year.

### CPT view

*The Trust is still in negotiation with the second largest commissioner and therefore the forecasts have not yet been agreed with them.*

*The ability of the Trust to make a surplus and pay its creditors as they fall due are two key financial sustainability tests. The Trust does not believe it will meet these two tests without government funding and the CPT concurs.*

## Medium term financial projections

The Trust is forecasting a relatively flat, albeit significant, annual deficit for the five years to FY18.

The Trust has undertaken a full budgeting process which underpins the figures for FY14. The outer years are driven by modelling assumptions which are described in detail in this section.

The long term financial model (LTFM) excludes the impact of potential land disposals which are commercially sensitive but do not affect the

underlying income and expenditure position.

Across the five years, delivering this relatively flat annual deficit would require the Trust to make £57m of cost savings.

The Trust acknowledges that this level of savings, and the delivery of the results in the outer years, will be unachievable without the combined and concerted efforts of the local health economy.

Financial Summary	FY13	FY14	FY15	FY16	FY17	FY18
<b>Income &amp; Expenditure £m</b>						
NHS acute income	198.1	204.0	199.9	195.8	191.8	188.0
Non-NHS clinical income	2.3	2.4	2.4	2.4	2.4	2.4
Other income	22.7	17.2	17.4	17.5	17.7	17.9
Pay costs	(150.1)	(151.0)	(145.9)	(143.7)	(141.9)	(139.0)
Non-pay costs	(65.1)	(63.0)	(60.5)	(59.8)	(59.0)	(57.8)
PFI operating expenses	(18.1)	(18.6)	(19.3)	(20.0)	(20.7)	(21.3)
<b>Recurring EBITDA</b>	<b>(10.2)</b>	<b>(9.2)</b>	<b>(6.1)</b>	<b>(7.7)</b>	<b>(9.6)</b>	<b>(9.8)</b>
Restructuring costs (non-recurring)	(2.8)	(4.1)	(5.1)	(2.9)	(2.8)	(2.8)
<b>EBITDA</b>	<b>(13.0)</b>	<b>(13.3)</b>	<b>(11.2)</b>	<b>(10.6)</b>	<b>(12.4)</b>	<b>(12.6)</b>
Depreciation and amortisation	(14.2)	(13.7)	(14.4)	(14.4)	(14.4)	(14.4)
Net interest	(12.2)	(12.5)	(13.1)	(13.5)	(14.0)	(14.4)
Impairments	-	(1.6)	-	-	-	-
<b>Net Surplus/ (Deficit)</b>	<b>(39.4)</b>	<b>(41.1)</b>	<b>(38.7)</b>	<b>(38.5)</b>	<b>(40.8)</b>	<b>(41.4)</b>
<b>Cashflow £'m</b>						
EBITDA	(13.0)	(13.3)	(11.2)	(10.6)	(12.4)	(12.6)
Change in working capital and provisions	(6.7)	0.3	(4.1)	(4.2)	(2.4)	(2.5)
<b>Cashflow from operations</b>	<b>(19.7)</b>	<b>(12.9)</b>	<b>(15.3)</b>	<b>(14.8)</b>	<b>(14.8)</b>	<b>(15.1)</b>
Capital expenditure	(3.4)	(6.0)	(5.4)	(5.6)	(5.8)	(5.9)
Proceeds on disposal of assets	-	-	-	-	-	-
Public dividend capital received	44.1	-	-	-	-	-
Net Interest paid/received	(12.2)	(12.5)	(13.1)	(13.5)	(14.0)	(14.4)
Repayment of loans and leases	(8.9)	(9.2)	(9.4)	(9.6)	(9.9)	(10.1)
<b>Net increase/ (decrease) in cash</b>	<b>-</b>	<b>(40.6)</b>	<b>(43.1)</b>	<b>(43.5)</b>	<b>(44.4)</b>	<b>(45.6)</b>

Source: Trust LTFM



## **Projections**

The bridge below explains the source of the movement in the Trust's outturn position from FY13 to the expected outturn in FY18.

### **CPT view**

*Even if the Trust delivers the forecast CIPs of £57m over five years, there will still be a small deterioration in the underlying deficit.*

## **Medium term deficit bridge**

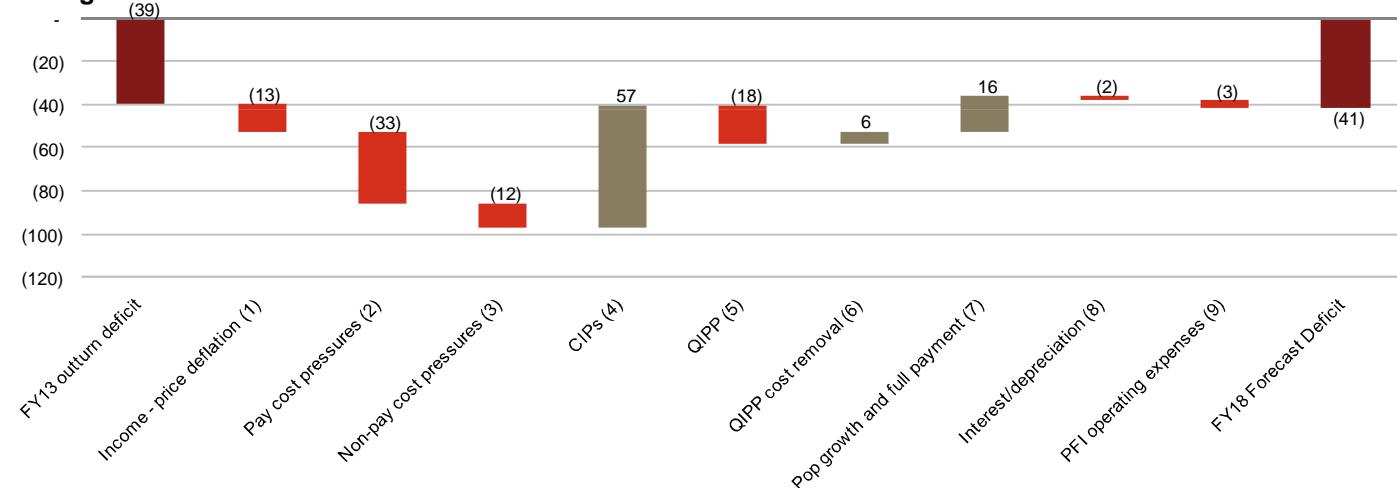
The marginal deterioration in the financial position of the Trust over the five years from FY13 is primarily driven by the rate of cost inflation, and income reduction outstripping the level of cost savings made by the Trust.

Over the five year period of the forecast, the Trust has forecast tariff deflation of £13m over, 'cost of living' increases and incremental drift (staff progressing up pay-scales) are forecast to produce an additional cost pressure of £33m (2), and non-pay cost inflation on items such as drugs and clinical supplies is forecast to increase by £12m (3).

The Trust has forecast £57m of CIP savings (4) which almost offset the effect of these financial pressures. The CIPs are forecast to be 70% pay related (£40m) and 30% non-pay related (£17m).

The Trust has highlighted that this level of efficiency challenge will require the collective and collaborative improvement of the local health economy. For example,

**Bridge of the Trust's forecast deficit movement from FY13 to FY18**



demand management to reduce unplanned emergency admissions and the improvement in community care facilities.

The commissioners' Quality, Innovation, Productivity and Prevention (QIPP) plan aims to move activity away from an acute setting, and has been accounted for in the model. These have a significant impact over the five years, reducing demand on the hospital by £18m (5).

The Trust has assumed that it will be able to reduce its costs in respect of the reduced demand from commissioners at 33% (6) of the value of that work (£6m).

The Trust is assuming that it will be paid for all the work that it undertakes in FY18 and has included agreed activity increases with its main commissioner for the coming year (7).

On the following pages the CPT has described the major assumptions in the forecast, with a focus on FY14.

## Income movements

The Trust's forecasts acknowledge the commissioners' intentions to reduce the activity performed at the Trust.

### CPT view

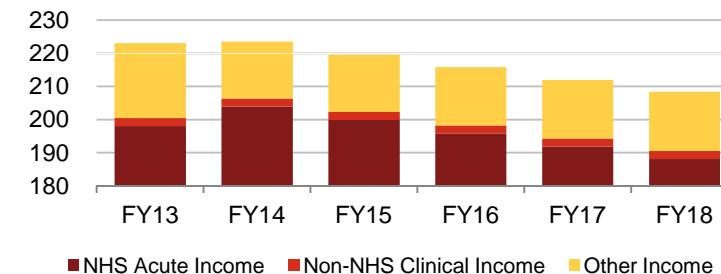
*The Trust has taken a pragmatic and sensible approach to the modelling of its income in line with the challenges faced by the NHS generally.*

*Achievement of the reduction in activity is dependent upon the commissioners' plans being met.*

## Income movements

The Trust is anticipating a decrease in income of £15m over the period to FY18. This assumes a slight increase in income in FY14 followed by a gradual decline to FY18 as is set out below.

### Total income summary (£m)



As noted previously, the Trust has detailed calculations in respect of income for FY14 and then uses assumptions to derive the income levels thereafter.

The FY13 to FY14 movement comprises the following:

(£m)

Clinical income outturn FY13 (£m)	200.4
Normalisation	(2.4)
<b>Underlying FY13 forecast</b>	<b>198.0</b>
Increase largely due to full payment	6.2
Tariff deflation	(3.6)
Tariff gain due to new pricing principles	1.5
Population growth	3.2
QIPP	(7.5)
Other	6.2
<b>Forecast FY14</b>	<b>204.0</b>

The methodology supporting this calculation is detailed and logical. However, at the time of writing the Trust had only agreed one of the two principal commissioning contracts.

The Trust has received some detail from their main commissioner in respect of their plans to manage demand (QIPP plans) and has assumed in the LTFM that these plans deliver in full.

The other commissioner has expressed an aspiration to drive a similar proportional level of demand management. To date, the Trust has not seen detailed plans to support this and therefore has included a sensible assumption in the model, pending further detail from the commissioner.

From FY15 to FY18 the Trust's income is assumed to reduce by c.£15m, driven by the following factors:

- A 2% increase in activity volume as a result of population growth;
- A constant reduction in activity driven by QIPP delivery, equating to c.3% of revenue; and
- Tariff deflation ranging from 2.4% in FY15 to 1.2% in outer years.

The tariff deflation figure looks high in FY15 but is effectively a balancing figure to derive an overall efficiency requirement in line with Monitor's guidance.

During the period under review, service developments have been kept to de-minimus levels. This is a sensible approach given the financial constraints of the commissioners. The Trust is, however, considering certain service developments and these are discussed in Appendix P.



## **Workforce cost summary**

In line with its peers, the Trust's largest area of spend is workforce, which represent 63% of total operating costs.

### **CPT view**

*Whilst the Trust has forecast a reduction of workforce costs by FY18, there are limited detailed plans in place describing how these efficiency savings will be delivered.*

## **LTFM five year pay cost assumptions**

The CPT's review has considered the Trust's workforce costs, as they are Trust's largest cost category.

The Trust's LTFM assumes that the majority of the £57m savings will be delivered through reductions in workforce costs. The graph below shows the expected level of inflation and workforce CIPs across each year of the forecast.

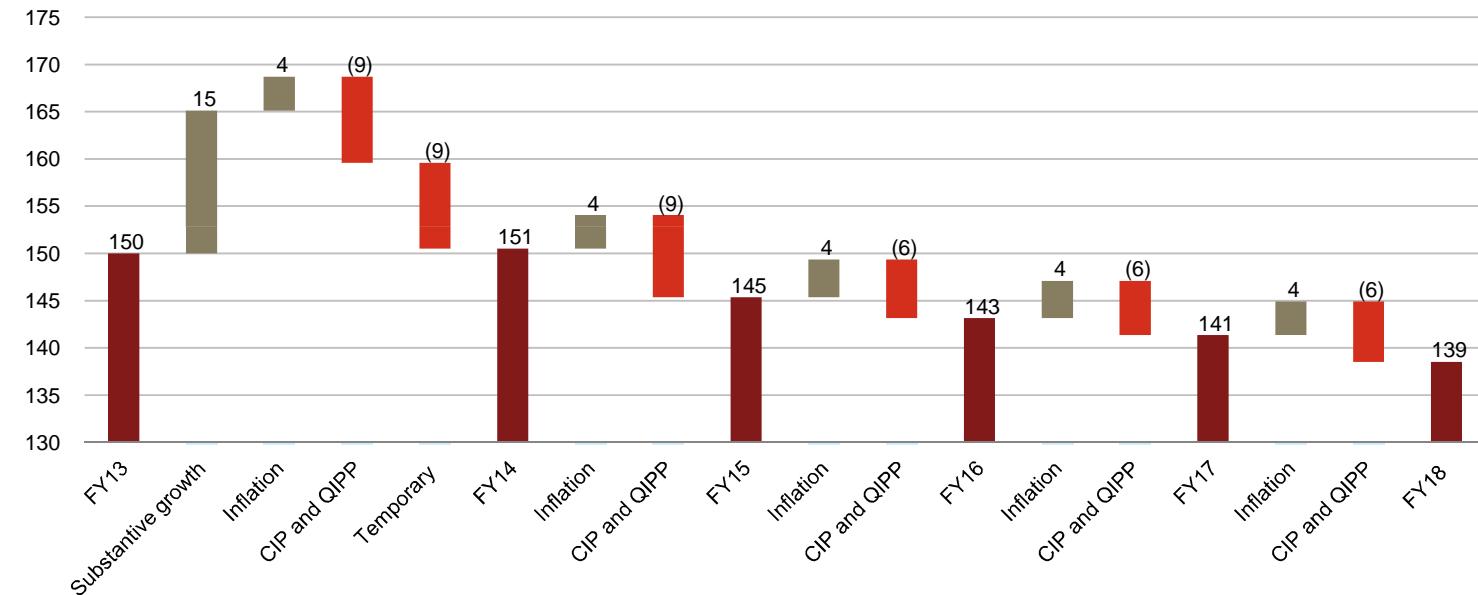
The LTFM forecasts the delivery of pay CIPs of between 5%-6% per year to achieve a reduction in pay cost from £150m in FY13 to £138.5m in FY18. This represents an overall reduction of £11.5m (8%) over the course of the five year plan after factoring in inflation totalling £19m.

Given that the outer years rely on planning assumptions, the CPT's review has focused on FY14 and considered the appropriateness of the pay inflation assumptions and the achievability of CIPs.

## **FY13 outturn to FY14 forecast**

The Trust has been through a budget setting process to determine the pay cost prior to CIPs. Whilst the Trust recognise the opportunities for pay productivity it does not currently have a formal workforce plan for the outer years. These years are based on high level assumptions. The Trust's intention is to develop a workforce plan over the next 3 months, and the CPT believe it should be progressed as a matter of urgency so that pay cost reductions can be planned and implemented in a structured way. A workforce plan will enable better targeting of pay cost reduction and the ability to monitor progress against targets.

**LTFM five year pay cost analysis (£m)**





## **Workforce cost assumptions**

The LTFM assumes a small increase in pay costs for FY14, but the total cost then reduces as a result of CIPs exceeding pay inflation.

### **CPT view**

*The overall reduction in pay costs across the five year forecast is very challenging, particularly for a Trust that has historically been unable to control those costs.*

## **FY13 outturn to FY14 forecast (continued)**

The LTFM assumes a marginal increase in pay costs from £150m to £151m in FY14. This small overall increase actually masks some major movements:

- Substantive pay costs rise by £15.1m. This is partly a function of the budgeting process, whereby Trust budgets are being used to focus managers on replacing temporary staff with substantive staff. There have also been strategic increases in staff numbers in some areas, for example, family health, to meet national targets;
- Agency spend reduction of £9.1m is reflective of the budgeting process described above. Full achievement of this is likely to be highly challenging due to a number of factors including:
  1. National skills shortages; and
  2. The Trust's low conversion rate of candidates to hired nurses.
- Pay inflation of c.2.5% is a result of a cost of living pay award and takes account of any movement of staff between pay grades;
- CIPs of £9.1m are not underpinned by detailed plans. There is therefore an inherent risk to their delivery due to the time lag between developing and fully implementing the plans.

Overall, the Trust may find it challenging to hold pay costs to this small increase. Failure to do so in FY14 will have a knock on effect on the pay cost reductions required in FY15 and beyond.

## **FY15 to FY18 forecast**

For the outer years of the forecast the pay costs reduce as a result of CIPs being higher than the level of inflation.

Given that the Trust is using high level planning assumptions to drive the forecast in the outer years, it is difficult to form a view on their achievability. That said, they are consistent with the orders of magnitude that the CPT has seen in other trusts' assumptions.

The reductions in the outer years need to be considered in the light of previous comments, which highlighted that whole health economy support will be required to deliver them.



## **Non-pay cost and other movements**

Non-pay costs are expected to decrease by £7.3m between FY13 and FY18, after the delivery of £20.3m of CIPs.

### **CPT view**

*The overall target reduction for non-pay costs over the five year plan is challenging, and the Trust has not prepared detailed plans to support all of the FY14 CIPs.*

## **Non-pay cost movements**

Non-pay costs include a combination of drug costs, clinical supplies and other costs, including the PFI/estate costs.

The Trust is forecasting that non-pay costs will fall over the five year period from £65.1m at the end of FY13, to £57.8m in FY18.

