



Strategic Plan Document for 2014-19

Peterborough and Stamford Hospitals NHS Foundation Trust

Strategic Plan Guidance – Annual Plan Review 2014/15

The cover sheet and following pages constitute the strategic plan submission which forms part of Monitor's 2014/15 Annual Plan Review.

The strategic plan must cover the five year period for 2014/15 to 2018/19. Guidance and detailed requirements on the completion of this section of the template are outlined in Section 5 of the APR guidance.

Annual plan review 2014/15 guidance is available [here](#).

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good strategic plan should cover (but not necessary be limited to) the following areas, in separate sections:

1. Declaration of sustainability
2. Market analysis and context
3. Risk to sustainability and strategic options
4. Strategic plans
5. Appendices (including commercial or other confidential matters)

As a guide, we would expect strategic plans to be a maximum of fifty pages in length.

As a separate submission foundation trusts must submit a publishable summary. While the content is at the foundation trust's discretion this must be consistent with this document and covers as a minimum a summary of the market analysis and context, strategic options, plans and supporting initiatives and an overview of the financial projections.

Please note that this guidance is not prescriptive. Foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans (Years one and two of the five year plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

Strategic Plan for y/e 31 March 2015 to 2019

This document completed by (and Monitor queries to be directed to):

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Date	25 June 2014

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and
- The 'declaration of sustainability' is true to the best of its knowledge.

Approved on behalf of the Board of Directors by:

Name (Chair)	Rob Hughes
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Caroline Walker
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Signature



Approved on behalf of the Board of Directors by:

Name <i>(Finance Director)</i>	Dominic Tkaczyk
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Signature

A handwritten signature in black ink, appearing to read 'D Tkaczyk', written in a cursive style.

Declaration of sustainability

The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time.

Not confirmed

While the Trust is clinically and operationally sustainable, the Board cannot confirm financial sustainability over the next five years. We will improve the underlying deficit by deliver a challenging Cost Improvement Programme of 5% and work with commissioners to reduce demand for urgent care (QIPP) to gradually reduce the deficit from £45.0m for FY15 to £31.7m in FY19.

Our three strategic aims are:

- Doing the very best for patients inside our hospitals
- Getting value for money for taxpayers from our hospitals
- Making the most of the hospitals for the future

We have a strategy to improve patient safety and experience, and aim to be in the top hospitals in the country in both areas through delivering year on year improvement in mortality, patient safety thermometer and patient survey scores.

We face two significant challenges in the coming five years: a growing and ageing population and lack the capacity to continue absorbing this demand; and an historic £40m deficit which requires significant action to redress.

We have a high proportion of single inpatient rooms in one of the most modern hospitals in the NHS. With planned investment in the Stamford hospital site and new radiotherapy equipment in Peterborough, we anticipate more patients will choose our Trust for their care.

Our Trust is known for providing safe services and good patient experience. More people are choosing to come here, particularly from South Lincolnshire. We will build on our reputation for quality and positive patient experience, supported by excellent facilities. However, we aim to meet the rising demand for urgent care by working with commissioners and other providers to develop alternatives to urgent hospital care. This will provide better experience for patients who do not need hospital care and more certainty for patients who require elective care as beds remain available for them.

The provider landscape in our area is complex with many Trusts in deficit and some services which cannot continue in their current form, not least because of the introduction of seven day working. As part of the Challenged Local Economy work sponsored by Monitor and NHS England, the providers and commissioners in Cambridgeshire and Peterborough have agreed to work together to develop more detailed plans to significantly change the way services are provided to meet anticipated demand in a sustainable way. We are supportive of this work and will proactively support the development of plans in the coming 12 months.

A competitive tender process under the banner of Project Orange has commenced to offer management of individual services or the whole Trust to interested parties. Project Orange is a key requirement for the all-round sustainability for the Trust and could have a significant positive impact on the local health economy. In 2014/15 the tender will be developed and advertised in the Official Journal of the EU (OJEU) and potential bidders taken through the pre-qualification and competitive dialogue stages, with the intention to bring it to a conclusion by 2015/16.

Our staff are key to delivering ‘Right care; first time; every time.’ We will embed the Trust values throughout the organisation and engage staff in developing and delivering the future direction of the Trust and individual service strategies.

This strategy sets out the Trust direction for the coming five years, the scope of the work involved poses greater uncertainty perhaps than we have experienced for some time, and as such there are elements which are not easily defined. Commissioner intentions arising from the Challenged health economy work are yet to be fully developed, and could impact on services provided by the Trust and other local providers. Project Orange, will have a similar impact on how the Trust is managed in the future. However, the Trust remains committed during this period to continuously improving patient safety and experience, and keeping them at the centre of every decision we make.