In order to achieve this, the Trust will need to deliver £17.4m of non-pay CIPs over the 5 years.

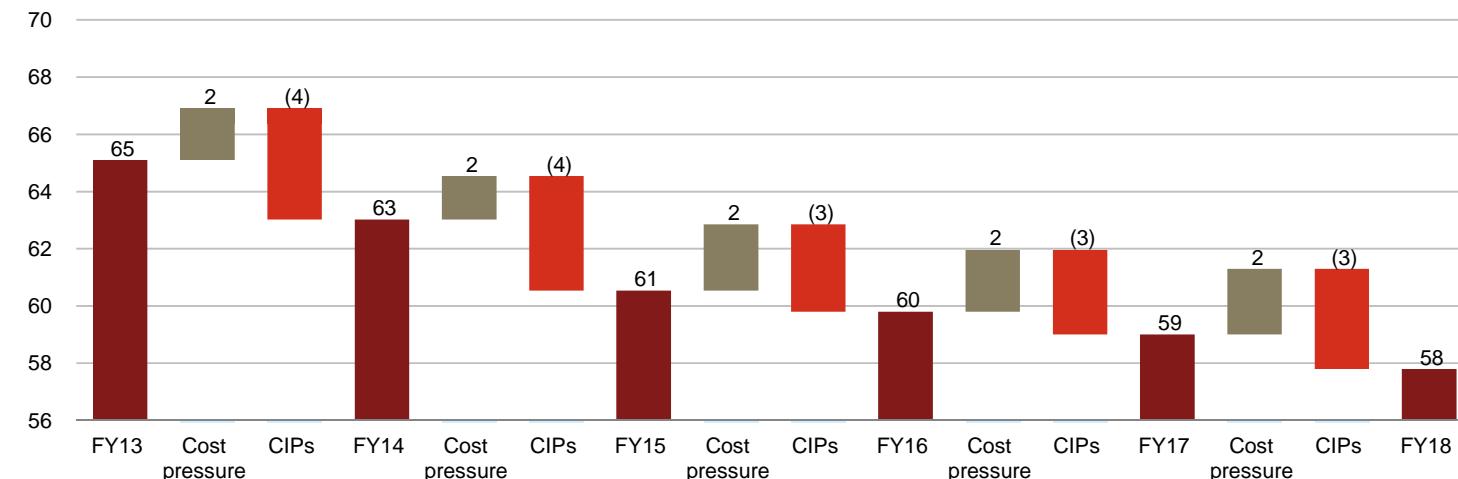
As with the pay CIPs for FY14, the non-pay CIPs are not supported by detailed plans to underpin their delivery which means there is a high risk to their achievability.

The Trust has also made assumptions around the level of inflation that will impact on the various costs included in non-pay.

These are reviewed in more detail in Appendix Q. The CPT believes that the assumptions used are broadly reasonable and are in-line with the forecasts of other trusts reviewed recently.

Non-pay costs (£m)	FY13 Outturn	Change	FY18 forecast
Drug costs	19.9	3.5	23.4
Clinical supplies and services	16.7	7.2	23.9
Non-clinical supplies	31.4	(0.6)	30.8
<b>Non-pay costs</b>	<b>68.0</b>	<b>10.1</b>	<b>78.1</b>
Non-pay CIPs	(2.9)	(17.4)	(20.3)
<b>Total</b>	<b>65.1</b>	<b>(7.3)</b>	<b>57.8</b>

## **LTFM five year non-pay cost analysis (£m)**





## **Non-pay cost and other movements**

The Trust has budgeted each year for a level of restructuring costs to support its transformation. The forecast also includes a general contingency of £2m each year.

### **CPT view**

*The Trust has taken a sensible approach by including a £2m general contingency and restructuring costs to support its transformation.*

*The working capital assumptions in respect of debtor and creditor days appear reasonable.*

## **Other movements in medium term financial projections**

**Restructuring costs.** These costs have been set aside by the Trust to support transformational change and delivery of the CIP programme. They amount initially to £4.1m in FY14, increasing by £1m in FY15, and then stabilising at c.£3m from FY16.

**PFI operating expenses and net interest.** PFI operating expenses move from £18.1m in FY13 to £22.1m in FY18, mainly as a result of inflation estimated at between 3.2% and 3.8%. The PFI operating costs increase by the rate of the RPI, and the Trust has used the Bank of England's forecasts in preparing the LTFM.

**Impairments.** The Trust is expecting some impairments on the value of the PDH land which it is looking to sell. The impairments will affect the overall deficit position by the difference between the value of the land in the accounts and the sales value. These have no cash impact for the Trust.

**General contingency.** The Trust has built a general contingency of £2m into the LTFM in each year in case of higher levels of inflation, investment in quality requirements (see below) and any other unexpected costs. This contingency will rise each year as it inflates in line with pay and non-pay. It is standard practice for many foundation trusts to include a level of contingency in their forecasts.

**CQUIN costs.** Each year, the Trust receives funding from its commissioners in relation to a number of locally chosen quality standards. In FY13 these are worth £3.3m. Many trusts include a separate contingency fund which can be used to help ensure that the CQUIN quality standards are met.

Although the Trust has not done so, part of the general contingency is expected to be used in ensuring that investments are made in support of improving the quality of care in line with CQUINs.

**Winter pressures.** The Trust incurred a high level of outsourcing costs in FY13 as a result of winter pressures. The Trust overspent against budget by £2.5m, partly due to winter pressures but also to ensure the Trust met its 18 week referral to treatment target. A £1.5m contingency has been included in the budget for FY14, intended to cover any similar additional costs in the current year.

**MoD.** The Trust has assumed a status quo position in relation to the MoD activity and contract. The treatment of MoD staff will be commissioned by the NHS Commissioning Board from April 2013, and is assumed to generate a similar level of income going forwards. In relation to the hosting contract which allows the Trust to benefit from the use of MoD medical staff, a contract extension has been signed for the end of the current year and is expected to continue beyond this.

## **Change in working capital and provisions**

The assumptions underlying the model in relation to working capital are as follows:

- **Debtors<sup>1</sup>.** NHS receivables are expected to be fully received within 30 days. For non-NHS receivables, 70% are assumed to be received within 30 days, with the remainder received within 60 days, and;
- **Creditors<sup>1</sup>.** All payables are assumed to be paid within 30 days.

<sup>1</sup> There are minor adjustments to the profile of working capital components at the year end



## **Capital programme**

The Trust's capital plan for FY14 has indicated £6.0m of investment.

### **CPT view**

*As the Trust doesn't have any reserves and isn't generating surplus cash, it will need to agree funding with national stakeholders in order to undertake the identified capital works.*

*Some of the works are essential and are required to meet national standards, for example, the outlined accommodation investment.*

*The other investments will need to show a sufficiently good return on investment if they are to be supported by national stakeholders.*

*For expenditure in FY14, the Trust has derived its capital expenditure forecast via a sensible and detailed process. The outer years are not supported by the same level of detail.*

## **Capital programme**

The table below sets out the Trust's planned level of capital expenditure in the Trust over the length of the forecast:

£m	FY14	FY15	FY16	FY17	FY18
<b>Capital expenditure</b>	6.0	5.4	5.6	5.8	5.9

Capital expenditure does not have a direct impact on the net deficit of the Trust each year. Capital expenditure is required to ensure that the Trust complies with improvements in medical delivery and also to replace ageing equipment. Usually, a trust would fund this through retained surpluses, but this will not be possible in the Trust's case.

The Trust is forecasting capital expenditure of £39.3m over the next five years, of which just under half is forecast in FY14.

### **FY14 capital expenditure**

The capital programme for FY14 has a planned value of £6.7m, of which £4.1m is for maintenance and the replacement and upgrade of equipment. This covers reasonably small items of equipment which are part of a rolling programme of replacement.

FY14 capital plan (£m)	FY14
Building and Engineering	0.6
Maintenance, replacement and upgrade	4.1
Land	0.3
New investments	1.7
Over-commitment	(0.7)
<b>Total</b>	<b>6.0</b>

The capital programme is derived from a detailed review of the Trust's equipment and the likely replacement intervals. It does not include the lifecycle PFI costs which are accounted for separately in the forecast.

In addition to the level of capital expenditure in the table, the PFI provider has certain responsibilities in respect of maintaining and replacing the Trust's equipment. Of the unitary charge, about £4.2m per annum relates to lifecycle replacement.

There are three business cases that the Trust will be seeking to approve separately. These are not included within the financial forecast at present:

1. Radiotherapy development. £4.7m investment covering the cost of construction of two new bunkers and one linear accelerator;
2. Residential accommodation. £5.9m investment to ensure that the hospital is providing the required quality of accommodation to its staff in line with guidance on proximity to the hospital; and
3. Stamford redevelopment. The Trust is considering the reconfiguration of the Stamford site and some capital investment is likely to be required to make the necessary changes once a decision is made. This may be off-set by the partial sale of land at the site.

Given the Trust's financial position, it is unable to raise external finance or to fund this through a trading surplus. Therefore, in addition to the normal Trust requirements of board approval for capital expenditure, the Trust will need to agree a central source for the funds and a payback period.



## **Trust sensitivities**

The Trust have modelled an upside scenario which would see the recurring deficit fall to £28m by FY18.

### **CPT view**

*The CPT do not believe that the level of CIPs to achieve the upside scenario is achievable.*

*The CIPs required to reduce the deficit to £28m would not only require significant external support from commissioners and improvement in community healthcare, but would also be very challenging to achieve whilst trying to ensure that clinical quality is not impacted.*

## **Trust sensitivities**

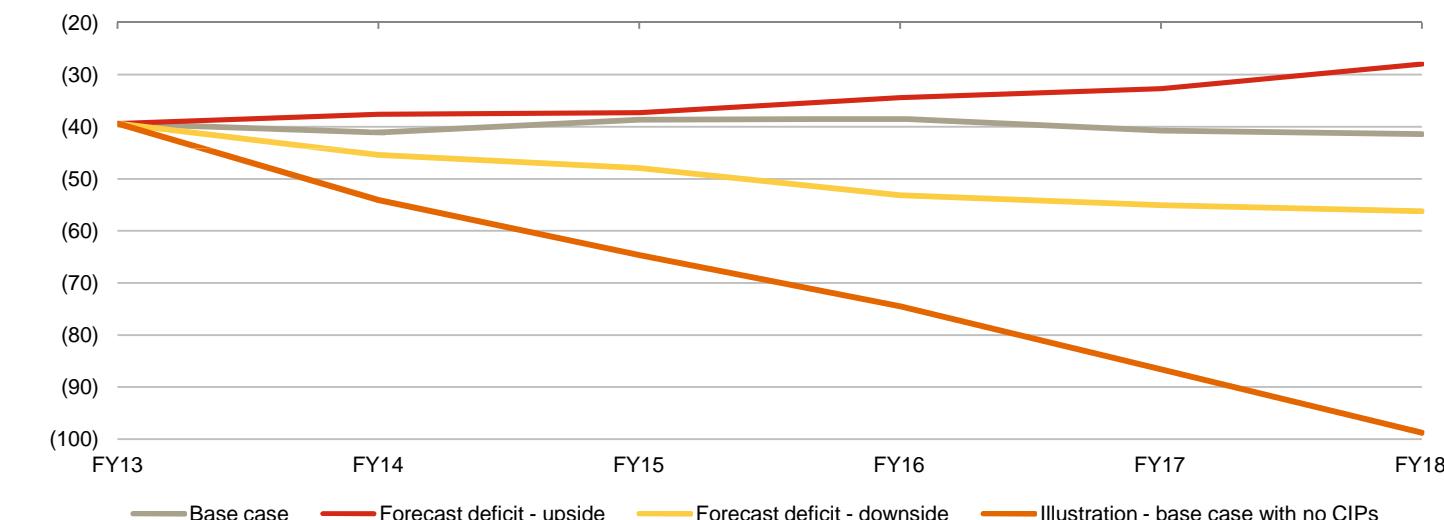
In order to assess the risk to the delivery of the forecast in the LTFM, the Trust have prepared an analysis which shows the effect of the Trust over or under delivering against its CIP target. The next two pages show the upside potential and downside risk to the forecast and the effect of the CIPs in the forecast.

### **Upside potential**

The Trust has modelled an upside scenario in their LTFM, which sees the Trust's deficit reducing to £28m by FY18.

This has been modelled on the basis that the Trust is able to over-achieve on its CIP programme year on year across the forecast. The CIP programme is included in the LTFM at between 5% and 6% per annum, and the upside models an over-achievement of 1% in FY14 and then 0.5% in each of the following years.

### **Trust LTFM with upside and downside sensitivities**



The rational for this is a combination of the following:

- The commissioners are able to successfully achieve their QIPP targets and the Trust are able to remove significant costs, in excess of the marginal rate of 33% modelled in the LTFM. This would be most likely where commissioners remove a whole service rather than a series of reductions across various services;
- The Trust's successful achievement of Best Practice Tariff which will free up capacity to deliver care to patients with a higher level of acuity. This will increase income per patient; and
- Successful management of beds, which would allow the Trust to reduce premium payments to temporary staff, which tend to rise when there is poor management of beds.



## **Trust sensitivities**

The Trust have modelled a downside scenario which would see the recurring deficit rise to £56m by FY18.

### **CPT view**

*The CPT's work on efficiencies has highlighted that there are a number of areas where the Trust should be able to make immediate savings.*

*The CIPs in later years will need change in the wider health economy e.g. reduced delayed discharges.*

*However, the CPT's view is that there are efficiencies available to mitigate some of the downside risk, and that the contingencies included in the forecast (described on page 80) give the Trust some additional headroom to deal with any unforeseen issues.*

## **Downside risk**

The Trust have modelled a downside scenario on their LTFM, which sees the Trust's deficit increasing to £56m by FY18.

This has been modelled on the basis that the Trust is unable to achieve its CIP programme year on year across the forecast. In FY14 it is assumed the Trust is not able to deliver c.1/3<sup>rd</sup> of its CIP programme on a recurring basis and each subsequent year there is a further worsening of the Trust's CIP achievement until in the last year of the model there is no CIP achievement. The rationale for this is a combination of the following:

- The Trust is unable to manage capacity effectively. This means that there would be no improvement in length of stay and the Trust are not able to repatriate the activity that is currently outsourced;
- The Trust is unable to meet its Best Practice Tariff targets. These are often linked to moving work into outpatients and also increasing day case procedures. Therefore, this would not only reduce income but also it is likely to have a knock-on effect on the Trust's ability to reduce length of stay; and
- It is assumed that QIPP is delivered successfully by the Trust's commissioners. However, the Trust may not be able to reduce cost to the extent that is expected in the LTFM. This is likely to occur when the QIPP schemes are focussed on small reductions in a lot of different areas rather than a large impact on one.

## **Illustrative base case with no CIPs**

On the previous page, the graph sets out the effect on the Trust's base case forecast if the forecast CIPs are not delivered. If no CIPs are delivered over the five year period to FY18, the Trust deficit would rise to just under £100m p.a. This illustrates the importance of CIPs to the financial performance of the Trust.



## **Medium term projections summary**

The Trust's forecasts indicate that it does not meet any of the tests of financial stability.

### **CPT view**

*The Trust's medium term projection clearly indicates it does not meet any of the tests of financial sustainability and the CPT concurs.*

## **Conclusions on the medium term projections**

As referred to earlier in this report there are a range of risks and opportunities associated with the Trust's forecast. The significant risks include:

- The Trust has only signed a contract with one out of the two principal commissioners;
- The commissioners' QIPP plans are in the early stages of implementation;
- CIP planning is at an early stage of development and only covers part of the first year of a five year model;
- The Trust does not have a formal workforce plan at the moment, and
- The inherent risk of inflation assumptions proving to be incorrect over, what is, a reasonably long period.

The Trust's downside, discussed on the previous page, sets out some of the challenges the Trust is encountering and the likely financial consequences of not being able to address them.

## **Can the Trust address the causes of the deficit through actions within its control?**

The Trust is in a position to address most of the operational issues which have led to its deficit. However, even if the Trust could utilise its spare capacity more fully, it is left with a deficit mainly as a result of its excess estate costs.

Looking forward, the impact that the estate costs has on the Trust's financial position is likely to increase as a result of the PFI cost inflating by RPI. In addition, in the absence of additional income from better space utilisation, the Trust's income is set to fall and therefore the estate costs as a proportion of income grows even faster than the RPI increases.

## **Medium term projections summary**

The Trust's forecasts clearly indicate it does not meet any of the tests of financial sustainability:

- It will not be able to return to a financial surplus in the medium term;
- The Trust remains cash consumptive for the duration of the period under review; and
- Were it not for the support of the Department of Health, the Trust would not be able to pay its debts as and when they fall due.

Even if the Trust is able to mitigate the effects of falling revenue and inflationary cost increases, the financial position gets gradually worse from the middle of the forecast period as a result of a PFI cost that inflates in line with RPI.



## **Financial summary**

The CPT has assessed the potential cost savings and income opportunities identified through workforce and clinical analysis.

### **CPT view**

*The CPT has identified a workforce cost saving opportunity of £6.2m, that could be achieved in the short to medium term to 'catch up' with the average performance of a selected group of peers.*

*If all corporate and clinical measures were implemented, there is a potential financial contribution to the Trust of £3.7m per year.*

*A potential income from improved coding is highlighted but may not be available as a result of the commissioners' financial constraints.*

## **Efficiency opportunities**

The CPT has undertaken an assessment of the Trust's existing levels of operational and workforce efficiency. The purpose of this analysis was to identify and quantify the existing levels of inefficiency within the Trust when compared to an appropriate group of peers.

The table below shows the overall cost saving and potential income opportunities for the Trust against the average of its peers.

The financial benefits would arise if the Trust were to improve performance to meet the average performance of peers in workforce size and shape, the number of occupied beds, outpatient efficiency, and theatre utilisation.

The potential income opportunities arise from improvements to clinical coding. The CPT is aware that the Trust's commissioners may not be able to fund additional income for the Trust.

Efficiency area	Efficiency opportunity (£)
Workforce	6,169,000
Corporate Functions (non-pay)	1,178,000
Bed Savings/LOS	550,000
Outpatient Efficiency	343,000
Theatres	937,000
<b>Subtotal</b>	<b>9,177,000</b>
Income potential	777,000
<b>Total increased contribution</b>	<b>9,914,000</b>

The value of the workforce efficiencies has been adjusted to remove the risk of double counting against the savings identified in the clinical analysis.

An overview of these opportunities is described in the following pages. Further detail can be found in Appendices R to X.

The saving opportunities highlight where the Trust currently needs to catch-up with its comparator peer group. However, peers will have their own CIPs for the coming years. The Trust will have to deliver the amounts set out below in addition to meeting the national challenge of delivering between 4% and 5% efficiency per year over coming years.

If the Trust was to target reaching the upper quartile of performers in its peer group, then additional savings of £5.4m could be made across these areas to bring the total to £15.3m as set out below.

Efficiency area	Upper quartile efficiency opportunity (£)
Workforce	9,295,751
Corporate Functions (non-pay)	1,491,722
Bed Savings/LOS	1,680,000
Outpatient Efficiency	687,000
Theatres	1,405,500
<b>Subtotal</b>	<b>14,559,973</b>
Income potential	777,000
<b>Total increased contribution</b>	<b>15,336,973</b>



## Workforce efficiency opportunities

The CPT has reviewed the Trust's workforce against a refined set of peers.

### CPT view

*At the time of its review, the CPT identified efficiency opportunities of £6.2m if the size and shape of the Trust's workforce were to be addressed. This reflects the amount that the CPT believes the Trust can 'catch up' with the performance of its peers.*

*Corporate function non-pay opportunities of £1.1m have also been identified.*

### Efficiency opportunities – pay and corporate functions

The structure of the Trust's existing substantive workforce is typical of a district general hospital in terms of the relative proportions of workforce groups. However, when benchmarked against a set of comparator peers who deliver similar volumes of activity, case-mix and revenue (see Appendix R), the Trust has a larger workforce in the groups highlighted in the table below.

The benchmarking presents the Trust with clear opportunities for both 'right sizing' and 'right shaping' the workforce, be it through optimising skill mixes, increasing management spans of control or through sufficiently mapping resources to meet demand. This in turn will drive much greater clinical and non-clinical productivity and efficiencies, which will support the Trust in decreasing their workforce costs base.

The analysis also highlights that the Trust employs a large proportion of more senior - and therefore

expensive – staff relative to its peers amongst the Additional Clinical Services workforce group.

The CPT has also undertaken workforce productivity analysis for the Trust's nursing and medical staff groups. This productivity analysis supports the workforce efficiency analysis, in that the Trust's medical workforce group is less productive than the peers. See Appendix S.

The CPT notes that the Trust's FY14 forecast shows a planned increase to its substantive workforce. This growth trajectory does not take account of the key areas of workforce inefficiency. In particular, the Trust has planned to increase its staffing in the same workforce areas that the CPT has identified as the largest areas of workforce inefficiency, for example, in the Trust's nursing and medical staff groups.

Corporate function (non-pay) efficiencies have been identified across the six key functions: HR, Finance, Payroll, IT, Procurement, and Occupational Health and Safety. The CPT's review focused specifically on overhead costs, staff training and outsourced /consulting costs.

£'000	Net opportunity	% of staff group cost
Additional prof scientific and tech	507	7.8%
Additional clinical services	122	1.1%
A&C bands 1-6	934	6.2%
Healthcare scientists	446	12.7%
Medical & dental	3,818	13.4%
Nursing & midwifery	342	1%
<b>Total workforce savings</b>	<b>6,169</b>	
Corporate function non -pay	1,178	15.9%
<b>Total savings</b>	<b>7,347</b>	<b>5.5%</b>



## Clinical efficiency opportunities

The CPT has assessed the level of clinical opportunity available to the Trust.

### CPT view

*The CPT has identified income opportunities of £0.8m by improving clinical coding, and potential savings of £1.8m by improving average length of stay, outpatient efficiency and theatre utilisation. This reflects the amount that the CPT believes the Trust can 'catch up' with peer average performance.*

## Efficiency opportunities – clinical

The CPT collected data from the Trust and the HED benchmarking system to identify the Trust's current performance in the following areas: bed days, outpatient efficiency, theatre utilisation, pathology, pharmacy, radiology and clinical coding.

Those with a significant financial opportunity are discussed below.

### Bed days: £550,000

Compared to its peers, the CPT found that the Trust's length of stay performance was better than average at trust level. However, there is some potential for improvement in certain specialties. The CPT identified a potential opportunity to reduce the number of beds by 26 if the Trust moved to the peer average in those specialties where it is performing below average. Based upon the Trust's bed costs, a reduction of 26 beds would amount to a saving of £550,000. The reduction in bed numbers would not negatively affect patients, rather it would ensure they were given timely care and either seen as a day case or discharged appropriately.

### Outpatients: £343,000

The CPT reviewed the Trust's internal efficiency report. The majority of specialties were filling a high percentage of the available appointments they had scheduled. However, there were specialties (with significant patient activity) that appeared not to be fully utilising available appointments.

There is an opportunity to reduce the number of clinics and reduce costs by £343,000. This figure was

calculated by reducing scheduled appointments to a more appropriate number and applying the cost of each clinic removed. The reduction in the number of clinics may reduce the choice available to patients and cause an increase in the number of non-attendances, but the CPT is confident that the Trust has good practices in place to manage this.

### Theatres: £937,000

'Knife to skin time' is a recognised measure of the efficiency of operating theatres. The CPT investigated the Trust's 'knife to skin time' in a theatre session and compared it to a target of 65%. The Trust's average 'knife to skin' time was just 52%, with too much time before the start of, and between, operations. As such, if the Trust moved to average performance it could close two theatres at a saving of £937,000. The CPT believes that reducing the number of theatres would not negatively impact on patients.

### Clinical coding: £777,000

Clinical coding refers to the method by which specific treatments are recorded and paid for. Where there is more than one level of complexity for an ailment, i.e. without and with complications, the cost increases respectively.

The CPT compared the Trust's clinical coding to its peers and found that the Trust appeared to miss opportunities to record patients' increasing complexity levels, resulting in a loss in income of £777,000. The correct clinical coding has no impact on the patient, however the commissioner may not be able to pay for the increase.



## **Longer term projections**

The CPT has considered what a longer term financial projection may look like after the period covered by the LTFM.

### **CPT view**

*The longer term projections support the CPT's conclusions on financial sustainability.*

## **Longer term projections**

Whilst the CPT's review of financial sustainability focuses on the sustainability of the Trust with reference to the next five years, to help inform its conclusions it has also considered the longer term.

To develop this, the CPT has considered the Trust's forecasts and had discussions with the Trust's key commissioners. The CPT has received an activity forecast from the Trust's largest commissioner (c.60% of the Trust's activity) and met with the second largest commissioner to discuss their intentions.

The 10 year model uses the following assumptions:

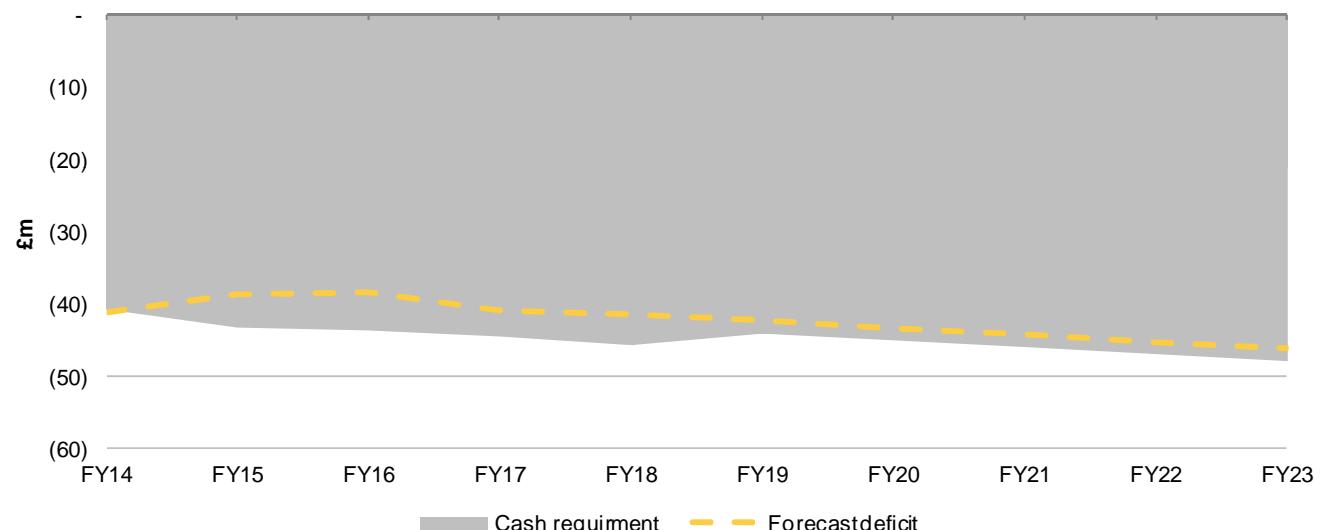
- No amendment to the Trust's five year LTFM;
- The continued delivery of commissioners' intentions to shift activity from the Trust to the community in

FY19 to FY23 – with the reduction in income being offset by population growth and the delivery of CIPs.

- The level of CIP achieved by the Trust in years 6-10 is also sufficient to cover the tariff deflation and cost inflation in those years;
- Working capital movements remain neutral in years 6-10;
- Capital expenditure continues at £5.9m for years 6-10, equivalent to the forecast level at FY18 (last LTFM year); and
- RPI is at 2.5%.

The CPT's review did not find anything that would cause it to change its conclusion on financial sustainability, due to the likely further deterioration in the financial position of the Trust.

**The Trust's forecast annual cash requirement over ten years**





## **Financial sustainability - sensitivities**

The CPT has looked at the potential to sensitise the Trust's forecasts in order to inform its view on sustainability.

### **CPT view**

*The level of CIPs the Trust is forecasting is challenging. Increasing the pace of CIP delivery further could give rise to quality of care issues.*

*The Trust's forecast level of income is broadly in line with the commissioners' expectations.*

### **Potential sensitivities**

The Trust have produced their own sensitivities around the forecast figures. Additionally, the CPT has considered whether it should apply any sensitivities to the LTFM to help inform its view on the financial sustainability of the Trust.

Detailed comments on the assumptions in the LTFM are set out in Appendix Q.

Outlined below are two of the major potential sensitivities which could be made to the forecast, namely the level of CIPs included and the forecast income.

#### **1. Level of CIPs**

The level of CIPs being forecast by the Trust ranges from 4.6% to 5.9% of income or 4.9% to 6.3% of controllable costs for each of the next five years.

The CPT has considered the following when deciding whether the level of forecast CIPs are realistic:

- a) The level of CIPs that other foundation trusts are forecasting to achieve;
- b) The findings of the clinical and operational sustainability reviews;
- c) The track record of the Trust and its capability to deliver CIPs with reference to the CPT's findings on the Trust's PMO (see pages 36 and 37);
- d) The level of efficiency required to 'catch up' with other trusts and, thus, the extra opportunity the Trust has over and above other foundation trusts (see page 85);
- e) The status of the Trust's CIP plans for FY14;

- f) Monitor's *Delivering sustainable cost improvement programmes* (January 2012), and National Quality Board guidance; and
- g) Ensuring safe CIP levels that do not impact quality of care.

Based on the level of CIPs the Trust is forecasting, the 'catch up' described in d) would substantially be achieved within five years.

The CPT would expect the Trust to be setting and achieving a challenging and safe level of CIPs and believes that the current forecast level is appropriate in the early years. The Trust does not believe that the outer years of the LTFM forecast could be achieved by working in isolation.

The CPT does not propose any additional sensitivities but does concur with the Trust's view that the balance of risk and opportunity is weighted to the base case's downside, with the CIPs target in the outer years looking challenging.

#### **2. Income**

The Trust is forecasting a reduction in income based on further tariff deflation and commissioner QIPP plans, offset by demographic changes that increase demand.

The CPT notes that the Trust's income has increased which is likely to be due, in part, to the opening of Peterborough City Hospital and the increasing trend in the quality of care provided by the Trust.

Based on the CPT's review of the assumptions, the information it has received in this area, and discussions it has had with the commissioners, the CPT does not propose sensitising the level of income.



## **Conclusions**

The Trust would have to make an unprecedented level of savings to become financially sustainable.

### **CPT view**

*The Trust is not financially sustainable.*

*The level of savings it would have to make in order to achieve financial sustainability could only be delivered through a reduction in costs which would destabilise the Trust's clinical performance.*

### **Level of additional cost savings needed for the Trust to be financially sustainable**

The CPT has considered the level of cost saving necessary for the Trust to be financially sustainable and whether these are realistic.

The Trust would have to achieve savings of c.21% for FY14 and FY15 to be financially sustainable, which is unprecedented for any foundation trust.

Making these savings over a short timeframe would almost certainly make the Trust clinically unsustainable due to the impact it would have on clinical delivery and patient safety. The pace of change would incur substantial redundancy costs and would destabilise the provision of services.

### **Conclusions on financial sustainability**

The CPT has 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 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.

The next phase of the CPT's work will consider how the local health economy can work together, and what the other options are, to reduce the Trust's deficit.

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# *Appendices*

# *Operational sustainability appendices*

## Appendix A

### Methodology

#### Document review

The CPT's review consisted of an analysis of relevant documentation and data to establish the operational and governance arrangements in place. The CPT reviewed a range of documents which informed us about the quality of management reports and how any issues are dealt with. These documents included:

- Trust and directorate organisational structures;
- Board and subcommittee terms of reference;
- Board and subcommittee agendas, papers and minutes;
- Directorate level meeting agendas, papers and minutes;
- Trust strategy and business plan;
- Trust quality strategy;
- Corporate and directorate risk registers;
- Board assurance framework;
- Internal audit reports on data quality;
- Example quality impact assessment (QIA) documentation;
- Trust and directorate scorecards; and
- Board self assessment against Monitor's Quality Governance Framework.

#### Interviews

The CPT conducted a number of interviews with key individuals at the Trust.

The CPT's interviews aimed to assess how governance arrangements are working in practice and to ascertain the operational sustainability of the Trust.

Interviews included:

- Board members;
- Clinical directors;
- Directorate general managers;
- Other key individuals in the PMO, Information Technology, HR and Finance teams.

#### Observations

The CPT observed a number of meetings in order to understand how operational and governance processes worked in practice. Observations included:

- Public and private Trust board meetings;
- Directorate management team meetings; and
- Executive Director meetings.

Due to the timing of the review, the CPT was unable to observe the Quality Assurance Committee meeting. The CPT sought to understand the operation of the subcommittee through document review and interview.

## Appendix A

Scope of workforce  
benchmarking

### CPT view

*The CPT has used a peer group for workforce benchmarking that has been refined to ensure comparator trusts are as similar as possible the Trust.*

*Benchmarking has been undertaken on all workforce groups as well as for corporate back office functions.*

*The CPT has also looked at trends from the NHS staff survey to underpin qualitative analysis.*

### Scope of workforce benchmark analysis

The scope of the CPT's workforce benchmarking analysis is designed to provide an independent view of the Trust's workforce compared to a set of peers. The peers have been selected against a set of criteria based on similarity of case mix, activity volume and number of beds. The peer group was then refined further to a group of five trusts against workforce size, Trust revenue and Trust costs and is referred to as the refined peers throughout the report.

The approach used:

- **NHS workforce profiling:** Using NHS data and applying the CPT's workforce methodology, the CPT assessed the overall size of the Trust versus agreed benchmark NHS organisations. The benchmark analysis covers all of the Trust's workforce groups, at each level of the Trust, based on staffing classifications and pay bands;
- **CPT Saratoga data and benchmarking information:** CPT's Saratoga practice has one of the largest and most robust databases of human capital metrics and a comprehensive database of key support function measures. The CPT has a number of quantitative metrics to identify improvements in all areas of back-office operations, highlighting potential cost savings, efficiency gains, service improvements and effective function delivery opportunities. The database contains HR, Finance, IT, Procurement, Payroll, Occupational Health and workforce metrics.
- **NHS Staff Survey:** Using NHS survey data to look at trends in key areas to underpin and evidence qualitative analysis and inform the CPT's findings.
- **Workforce refined peer:** The existing 20 trust peers, selected based on similarity of case mix and volume, have been filtered in greater detail to create a refined comparator group consisting of five key trusts.
- The five trusts have been selected through a process of reviewing workforce size, revenue and costs from 2011/2012 financial reports.

**Appendix B****Trust strategy**

This table shows the Trust's vision, strategy and key objectives as set out in the FY12/13 to FY16/17 business plan. We consider the quality of this strategy, and how it is monitored, in the Operational Sustainability section above.

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

<b>Doing the very best inside our hospitals</b>	<b>Getting value for money from our hospitals</b>	<b>Making the most of our hospitals</b>
<p><i>Quality and clinical performance</i></p> <p><i>Organisational development</i></p> <ul style="list-style-type: none"> <li>• Achieving the highest quality across the three Darzi domains of patient safety, patient experience and clinical effectiveness, by focussing always on the needs of our customers (patients, relatives and the public)</li> <li>• Achieving the highest performance by seeking ways to treat patients in the most effective way, thereby optimising patient activity and throughput, and making the best use of our staff and facilities</li> </ul>	<p><i>Productivity and effectiveness</i></p> <ul style="list-style-type: none"> <li>• Redesigning patient pathways, clinical and departmental relationships and workforce skill sets to ensure best practice internationally becomes our common practice</li> <li>• Achieving the highest standards of clinical engagement, leadership, accountability, performance and governance so as to create an organisation whose culture and behaviours can meet the challenges of the next 5-10 years</li> </ul>	<p><i>Maximising the value of the local health system's estate</i></p> <ul style="list-style-type: none"> <li>• Achieving the highest productivity through stretching cost improvement programmes and the application of 'LEAN' techniques and service line reporting</li> <li>• Divesting in non-core services where we cannot cover our costs with our income</li> </ul>
		<ul style="list-style-type: none"> <li>• Creating space in Peterborough City Hospital to treat more patients and develop our business, by optimising our patient throughout and clinical productivity and by selective rebuilding projects</li> <li>• Redeveloping Stamford Hospital to offer the best facilities to local people and to make the site fully productive</li> <li>• Cooperating with public sector partners in Peterborough to rationalise and make fully productive the public sector estate in the City</li> </ul>

## Appendix C

### CPT view

*The Trust has assessed all risks on the Board*

*Assurance Framework as 'high' or 'significant'. As these are long term objectives, a higher risk rating is in line with expectations.*

*Each item has an associated risk card which sets out the actions being taken to mitigate these risks.*

### Performance against strategy

This table summarises the Trust's current risk assessment for each strategic objective, as set out in the Board Assurance Framework presented to the March 2013 board. A key to the risk ratings is set out on the following page.

Goal	Objective	Trust risk rating at March 2013
Doing the very best inside our hospitals	Achieving the highest quality across the three Darzi domains of patient safety, patient experience and clinical effectiveness, by focussing always on the needs of our customers (patients, relatives and the public)	●
	Achieving the highest performance by seeking ways to treat patients in the most effective way, thereby optimising patient activity and throughput, and making the best use of our staff and facilities	●
	Redesigning patient pathways, clinical and departmental relationships and workforce skill sets to ensure best practice internationally becomes our common practice	●
	Achieving the highest standards of clinical engagement, leadership, accountability, performance and governance so as to create an organisation whose culture and behaviours can meet the challenges of the next 5-10 years	●
Getting value for money from our hospitals	Achieving the highest productivity through stretching cost improvement programmes and the application of 'Lean' techniques and service line reporting	●
	Divesting in non-core services where we cannot cover our costs with our income	●
	Creating space in Peterborough City Hospital to treat more patients and develop our business, by optimising our patient throughput and clinical productivity and by selective rebuilding projects	●

**Appendix C****CPT view**

*The Trust has assessed all risks on the Board*

*Assurance Framework as 'high' or 'significant'. As these are long term objectives, a higher risk rating is in line with expectations.*

*Each item has an associated risk card which sets out the actions being taken to mitigate these risks.*

**Performance against strategy (continued)**

Goal	Objective	Trust risk rating at March 2013
Getting value for money from our hospitals (continued)	Redeveloping Stamford Hospital to offer the best facilities to local people and to make the site fully productive	●
	Cooperating with public sector partners in Peterborough to rationalise and make fully productive the public sector estate in the City	●
Making the most of our hospitals	Working always in close collaboration with the regulatory authorities, the Department of Health and National Commissioning Board, Health and Wellbeing Boards, MPs and Councillors, Governors, Members and the public	●

**Key**

- High risk – update provided to Trust Management Board monthly.
- Significant risk – update provided to Trust Management Board every three months.
- Moderate risk – monitored through review of Board Assurance Framework
- Low risk – monitored through review of Board Assurance Framework

## Appendix D

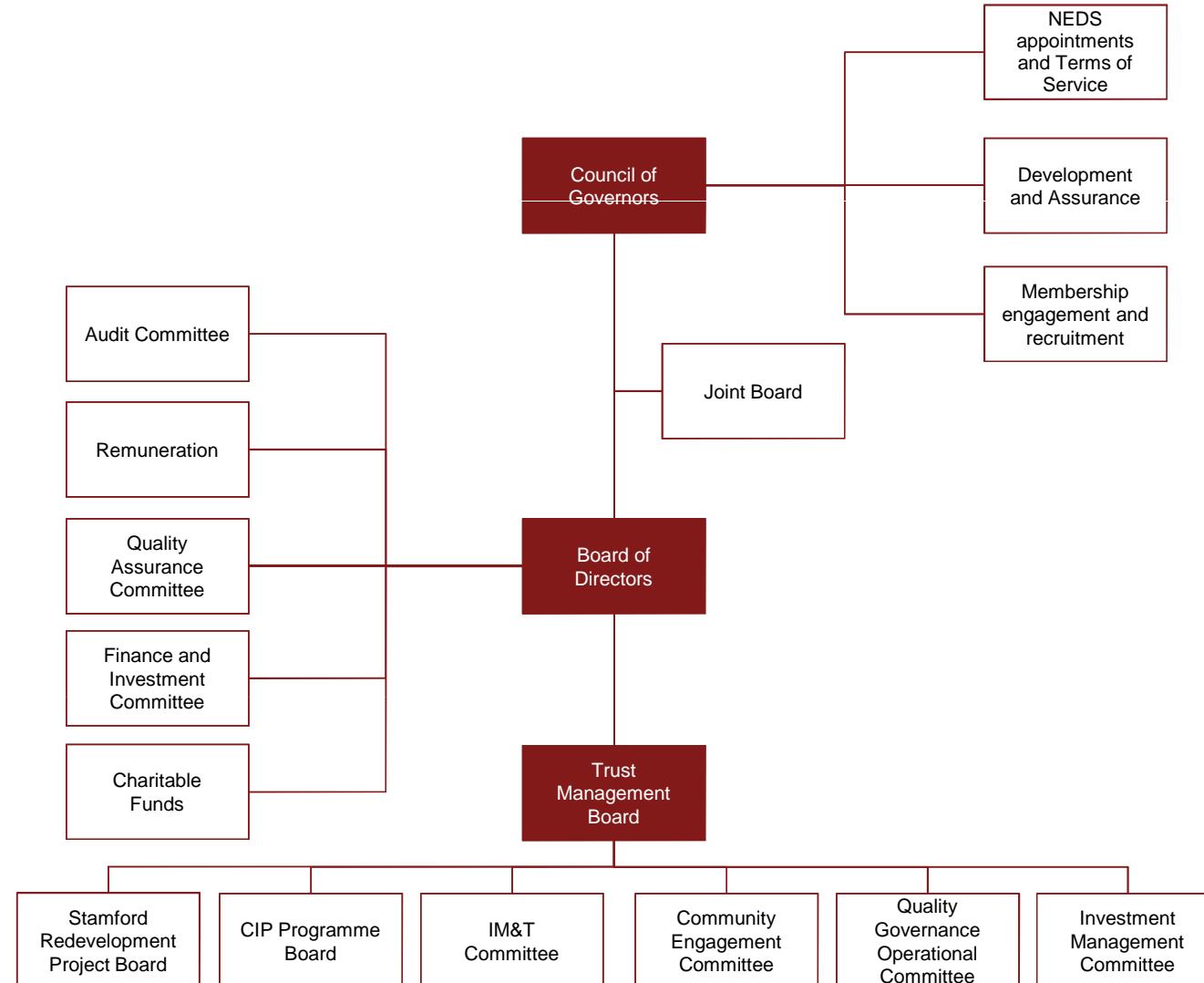
### CPT view

The Audit Committee, Remuneration Committee, Quality Assurance Committee, Finance & Investment Committee and Charitable Funds Committee are all subcommittees of the Board and are chaired by Non Executive Directors.

The Trust Management Board is an operational committee attended by Executive Directors, Clinical Directors and General Managers.

## Trust committee structure

This diagram sets out the Trust's committee structure as set out in the Strategic Framework for Risk Management



**Appendix E****Directorate structure**

This diagram sets out the directorate and service level structures within the Trust

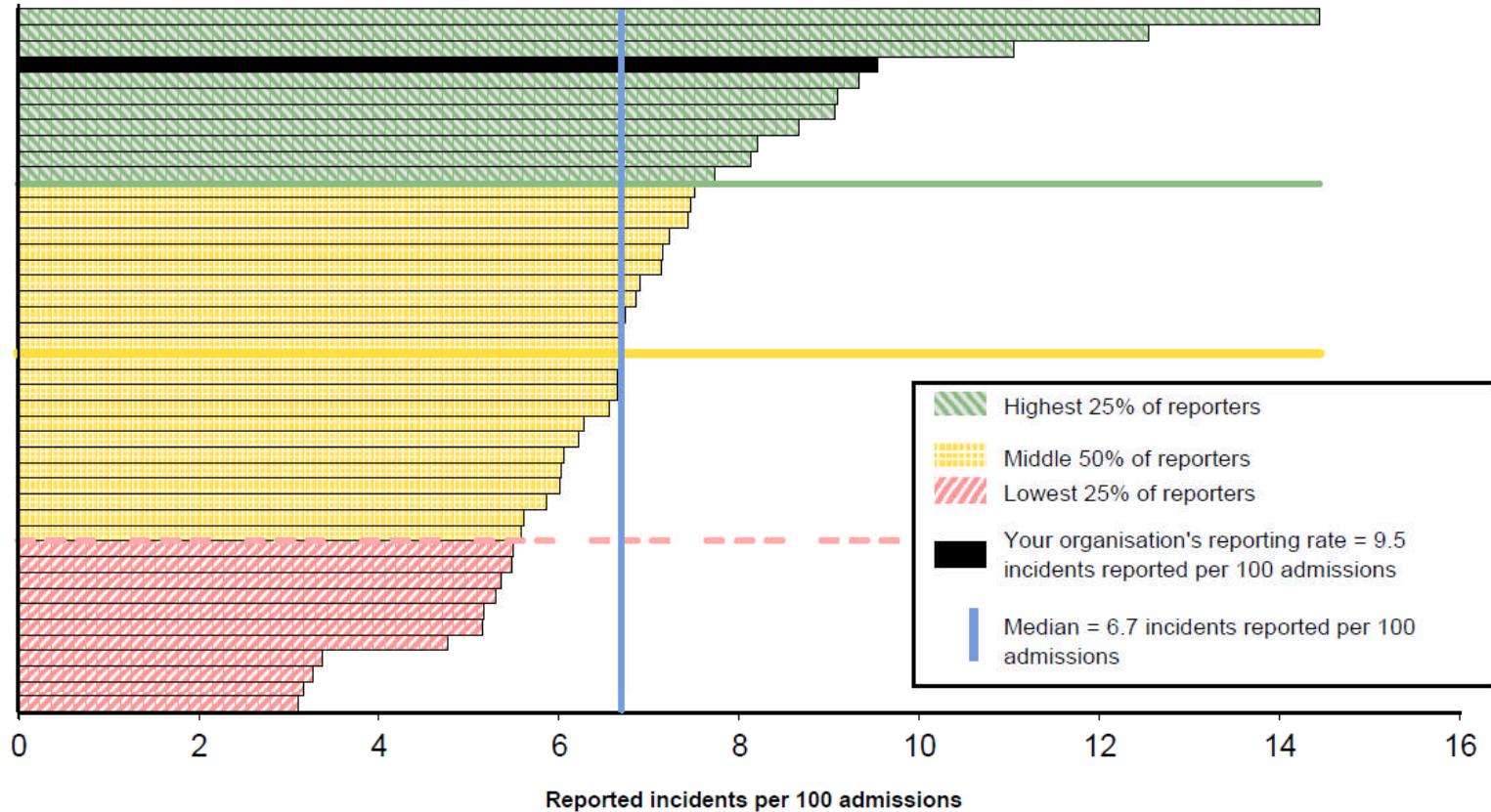
<b>Cancer and Diagnostics</b>	<b>Clinical Support</b>	<b>Emergency and Medicine</b>	<b>Surgery and Musculoskeletal</b>	<b>Theatres, Anaesthetics and Critical Care</b>	<b>Family and Public Health</b>
<ul style="list-style-type: none"> <li>• Clinical haematology</li> <li>• Lymphedema</li> <li>• Oncology</li> <li>• Palliative care</li> <li>• Radiotherapy</li> <li>• Robert Hornell MacMillan Centre</li> <li>• Diagnostic imaging</li> <li>• Medical photography</li> <li>• Mortuary (including bereavement)</li> <li>• Pathology</li> </ul>	<ul style="list-style-type: none"> <li>• Central sterile services department</li> <li>• Choose and book</li> <li>• General outpatients</li> <li>• Health records</li> <li>• Outpatient admin</li> <li>• Patient transport services</li> <li>• Pharmacy and medicines management</li> <li>• Therapy services (including commissioned services)</li> </ul>	<ul style="list-style-type: none"> <li>• Ambulatory care unit</li> <li>• Emergency department</li> <li>• Emergency short stay</li> <li>• Capacity team</li> <li>• Cardiology services</li> <li>• Diabetes and endocrinology</li> <li>• Endoscopy</li> <li>• Gastroenterology</li> <li>• Medicine for older people</li> <li>• Neurology</li> <li>• Renal</li> <li>• Respiratory and respiratory investigations</li> <li>• Stroke services</li> </ul>	<ul style="list-style-type: none"> <li>• Audiology</li> <li>• Ear, nose and throat</li> <li>• General surgery</li> <li>• Lower gastrointestinal</li> <li>• Ophthalmology</li> <li>• Oral</li> <li>• Orthopaedics</li> <li>• Orthopaedics/fracture outpatients</li> <li>• Orthotics</li> <li>• Plastics and dermatology</li> <li>• Rheumatology</li> <li>• Upper gastrointestinal</li> <li>• Urology</li> <li>• Vascular</li> </ul>	<ul style="list-style-type: none"> <li>• Anaesthetics</li> <li>• Critical care unit</li> <li>• Pain management</li> <li>• Pre-admission</li> <li>• Pre-assessment</li> <li>• Theatres and day surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Brest</li> <li>• Department of sexual health</li> <li>• Gynaecology</li> <li>• Neonatal</li> <li>• Obstetrics</li> <li>• Paediatrics</li> </ul>

**Appendix F****CPT view**

The Trust has an incident reporting rate in the top quartile for medium acute trusts. A high reporting rate is often indicative of an open and transparent culture that encourages learning from incidents.

The Trust also reports a higher proportion of 'no harm' incidents, which supports the conclusion that high reporting rates are indicative of a good culture, rather than an absolute higher number of incidents.

We consider risk management and incident reporting further in the Operational Sustainability section of the report.

**National Patient Safety Agency Incident reporting data**

Incident reporting rates per 100 admissions for medium acute trusts, as shown in the NPSA Organisation Patient Safety Report for Peterborough and Stamford Hospitals NHS Foundation Trust (period of 1 April 2012 to 30 September 2012).

# *Clinical sustainability appendices*

## Appendix G

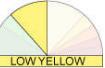
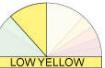
### Quality Risk Profiles

This provides a summary of the Quality and Risk Profiles (QRP) published in February 2013, which provides evidence for clinical sustainability.

### Quality risk profiles

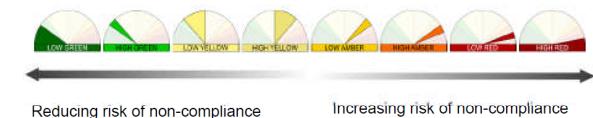
QRPs bring together information about a care provider and an estimate of risk of non-compliance against each of the 16 essential standards of quality and safety. This is judged on a range of data sources, both qualitative and quantitative, to build each QRP. These include national

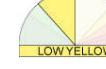
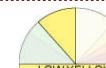
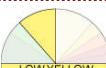
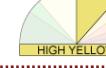
### The Trust: Quality risk profiles

Outcome	Risk estimate	
	Previous	Latest
Outcome 1 Respecting and involving people who use services		
Outcome 2 Consent to care and treatment		
Outcome 4 Care and welfare of people who use services		
Outcome 5 Meeting nutritional needs		
Outcome 6 Cooperating with other providers		
Outcome 7 Safeguarding people who use services from abuse		
Outcome 8 Cleanliness and infection control		
Outcome 9 Management of medicines		

clinical audit datasets, routine data collections, information from people using services and data from other regulatory bodies. A summary of these profiles is regularly reported to the board of the care provider and an action plan is set out as a result.

### Dial keys



Outcome	Risk estimate	
	Previous	Latest
Outcome 10 Safety and suitability of premises		
Outcome 11 Safety, availability and suitability of equipment		
Outcome 12 Requirements relating to workers		
Outcome 13 Staffing		
Outcome 14 Supporting staff		
Outcome 16 Assessing and monitoring the quality of service provision		
Outcome 17 Complaints		
Outcome 21 Records		

## Appendix H

### Healthcare Evaluation Database (HED) clinical quality indicators

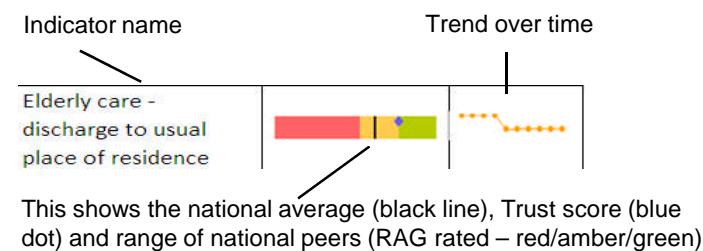
This presents a profile of quality indicators from HED. The overall reassuring picture provides further evidence of the Trust's current clinical sustainability.

### Healthcare Evaluation Database (HED) clinical quality indicators

The clinical indicators used in this report are Trust-wide indicators which are obtained from the HED tool.

HED indicators provide a high level overview of the Trust's clinical safety and quality against national peers, as well as the performance trend over time.

#### Understanding the indicators



#### The Trust: Areas for development

Indicator	Performance	Trend
Rate of 3rd and 4th Degree Tears in Maternity spells		

#### The Trust: Areas where better than expected

Indicator	Performance	Trend
MRSA Infection Rate		
MSSA Infection Rate		
VTE 90 day readmissions per 1,000 spells		

### The Trust: Areas where performing within the expected range

Indicator	Performance	Trend
C Diff Infection Rate		
HSMR		
Mortality Cumulative Summary (HRG)		
Mortality Relative Risk (HRG4)		
SHMI		
30 Day Emergency Readmission Relative Risk (HRG4)		
Fractured Neck of Femur surgery within 48 hours		
VTE risk assessment		
PE 90 day post discharge mortality per 1,000 spells		
Elderly care - discharge to usual place of residence		
Rate of C-Section in Maternity spells		
PROM - hip replacement		
PROM - knee replacement		
14 days emergency readmission rate		
Death in low-mortality CCS groups		
Deaths in high-risk conditions		
EColi Infection Rate		
Complication Rate in elective admissions		
Complication Rate in non-elective admissions		

## Appendix I

### Readmission rate

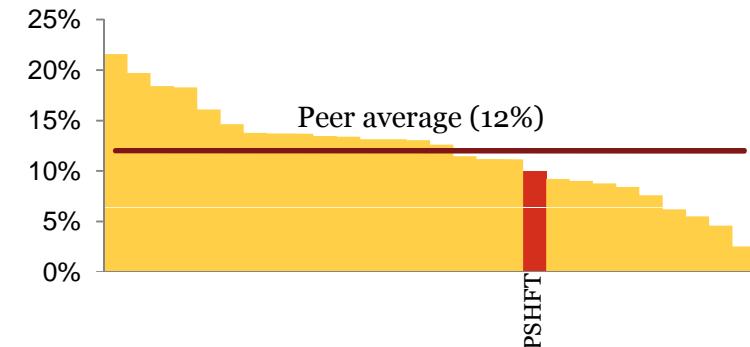
*The Trust appears to have a better than peers readmission rate adjusted to clinical case mix and activity volume.*

### Readmission rate

Readmission rate can provide some insight into the effective treatment for patients at a trust, although consideration of different scenarios should be taken. Patients successfully discharged from an organisation (not transferred), where they had an emergency or non-emergency episode are deemed liable to be traced for readmission. If the patient is readmitted back to the original provider and/or readmitted back to another provider as an emergency within 28 days of the previous discharge they are identified to have been readmitted.

As part of the investigation into the clinical sustainability of the Trust, CPT compared the average readmission rate of the Trust to selected peers, which have similar clinical case mix and activity volume. The Trust appears to have a readmission rate of 10%, which is better than the peer average of 12% (see the graph to the right). This reveals reasonable performance for the level of clinical activity and case mix at the Trust.

### The Trust: readmission rate compared to peers



## Appendix J

### **Independent review of the Trust's Midwifery Led Birthing Unit**

This provides a summary of the review for the maternity department at the Trust, commissioned by the Head of Midwifery (HoM) and Chief Nurse published September 2012.

### **Independent review of the Trust's Midwifery Led Birthing Unit**

An independent review of the Midwifery Led Birthing Unit (MLBU) was performed in September 2012 to assess the safety of the MLBU and to give assurance to the Trust board on the governance framework, including clinical pathways, staffing, escalation, communication (written and verbal), clinical outcomes and the views of relevant stakeholders and users. The key findings were as follows:

- Significant investment in the last two years has resulted in improved levels of midwifery staff and more recently Consultant Obstetric staffing at MLBU;
- Capacity at the Trust is sufficient at this current time, but services will face challenges in the future due to a rising birth rate and an expanding catchment area;
- The Trust currently meets the 1:32 midwife to birth ratio, although this is achieved by supplementing with bank and agency staff;
- The Trust has 10 staff ready to start new posts from April, which will count towards the improvement of this ratio;
- As of December 2012, midwives were able to provide 1:1 care in labour for 94.6% of the time (regional average is 97%). This figure was 93.2% in January 2013;
- The on-the-day manager has no case load and therefore supplies additional support as required; and
- The recording of the foetal heart rate was not fully compliant with NICE; the Trust purchased a number of non digital display monitors to assist with compliance with the NICE guidelines.

Key findings from multiple sources

- Concerns were recently raised about the safety of the MLBU following two Serious Untoward Incidents (SIs) in the last 18 months. Considerable progress has been made with the recommendations and actions from the March 2011 SI report.
- Maternity Services achieved Level 2 Clinical Negligence Scheme for Trusts (CNST) in February 2010, and passed the CNST Level 2 assessment in February 2013 for the new Level 2 Standards.

Recruitment is underway to recruit three whole time equivalent (WTE) consultants and one WTE specialty doctor in order to meet the Royal College of Gynaecology standard of 98 hours of consultant presence for between 4,000 – 5,000 births. The Trust currently employs three locum obstetricians until permanent replacements are found.

## Appendix K

### **Review of quality metrics for Maternity services**

This provides a review of the common metrics used to indicate the clinical sustainability for Maternity services.

The Trust's Maternity services demonstrated overall reassuring pictures after reviewing these metrics, but close monitoring of these standards should continue through the maternity services quality governance forum.

### **Review of quality metrics for Maternity services**

The CPT assessed the clinical quality for Maternity services based on several commonly used metrics. The Trust appeared to provide acceptable quality of care overall.

The CPT has identified some concerns about perineal trauma. An internal report was commissioned in January 2012 to review this in further detail, which included a detailed case review of 19 sets of notes undertaken by the Trust. This analysis reviewed the Trust's internal report in order to understand if any additional actions should be taken. However, this review did not identify any deficiencies in care either.

The annual C-section rate at the Trust is better than that of regional and national peers; although an increasing trend can be seen over the past 4 years.

The post partum haemorrhage (PPH) at the Trust did not breach the national standards for thresholds over one litre and over two litres, but an increasing trend of both incident rates has been observed. The Trust has taken specific actions to address this increasing threshold rates, including:

- New obstetric training (PROMPT) in emergencies, which was piloted in December 2012 and now facilitated monthly. Lessons learnt from each skill drill are also discussed at the Labour Ward Forum and emergency skills drills have commenced on the Delivery Suite;

- Drug dosage information has been reissued and a second PPH trolley has been introduced;
- Root cause analysis is undertaken on all PPH>2L and actions implemented;
- Revised governance and audits have been introduced; and
- Although incidence rates have not breached the stated thresholds, given an upward trend the Trust has arranged for a peer review by a consultant obstetrician from Norfolk and Norwich Hospital in association with the SHA Lead Midwife.

The Trust's Maternity services demonstrated overall reassuring performance, but need to continue monitoring these standards closely.

**Appendix L****Staffing levels: Consultants**

**Comparison of staffing levels against available Royal College guidance**

This provides a breakdown of the Trust's staffing levels against specific Royal College standards where available. The findings support the assessment of workforce sustainability.

Specialty	Minimum consultant WTE to deliver a 24/7 rota	Trust WTE
<b>Emergency surgery</b>	8 – 9	9
<b>Paediatrics</b>	8 – 9	11
<b>A&amp;E</b>	8 – 10	7.2 <sup>1</sup>

<sup>1</sup> WTE currently includes three WTE Locums and three WTE consultants who have been recruited and will be starting at the Trust during 2013.

Specialty	Minimum consultant WTE to deliver a 24/7 rota	Trust WTE
Maternity (combined MLBU and Delivery Suite)	98 hours per 4,000 – 5,000 births per year	66 hours <sup>2</sup>

<sup>2</sup> The number of births is increasing in Peterborough and predicted to reach 5,000 by the end of FY13. The Trust is in the process of recruiting three WTE consultants and one WTE specialty doctor which will enable it to meet the Royal College standard of 98 hours.

Staffing level sources:

- The College of Emergency Medicine, *Emergency Medicine Consultants: workforce recommendations (2010)*
- Royal College of Surgeons, *Emergency Surgery: Standards for unscheduled surgical care (2011)*
- Royal College of Obstetricians and Gynaecologists, *The Future Workforce in Obstetrics and Gynaecology (2009)*
- Royal College of Paediatrics and Child Health, *Facing the Future: A review of paediatrics services (2011)*
- Royal College of Nursing, *Mandatory Nurse Staffing Levels, Policy Briefing (March 2012)*.

# *Financial sustainability appendices*

## Appendix M

Historical workforce trends from FY10 to FY12.

### CPT view

*Increasing activity levels during the period FY10 to FY12 has resulted in an increased demand for clinical staff. The lack of strategic workforce planning and inconsistent application of controls has meant a continued and growing reliance on temporary staff, particularly among nursing and medical. The impact has been an FTE increase of 9% in the period.*

*The growth in reliance on temporary staff is a concern in light of the efforts made by others to reduce temporary staffing expenditure.*

## Historical workforce trends

The NAO report highlighted that the Trust's staff costs rose by 40% between FY06 and FY12, which included a 37% increase in the medical and dental workforce. The CPT has reviewed the profile of the growth in the size and cost of the Trust's staffing arrangements between FY10 and FY12. During the period the overall workforce cost increased by £13m and saw an overall FTE growth of 9%.

The CPT's analysis highlighted a consistent growth in the Trust's reliance on agency staff, from 4.65% in FY10 to 5.2% in FY12. The majority (c.65%) of the temporary staffing cost increase has been in nursing and medical. Given the premium cost of agency staffing and the significant efforts being made by other trusts to reduce agency usage, this increase in pay expenditure is a concern.

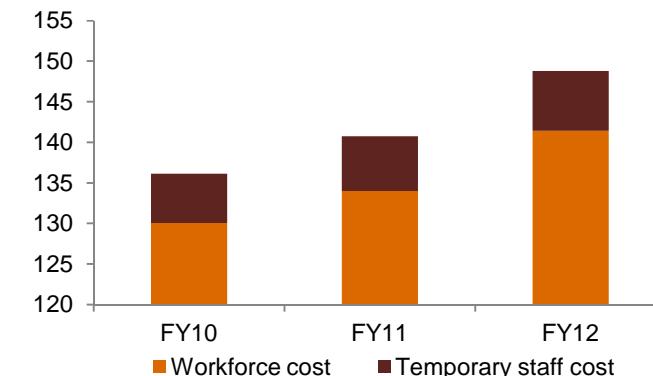
It is evident that the Trust has staff cover arrangements in place, but that this system has not been equipped to deal with the level of increased demand for clinical staff given the increase in activity (see charts to the right).

The combined effect of the following has resulted in relatively high overall pay costs:

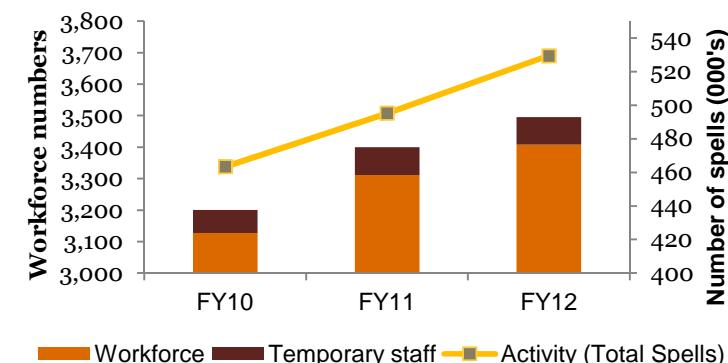
- An increasing reliance on agency staffing; and
- A comparably high earning profile driven by bands 8b to 8d, healthcare scientists, and nursing and midwifery staff groups.

The CPT's engagement with the Trust has highlighted that there has been a lack of strategic workforce planning and an inconsistent application of robust workforce controls across operational areas. This is reflected in the workforce trends identified. Whilst the Trust has identified the need to reduce its temporary staff costs in recent years as part of planned efficiencies, this has not happened.

### Total staff cost (£m)



### Workforce trend



## Appendix N

### Agenda for change earnings analysis

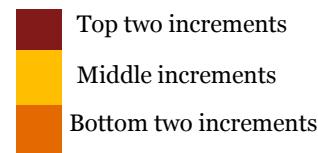
The charts on the right indicate the Trust's earnings analysis for staff on AfC pay bands.

#### CPT view

*The earnings analysis by band shows that among the top earners (bands 8a – 8d) over 60% of staff are at the upper end of the incremental range for the band.*

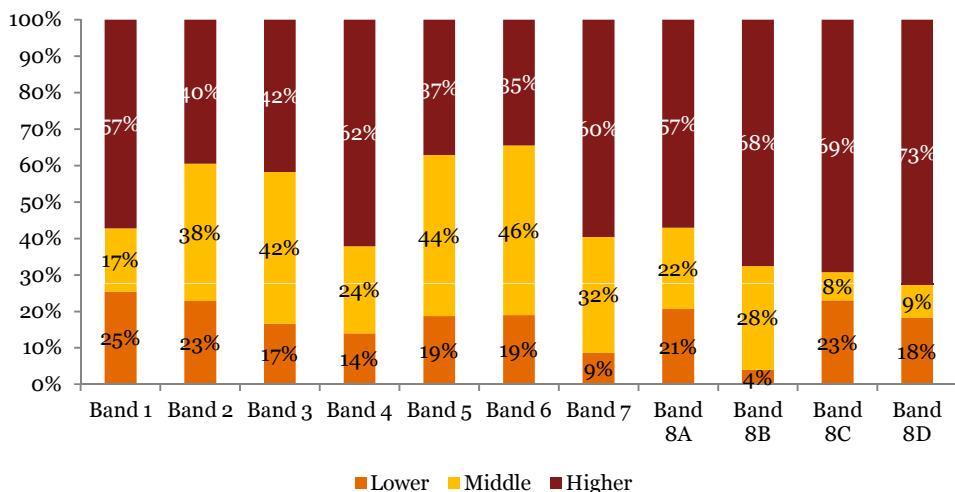
*The earnings analysis by staff group shows that among healthcare scientists, professional and scientific and administrative and clerical staff over 45% in each group are at the upper end of the incremental range within the banding structure.*

*Both of these analyses highlight the Trust's high pay costs and lack of historical controls.*

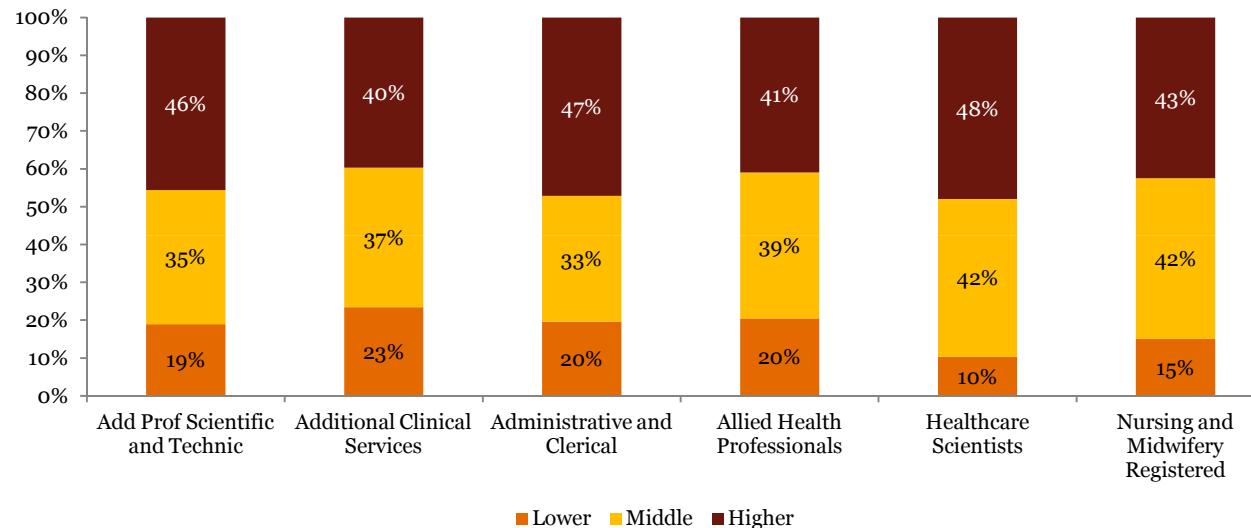


\*The pay scale spinal value classification has been used to identify whether someone is in the lower, middle or higher area of the band. Lower is defined by the bottom two increments within the band, higher is defined as the two highest increments within the pay band and the middle is any other increments in the middle of the band.

### Agenda for change earnings analysis by band



### Agenda for change earnings analysis by staff group<sup>1</sup>



<sup>1</sup> further detail on the typical roles within each staff group can be found in the Glossary section of this report.

## Appendix O

### FY12 performance

The Trust incurred a significant deficit in the first full year of operations at the new site.

### FY12 performance

The Trust forecast a deficit of £20.9m for FY12. This was based on NHS clinical income of £186m and planned CIP savings of £12m.

The actual outturn position was a deficit of £45.8m. This was driven by a number of factors, which included but was not limited to:

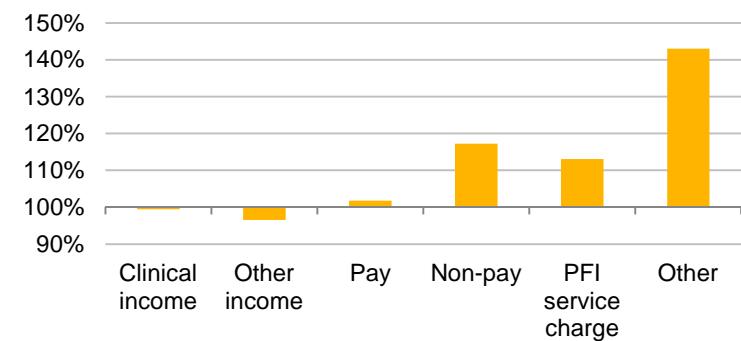
- Estate costs in FY12 (the first full year of occupation of the new PFI build) were £26.7m higher than in the prior year. The budget only provided for an increase of £17.3m in these costs;
- The Trust failed to recruit to substantive posts and hence, although there was a positive variance of £8.8m on the staffing budget, there was an £11.3m overspend on bank and agency staff;
- The CIP programme generated only £5.3m of recurrent savings against a target of £12m in the year; and
- The Trust did not receive the PFI structural support of £13m which was included in the plan. The Trust had received £20.5m of funding in FY11, of which £10m was an advance for subsequent years. This was offset by restructuring costs which were not fully utilised in the year.

### Income and expenditure account FY12

£m	Budget	Actual	Variance
<b>Income</b>			
NHS Clinical income	186.2	184.7	(1.5)
Non-NHS Clinical income	4.3	4.7	0.4
Other income incl PFI	22.9	22.1	(0.8)
<b>Total income</b>	<b>213.4</b>	<b>211.5</b>	<b>(1.9)</b>
<b>Expenditure</b>			
Pay	(141.4)	(143.9)	(2.5)
Non-pay	(57.6)	(67.5)	(9.9)
PFI service charge	(15.3)	(17.3)	(2.0)
<b>Total expenditure</b>	<b>(214.3)</b>	<b>(228.7)</b>	<b>(14.4)</b>
<b>EBITDA</b>	<b>(0.9)</b>	<b>(17.2)</b>	<b>(16.3)</b>
Depreciation/finance costs	(23.0)	(26.2)	(3.2)
PFI structural support	13.0	-	(13.0)
Restructuring expenses	(10.0)	(2.4)	7.6
<b>Surplus/(deficit)</b>	<b>(20.9)</b>	<b>(45.8)</b>	<b>(24.9)</b>

Source: Trust accounts FY12

### Actuals as a % of forecast (FY12)



## **Appendix P**

### **Service developments**

In the Trust's strategic plan of July 2012 a number of potential service developments were identified. These developments had a forecast potential income of c£60m.

Since the strategic plan was developed a different set of opportunities has been identified and worked on by the incoming head of business development.

The revised list recognises the financial constraints of the health economy and, therefore, focuses on the areas which would either:

- Deliver a repatriation of patients from surrounding areas;
- Be driven by changes in NICE/NHS England guidelines, resulting in services that will need to be procured in the future; and
- Establish Trust-run services for certain procedures currently provided from the Trust premises by third parties.

At the time of writing, the negotiations concerning these areas are at an early stage and the financial implications of the developments, if they were to be ultimately commissioned, have not been fully worked up.

The Trust has not included the above service developments in the LTFM. The LTFM currently contains a relatively small amount of directorate-led service developments (£1.2m).

Even if all the service developments that are currently being contemplated were successful, the CPT does not believe that the additional margin generated would be sufficient to materially alter its overall conclusion that the Trust is not financially sustainable in its current form.

The CPT will consider a broad set of potential service developments in the next phase of its work.

## Appendix Q

### Income

The income assumption for FY14 is based on the agreed contract with the Trust's main commissioner and the agreements made in principle with other commissioners to sign a payment by results tariff contract.

The Trust have assumed that all of the Quality, innovation, productivity and prevention (QIPP) plans which have been shared by their main commissioner are delivered in the year.

The Trust have not seen any detailed plans from their other principal commissioner. However, the projections do assume a similar level of QIPP schemes, in proportion to the income received from their main commissioner, less a reduction to acknowledge there are no supporting plans.

In the subsequent years, the Trust have assumed that their commissioners' QIPP plans will deliver £2.6m of additional income reduction after assumed population growth of 2%.

The Trust have accounted for the reduction in activity through the model by also reducing costs by a marginal rate of 33%. This looks a prudent assumption and the CPT would expect a slightly higher level of marginal cost associated with the work. However, without being able to review the specific plans of the commissioner and with the Trust's SLR data not being detailed at this time, the CPT is unable to give a specific sensitivity on this figure.

Finally, the Trust balance their overall projections to match Monitor's planning assumptions regarding the implied level of efficiency required by FTs. This is achieved by reducing their income accordingly.

### Efficiency savings

Assumption:

- £57m over 5 years

CIPs of £57m are forecast over the period of which 70% (£40m) are pay related and 30% (£17m) are non-pay.

The phasing of the CIPs are as follows:

FY14 - £13.0m

FY15 - £13.0m

FY16 - £10.0m

FY17 - £9.8m

FY18 - £11.5m

This represents a significant challenge for the Trust. The level of CIPs targeted are high, ranging between 5% and 6% of the Trust's costs base with the PFI unitary charge removed.

The Trust have delivered a CIP programme with a value of £13.2m, which is mostly recurrent due to the nature of the savings being driven by controlling costs when faced with increased capacity (as described on page 73) in FY13. This gives some comfort around the organisation's ability to deliver this level of savings. However, a significant proportion of this year's schemes have been driven by productivity efficiency savings where the Trust have been able to reduce unit cost by doing more activity for lower incremental cost. Across the five year forecast, the Trust will need to show a different set of skills to order to reduce costs against a backdrop of declining activity.

## Appendix Q

### Pay inflation

Assumption:

- 2.45% rising to 3.2% p.a.

As part of their budgeting process for FY 14, the Trust have built a “bottom-up” budget from within the directorates. This has built in the actual level of pay inflation in the year, including the 1% cost of living award for FY14.

For the outer years in the model, the Trust has assumed a level of inflation of 2.5% in FY15, rising to 3.2% in FY17 and FY18. This inflation will be required to cover future cost of living increases as well as incremental drift of staff up the banding pay scales.

In comparing the Trust’s assumptions with those of six other FTs whose plans the CPT has recently reviewed for FY14, this assumption is the 2<sup>nd</sup> highest.

### Drug inflation

Assumption:

- 4% p.a.

As part of the “bottom-up” budget which the Trust has built for FY14, there is an assumed level of drug inflation of c2% built into the current year.

In the outer years, the Trust have assumed 4% drug inflation for the duration of the LTFM. In excess of half of the Trust’s drug spend relates to “excluded” drugs, the cost of which is passed through to the commissioner. Therefore the actual level of inflation which the Trust have allowed for on included drugs is in excess of 8%. This is in line with many other foundation trusts.

### Other non-pay expense inflation

Assumption:

- 3.8% falling to 3.2% p.a.

The Trust has forecast other non-pay inflation at 3.8% for FY14, dropping to 3.2% in FY18. When compared to six other trusts that the CPT has worked with recently, this was the third highest rate of inflation used.

### Winter pressures

Assumption:

- £1.5m p.a.

In FY13, additional winter pressures forced the Trust to outsource work to meet its 18 week target. This cost the Trust c.£1.2m and also there was additional expense, particularly in relation to nursing staff, which has caused part of the over-run on agency spend.

The Trust have built in a contingency of £1.5m into the forecast which will increase inline with inflation each year. This is a reasonable assumption based on historic performance, albeit the Trust will be hoping that it will not need to outsource work to the extent that it did in FY13. If activity falls over the five years, as predicted, the CPT would expect the need to outsource elective work in winter to reduce significantly.

### General contingency

Assumption:

- £2m p.a.

The Trust have included a non-specific contingency of £2m within the financial forecasts which is reasonable and which most prudent trusts would include.

# *Efficiency opportunities appendices*

## Appendix R

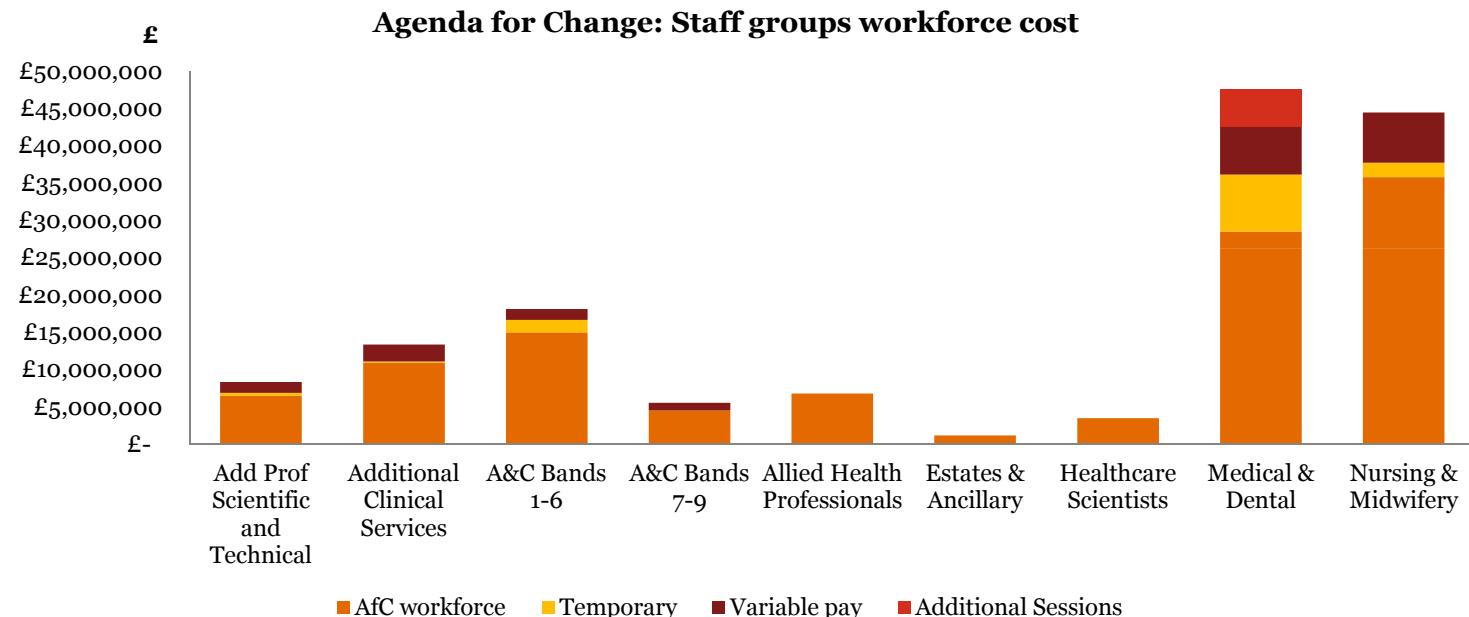
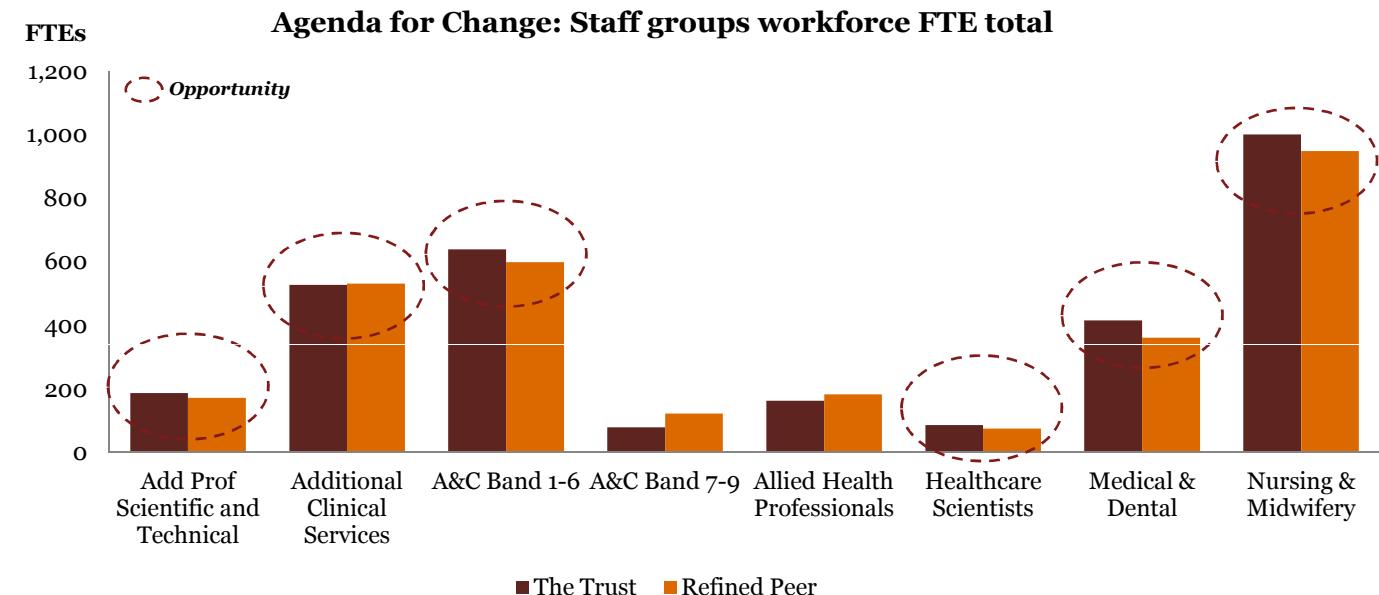
### Workforce efficiency opportunity

The first chart on the right shows the opportunity for workforce efficiency by staff group. The circles represent staff groups that have a larger FTE than the peers and the square represents a staff group with a higher earnings profile than the peers.

The second chart shows how the cost of the workforce is split between types of cost e.g. substantive pay, temporary staff, variable pay (e.g. overtime, unsocial hours etc.)

The two charts show an opportunity to reduce workforce costs by bringing the workforce more into line with peers and reducing expenditure on different types of pay cost such as temporary staff (see page 86).

A description of the typical job titles contained within each staff group is set out in the glossary.



## Appendix S Workforce productivity analysis

### CPT View

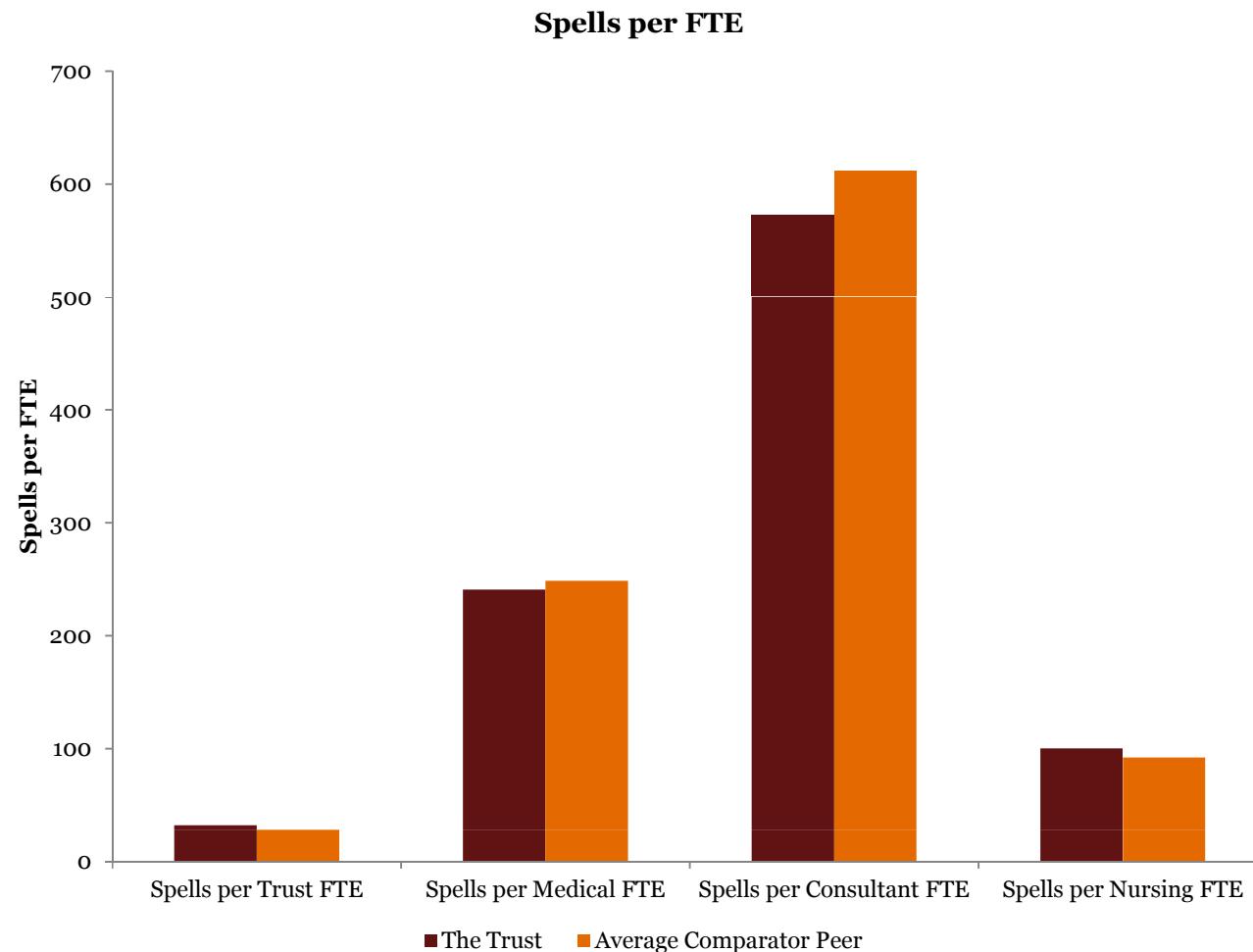
This chart shows the number of spells per FTE for the whole Trust, medical, consultants and nurses.

The chart shows the ratio of FTE per spell. The higher the ratio the more productive the staff.

This analysis shows that the ratio of nursing FTE to spells is above average against the peers and therefore more productive.

The ratio of medical and consultant FTE per spell is lower than the peers and therefore less productive.

The analysis underpins and supports the efficiency opportunity in Appendix S in relation to medical staff.



\*The comparator group used for this analysis is the wider peer group, which includes 20 other trusts who have been matched according to similarity of case mix.

## Appendix T

### Corporate functions

HR, Finance and Occupational Health and Safety function costs are within the bottom quartile of the peer group, whereas Payroll, IT and Procurement costs per FTE are within the top quartile of the peer group.

The corporate function cost saving table highlights the potential opportunity saving if the Trust were to reduce costs in line with the NHS peer median.

The corporate function saving opportunity is £2,112k. In order to avoid any double counting the pay cost opportunity shown here has been adjusted with the workforce benchmarking efficiencies. Therefore the corporate function opportunity is shown as a non-pay corporate cost opportunity of £1,178k.

\*The NHS and public sector peer groups have been selected from data within the Saratoga database.

#### Corporate Function Cost Savings (based on 3,517 FTEs)

	P&S Costs	P&S Function Cost per FTE	NHS Target Result	NHS Target Cost	Potential Cost Reduction
HR	£1,951,774	555	302	£1,062,239.70	£ 889,535
Finance	£2,960,239	842	524	£1,844,271.82	£ 1,115,968
Payroll	£ 267,547	76	109	£ -	£ -
IT	£1,311,938	373	552	£ -	£ -
Procurement	£ 434,453	124	155	£ -	£ -
Occupational Health and Safety	£ 502,889	143	113	£ 396,095.08	£ 106,794
				<b>TOTAL</b>	£ 2,112,297

\*The NHS Target Cost is the median cost per FTE, multiplied by the Trust's function FTEs

#### HR function size and cost

	P&S	NHS peer group			Public sector peer group				Rank
	2012	BQ	Median	TQ	BQ	Median	TQ	Rank	
FTEs per HR FTE (X:1)	80	97	126	150	10	87	112	150	18
HR costs per FTE (£)	555	439	302	242	16	686	427	286	36
HR costs/Total costs (%)	0.84	0.77	0.47	0.39	22	0.71	0.47	0.29	23
HR outsource rate (%)	0.0	2.4	5.1	8.9	LOW	2.3	5.1	8.0	LOW
% HR managers and professionals	53	46	31	25	12	63	52	32	44

#### Finance function size and cost

	P&S	NHS peer group			Public sector peer group				Rank
	2012	BQ	Median	TQ	BQ	Median	TQ	Rank	
FTEs per Finance FTE (X:1)	104	96	106	117	48	32	43	51	46
Finance cost per FTE (£)	842	629	524	436	14	696	504	417	12
Finance costs / Total costs (%)	1.28	1.22	1.05	0.72	13	1.11	0.72	0.69	12
Finance outsource rate (%)	12.8	11.0	14.1	20.9	30	15.7	18.6	24.4	10
% Finance managers and professionals	60.2	39	35	27	8	51	43	32	7

Key: BQ: Bottom quartile (lower end performance)  
 Median: the middle point on the scale between bottom and top  
 TQ: Top quartile (upper end performance)

## Appendix U

### Bed saving opportunities by specialty

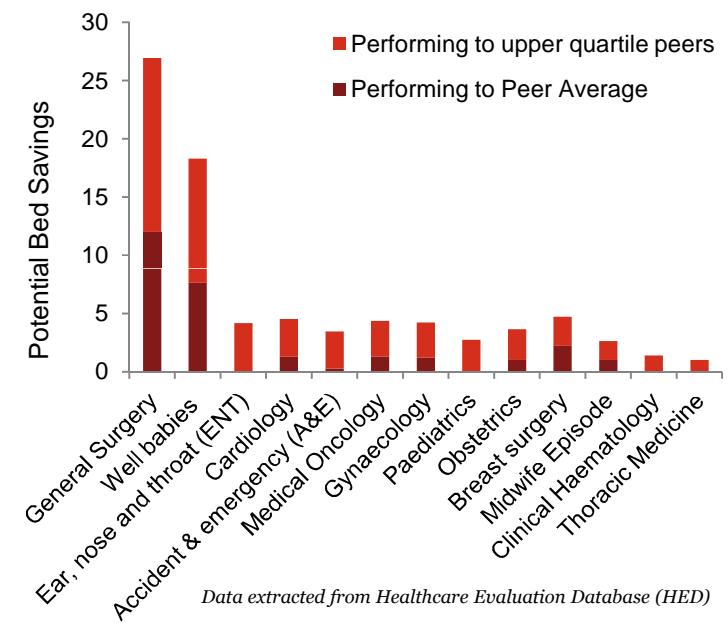
The CPT compared the Trust to a suitable set of peers with similarities in case mix and volume, providing a suitable benchmark against which to assess the Trust. Furthermore, the Trust was benchmarked against its peers by specialty, with average length of stay (ALOS) and day case rates compared to the peer average and upper quartile performance.

Bed days were calculated for the Trust at their current ALOS and day case rate (day case as a proportion of elective admissions). Bed day savings were found through comparing the peer bed days with the Trust's current bed days. Bed savings were calculated by dividing bed day savings by 365.

Decreasing ALOS can generate significant financial benefit, since it can reduce the overall number of beds required by the Trust, or allow for the closure of wards. Increasing the day case rate also results in potential bed savings since, this reduces the requirement to accommodate patients overnight.

At the Trust level, ALOS is four days, which is lower than the peer ALOS of 5.26 days. This does not, however, mean that there is no potential for improvement - as it masks both variation within the Trust at specialty level, and between trusts, with some trusts being better suited to comparison due to their case mix and clinical volume. Similarly, the CPT has identified that the Trust's day case rate of 80.26% is close to the peer average day case rate of 81.24%. While the Trust rate is slightly lower and so does offer some potential for improvement, this may be masking greater potential. This is illustrated on the graph, which displays the potential bed savings at peer average and upper quartile performance.

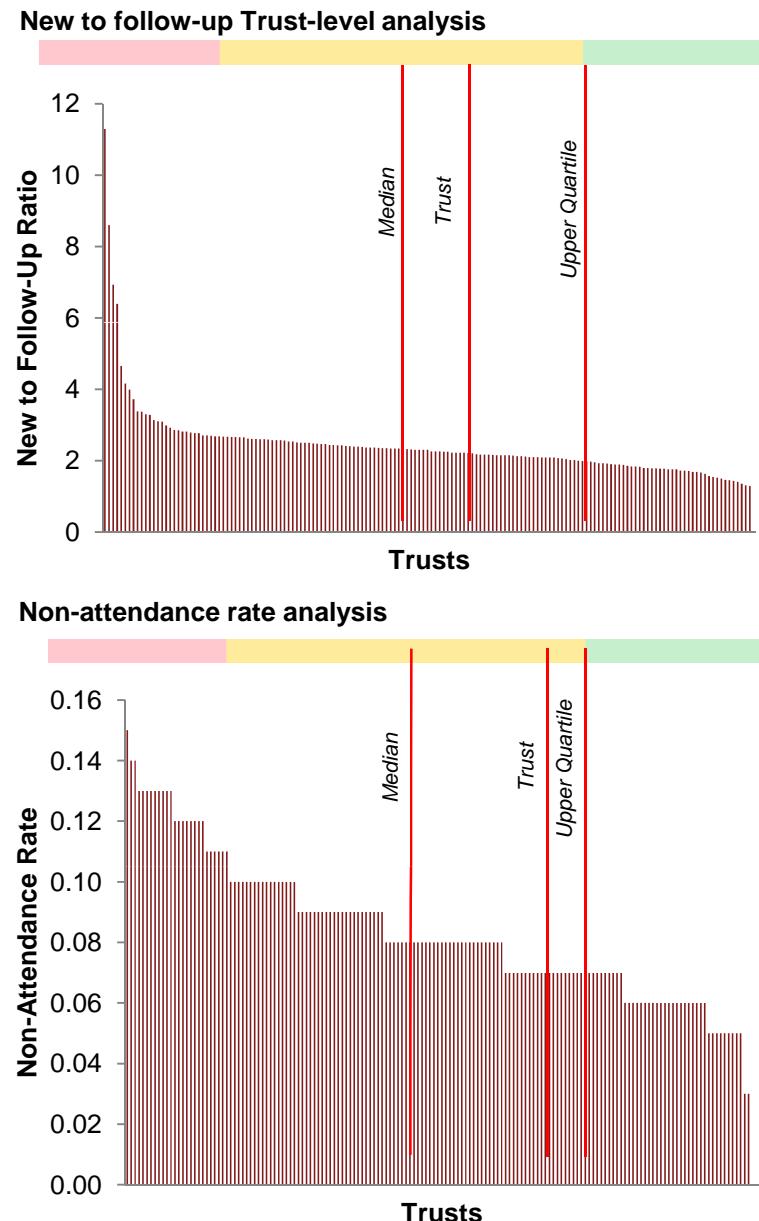
### Potential bed savings by specialty



Overall, the CPT's analysis has identified two specialties with significant opportunity for bed savings. These are General Surgery and Well Babies, with respective potential savings of 12.0 and 7.6 beds at peer average. These two specialties account for approximately three quarters of potential bed savings. Moreover, these bed savings do not take into consideration readmission rates. In addition, closing unnecessary wards bring benefits to patients with shorter bed stays, better in-hospital experience and less chance of hospital acquired infections.

Overall, a saving of 26 – 50 beds has been identified by the CPT. Based upon the Trust's costs of a bed, this would amount to a total potential saving of £0.55-£1.68m.

## Appendix V



## Outpatient efficiency

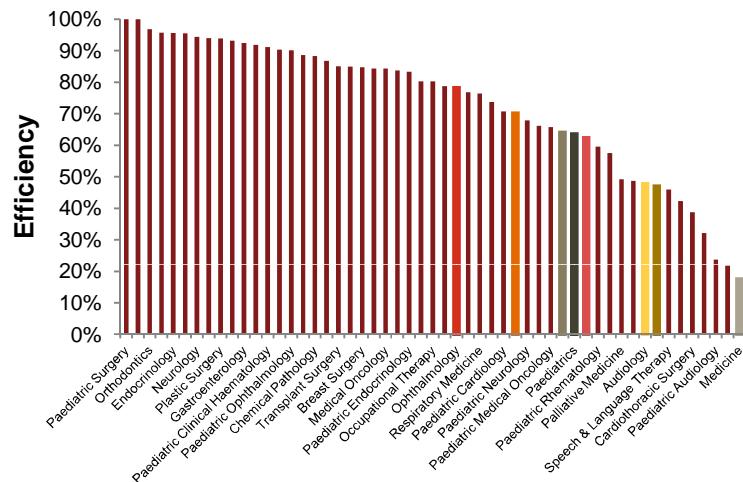
The new to follow-up (top graph) is a ratio of the volume of follow-up attendances to that of new visits. The non-attendance rates (bottom graph) were calculated from the number of non-attendances divided by the number of total planned attendances. This was then benchmarked to the national median and upper quartile performance.

The CPT's analysis allows the Trust to develop a good understanding of the level of efficiency at which its outpatient specialties are operating. It aims to identify opportunities to reduce waste so that the services can perform with greater efficiency.

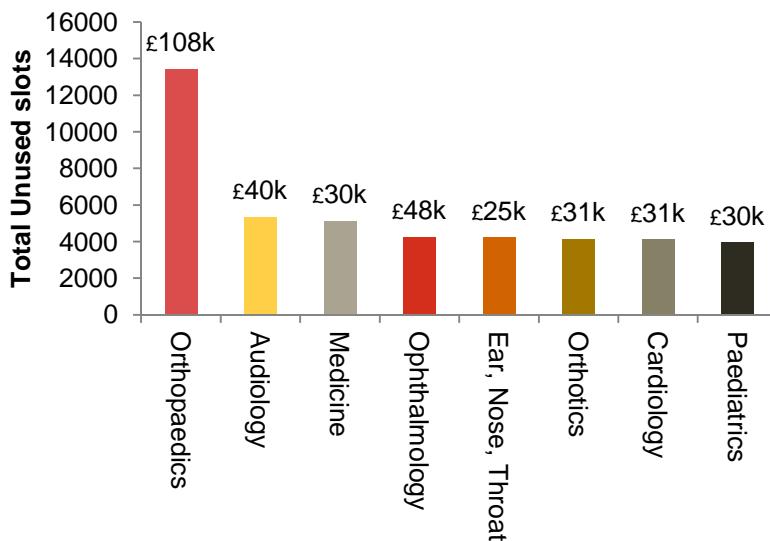
The graphs to the left indicate the new to follow up ratio and non-attendance rate for the Trust in comparison to all acute trusts nationally. The Trust is performing above national median average for its New to Follow-Up activity and at the Upper Quartile Non-Attendance rate.

The CPT drilled-down in to the New to Follow-Up rates at specialty level and shared potential opportunities with the Trust. As such, the Trust is aware of these but can explain the reasoning behind the instances of higher than average New to Follow-Up ratios. Similarly it was felt that non-attendance rates were equally well controlled.

While it may be possible to further improve these measures, the financial value of this would be low. Therefore , the CPT has not pursued analysis of the value of reducing the number of follow up appointments. Instead, the CPT has focussed upon the potential to increase clinical utilisation, as is detailed in the following slide.

**Appendix V (cont)****Clinical utilisation by specialty**

**Top eight specialties by volume of unused clinic slots, including potential savings achieved by reducing the number of scheduled clinics**

**Outpatient efficiency (continued)**

Opportunities to reduce clinic numbers were calculated by comparing the recorded activity levels with the number of planned slots.

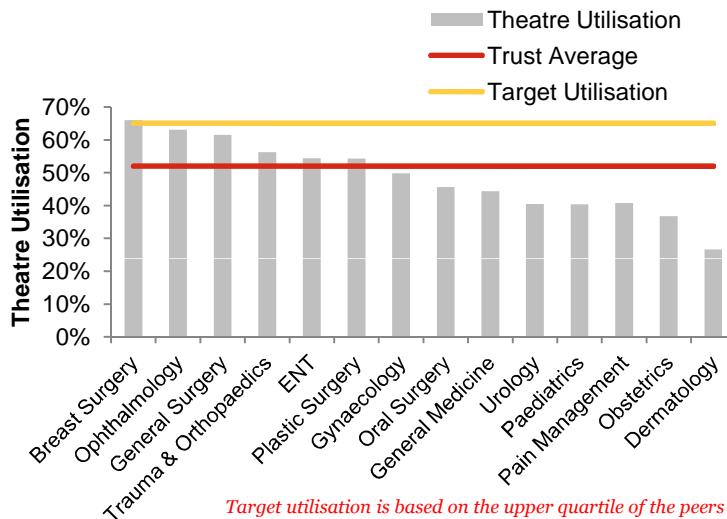
The CPT has identified that five specialties are all running at less than 40% utilisation, with six other specialties at below 50%. By considering low utilisation rates alongside activity volumes, the CPT was able to identify eight specialties (shown in the chart to the bottom left) where there was a financial opportunity to be realised.

Low utilisation is likely arising from specific clinics which have low activity and/or over allocation of clinic time. The CPT believes that where there are aspects of low utilisation the Trust should investigate the root-cause of this to ascertain if scheduling levels are correct.

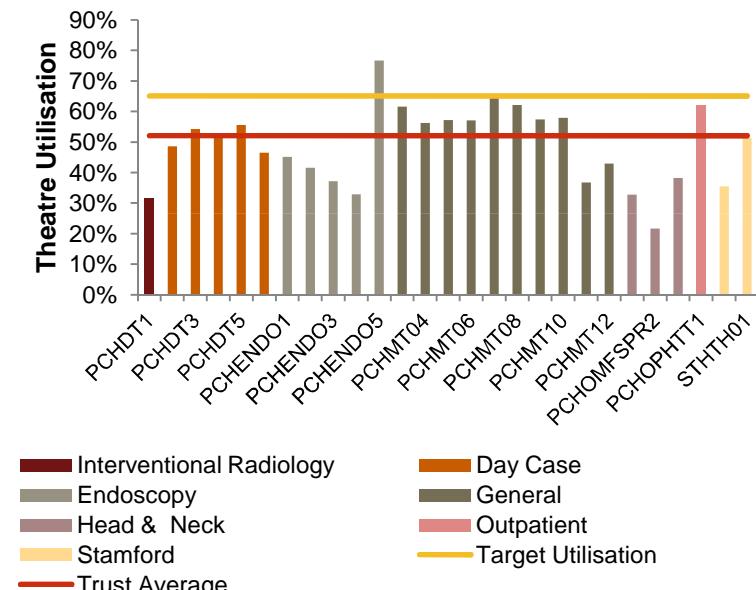
The CPT believes there is an opportunity to reduce the number of clinics, which in turn has an associated financial benefit. Where the cost of specific clinics has been supplied by the Trust, savings were calculated using these costs and a forecast of activity. This forecast was based on the Trust's current activity volume and the Trust's upper quartile utilisation rate, 91%. Cost savings were based on there being 16, 15 minute appointments in an average four hour clinic.

Overall this indicates eight specialties with significant potential for efficiency gains, with a total potential savings of £343k.

## Appendix W Theatre Utilisation by Specialty



## Theatre Utilisation by Theatre



## Theatre utilisation

Theatre utilisation is expressed as the percentage of 'knife to skin' time within a given session. The session length was calculated by the CPT as the planned session length plus the overrun of the session.

CPT analysis of the theatre utilisation by knife to skin time (a common metric to measure the efficiency of theatre utilisation) identifies that the majority of specialties are operating at lower utilisation than the Trust target, with approximately half demonstrating lower than national average utilisation most often due to delayed starts and excessive time between patients.

A breakdown of utilisation by theatre type demonstrated that those theatres which are commonly examined (day case, general and outpatient theatres) demonstrated above average utilisation and are approaching target utilisation. However, those that are less commonly assessed, including endoscopy, interventional radiology and head & neck demonstrated much lower utilisation. This most likely is due to part sessions, with inadequate activity to fill the session time.

Theatre Type	Theatre Utilisation
Interventional Radiology	31%
Day Case	51%
Endoscopy	45%
General	59%
Head & Neck	38%
Outpatient	62%
Stamford	45%

By increasing throughput by clearing waiting lists in the lowest utilised theatres to the national average, or by increasing overall throughput to meet the 65% target the Trust would require an extra 420 sessions. Alternatively, given lower utilisation rates of some theatres, the CPT believes the Trust could consider closing 2 theatres resulting in cost savings of £0.94m.

## Appendix X

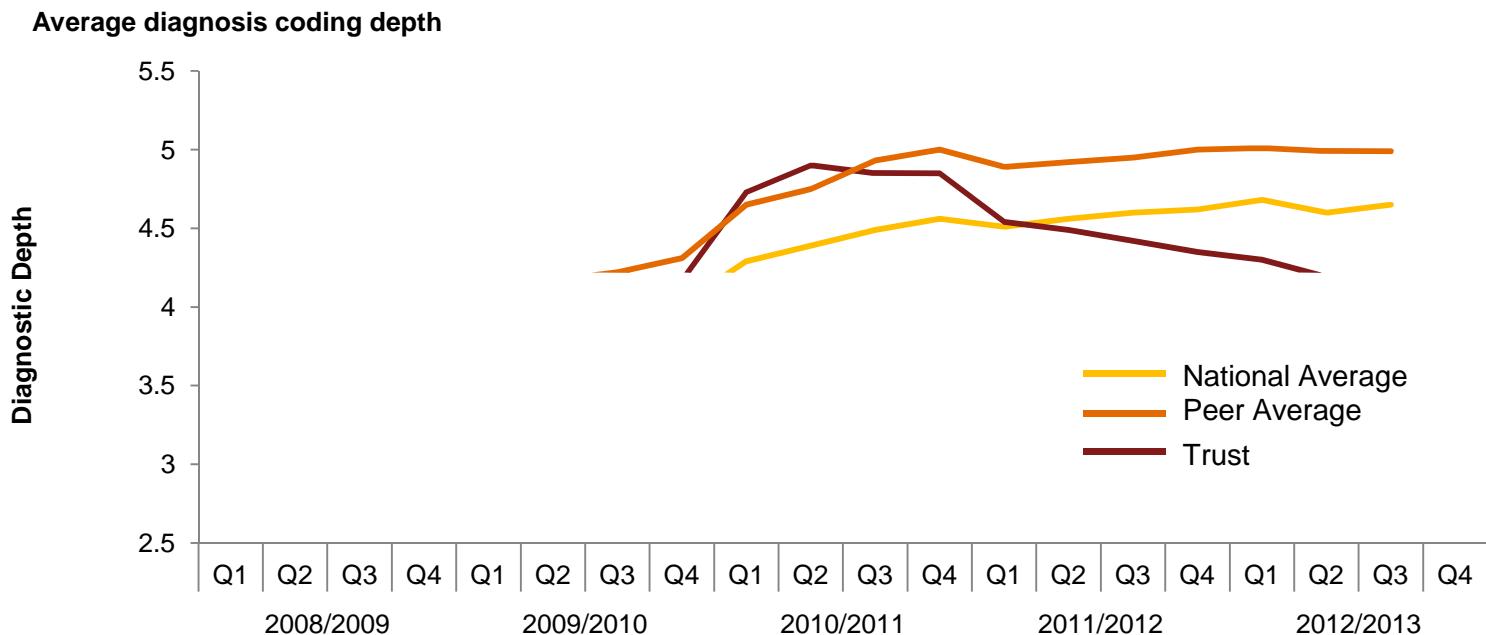
### Clinical coding

Where there is more than one level of complexity for an ailment i.e. without and with complications, the cost increases respectively according to the Payment by Results National Tariff (PbR). From a Healthcare Resource Group (HRG) coding perspective, this is referred to as adjacency. For example:

- FZ12A –General Abdominal - Very Major or Major Procedures with Major co-morbidity (CC)- £5,070 for elective patients
- FZ12B – General Abdominal - Very Major or Major Procedures with Intermediate CC- £2,902 for elective patients
- FZ12C – General Abdominal - Very Major or Major Procedures without CC- £1,922 for elective patients.

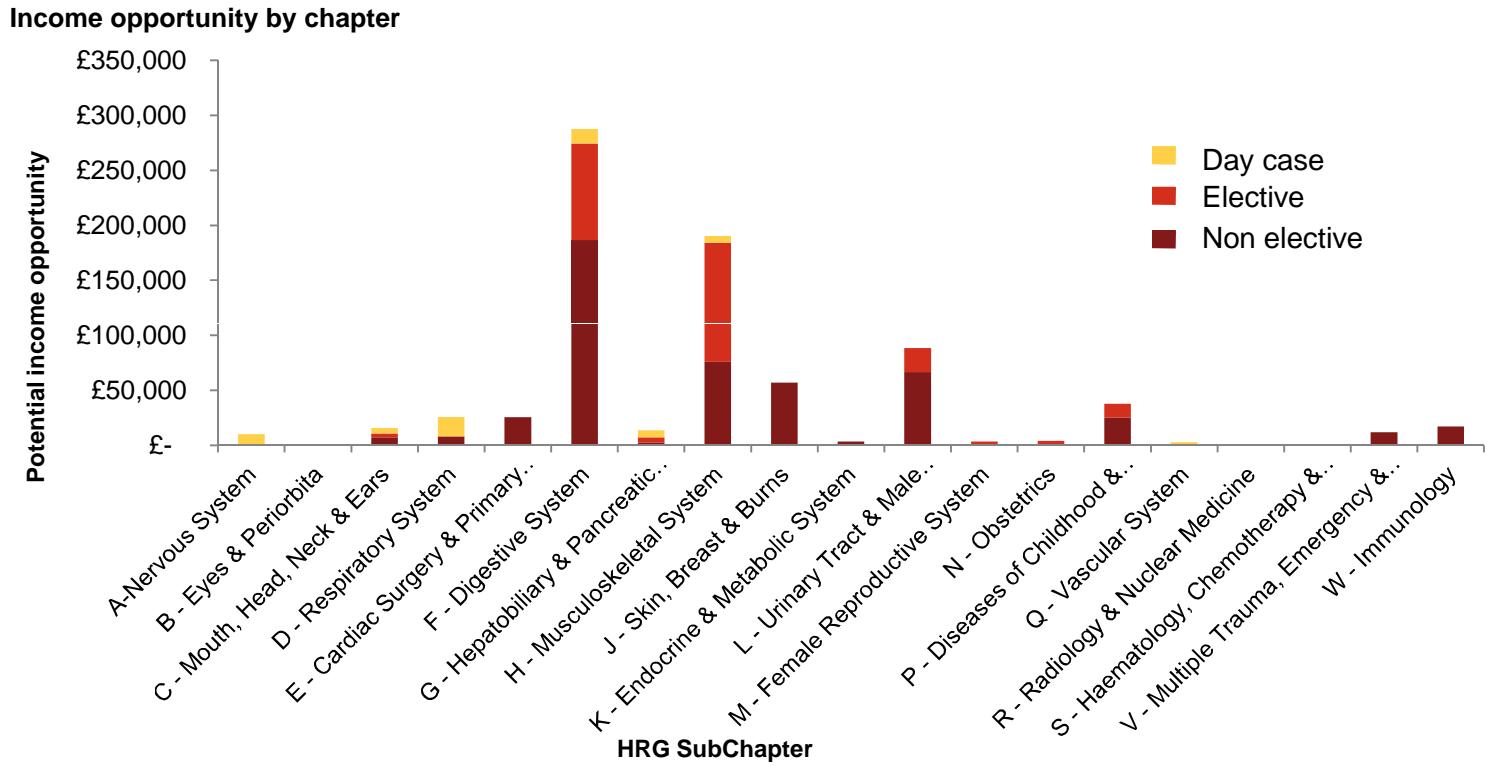
Overall, the Trust's recording of secondary diagnoses has been steadily increasing from Q1 FY 09. The CPT observed a sharp increase from Q3 FY10 to Q2 FY11 but from that point onwards, the diagnostic depth has been declining to Q3 FY13. The Trust's average coding depth was in line with the peers up to the start of the decline, with this trend being apparent for all admission types (Day Cases, Elective and Non-Elective), though elective coding has been found to be displaying the greatest downward trend and exhibits the largest departure from both peer and national average.

The Trust's average diagnosis coding depth was also above the national average before the decline but latterly, for Q3 FY13, it is at 4.09 compared to 4.99 and 4.65 for the peer and national averages.



## Appendix X

### Clinical coding income opportunity



The difference in the Trust's and its Peers' coded activity for each individual HRG was calculated by the CPT.

Where there was adjacency, the number of spells recorded with complexities and comorbidities (CCs) by the Trust was compared to the peer average.

The value of coding to peer average was calculated by the CPT at speciality and point of delivery (DC, EL, NEL) level, where opportunities existed for improvement. This was calculated by applying the PbR tariff to all activity currently not recorded by the Trust up to the peer average activity level. Failure to

adequately capture these secondary diagnoses will result in the commissioner being undercharged for the work performed.

A coding profile has been built using average activity levels per HRG for the last rolling year (extracted from HED) to identify where such under coding occurs and demonstrates that the Trust is undercharging the commissioner by approximately £0.77m per year.

Increasing the coding depth has no effect on patient care as it is purely administrative by nature, rather it entitles the Trust to the money it should rightly receive from the Clinical Commissioning Group.

# *Glossary and terms of reference*

## Glossary

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

<b>Term</b>	<b>Definition</b>	<b>Term</b>	<b>Definition</b>
<b>A&amp;E</b>	Accident and Emergency	<b>FYXX</b>	Financial year ended 31 March 20XX
<b>AfC</b>	Agenda for Change	<b>FYE</b>	Full Year Effect
<b>Capex</b>	Capital expenditure	<b>GRR</b>	Governance Risk Rating
<b>CCG</b>	Clinical Commissioning Group	<b>HCC</b>	Healthcare Commission
<b>CIP</b>	Cost Improvement Plan / Programme	<b>HMRC</b>	Her Majesty's Revenue and Customs
<b>CPT</b>	Contingency Planning Team	<b>I&amp;E</b>	Income and Expenditure
<b>CSIP</b>	Clinical Services Implementation Plan	<b>IBP</b>	Integrated Business Plan
<b>CQC</b>	Care Quality Commission	<b>KPI</b>	Key Performance Indicator
<b>CQUIN</b>	Commissioning for Quality and Innovation	<b>LTFM</b>	Long Term Financial Model
<b>C&amp;P CCG</b>	Cambridge and Peterborough Clinical Commissioning Group	<b>m</b>	Million
<b>DH</b>	Department of Health	<b>NHS</b>	National Health Service
<b>EBITDA</b>	Earnings before Interest, Tax, Depreciation and Amortisation	<b>NCA</b>	Non-contract activity
<b>EWTD</b>	European Working Time Directive	<b>NICE</b>	National Institute for Health and Clinical Experience
<b>FCE</b>	Finished Consultant Episode	<b>NRAF</b>	Net Return After Financing
<b>FM</b>	Facilities management	<b>PBR</b>	Payment By Results
<b>FRR</b>	Financial Risk Rating	<b>PCT</b>	Primary Care Trust
<b>FT</b>	Foundation Trust	<b>PDC</b>	Public Dividend Capital
<b>FTE</b>	Full time equivalent	<b>Peterborough</b>	Peterborough City Hospital
		<b>PFI</b>	Private Finance Initiative

**Glossary**

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

<b>Term</b>	<b>Definition</b>	<b>Term</b>	<b>Definition</b>
<b>PMO</b>	Programme Management Office	<b>WTE</b>	Whole Time Equivalent
<b>PPE</b>	Property, Plant and Equipment	<b>YoY</b>	Year on year
<b>QIA</b>	Quality Impact Assessment		
<b>QIPP</b>	Quality, Innovation, Productivity and Prevention		
<b>RCI</b>	Reference Cost Index		
<b>RPI</b>	Retail Price Index		
<b>SDP</b>	Service Development Plan		
<b>SHA</b>	Strategic Health Authority		
<b>SIFT</b>	Service Increment for Teaching		
<b>SLA</b>	Service Level Agreement		
<b>SLM</b>	Service Line Management		
<b>SLR</b>	Service Line Reporting		
<b>Stamford</b>	Stamford and Rutland Hospital		
<b>The Trust</b>	Peterborough and Stamford Hospitals NHS Foundation Trust		
<b>TSA</b>	Trust Special Administration or Administrator		
<b>WCF</b>	Working Capital Facility		
<b>WLI</b>	Waiting List Initiative		

## Glossary

This slide includes typical job titles within each staff group.

<b>Staff Group</b>	<b>Job Titles</b>	<b>Staff Group</b>	<b>Job Titles</b>
<b>Additional Professional, Scientific</b>	<ul style="list-style-type: none"> <li>• Theatre practitioners</li> <li>• Pharmacy technicians</li> <li>• Operating department practitioners</li> <li>• Day surgery practitioners</li> </ul>	<b>Healthcare Scientists</b>	<ul style="list-style-type: none"> <li>• Biomedical scientists</li> <li>• Audiologist</li> <li>• Healthcare scientists</li> <li>• Mortuary technicians</li> </ul>
<b>Additional Clinical Services</b>	<ul style="list-style-type: none"> <li>• Healthcare assistant</li> <li>• Assistant technical officers</li> <li>• Radiology care assistants</li> <li>• Technical instructors.</li> </ul>	<b>Nursing &amp; Midwifery</b>	<ul style="list-style-type: none"> <li>• Deputy sister</li> <li>• Midwife</li> <li>• Staff nurse</li> <li>• Ward manager</li> </ul>
<b>Administrative &amp; Clerical</b>	<ul style="list-style-type: none"> <li>• Clerical officer</li> <li>• Health records clerk</li> <li>• Medical secretary</li> <li>• Outpatients/appointments clerk</li> <li>• Secretarial assistants</li> <li>• Ward clerk</li> <li>• Operational manager</li> <li>• Administration Manager</li> <li>• Administration Team Leader</li> <li>• HR all roles</li> <li>• Finance all roles</li> <li>• IT all roles</li> <li>• Procurement all roles</li> </ul>	<b>Medical &amp; Dental</b>	<ul style="list-style-type: none"> <li>• Consultant</li> <li>• Foundation Doctor</li> <li>• Specialty doctor</li> <li>• Trust doctor specialty registrar</li> <li>• Registrar</li> </ul>
		<b>Allied Health Professionals</b>	<ul style="list-style-type: none"> <li>• Physiotherapist</li> <li>• Radiographer</li> <li>• Occupational therapist</li> <li>• Sonographer</li> </ul>

## **Terms of reference**

The terms of reference under which the CPT has conducted their 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 their 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 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.