Peterborough and Stamford Hospitals NHS Foundation Trust Five Year Strategy

Final version: 24 June 2014

Version control

Version	Date	Edits	Author
1	5 May 2014	First draft	KR
2	29 May 2014	Amends to reflect the CPCCG five year blueprint	KR
2.1	8 June 2014	Chief Executive and DoF review	KR
2.2	13 June 2014	Executive Director review	KR
2.3	16 June 2014	Executive director comments	KR
2.4	24 June 2014	Board comments and approval	KR

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Executive summary

Our vision is:

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

Our three strategic aims are:

- Doing the very best for patients inside our hospitals
- Getting value for money for taxpayers from our hospitals
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We have a strategy to improve patient safety and experience, and aim to be in the top hospitals in the country in both areas through delivering year on year improvement in mortality, safety thermometer and patient survey scores.

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The Trust is known for facing significant financial challenges, and we will continue to make improvements in efficiency where this benefits patients. We will deliver a challenging Cost Improvement Programme of 5% to deliver a gradually reducing deficit from £45.0m for FY15 to £31.7m in FY19.

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Our vision and strategy

Peterborough and Stamford Hospitals NHS Foundation Trust is an acute services provider with two sites at Peterborough and Stamford and a total of 612 beds. The new Peterborough City Hospital operates under a Private Finance Initiative (PFI) scheme.

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

This vision is supported by our strategy which is in three parts (Figure 1). Each part has areas of focus used to plan and monitor progress in delivering the strategy:

Figure 1 - Trust vision and strategy



Strategy development

This strategy is informed by the work of the Contingency Planning Team, subsequent internal and external reviews, and our local health economies five year plans (Figure 2).

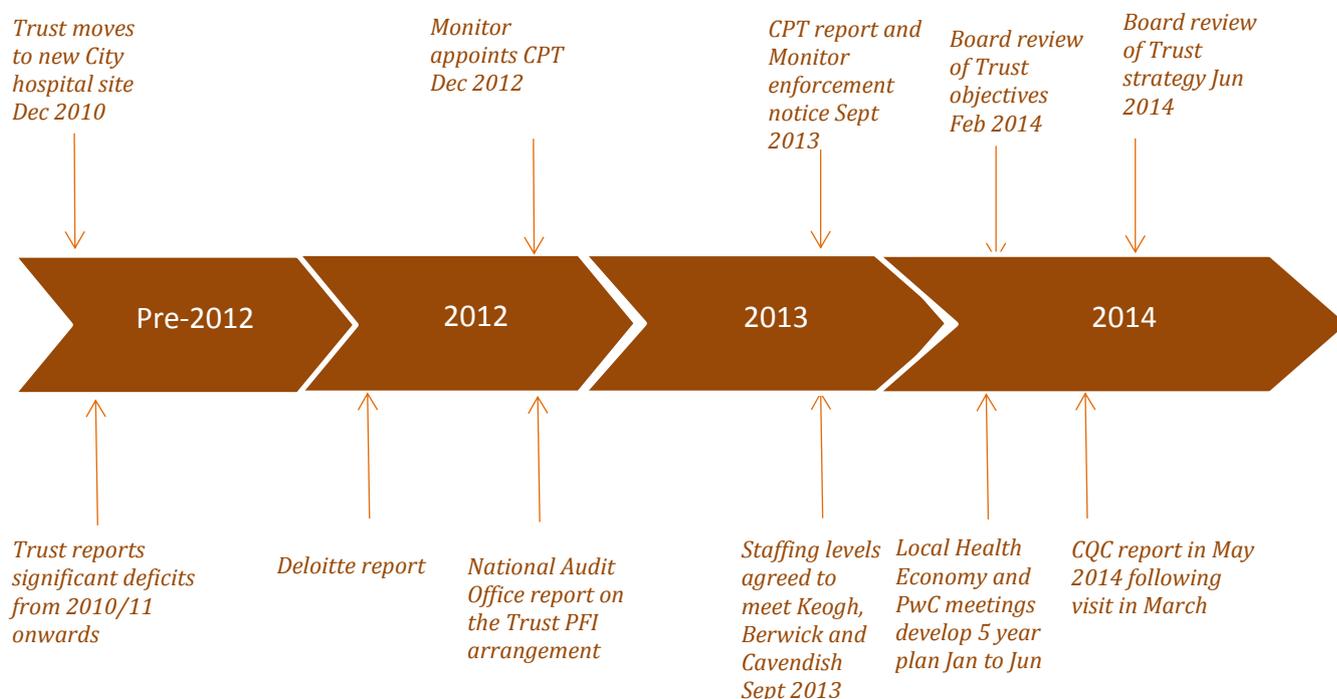
Figure 2 –Reviews contributing to this strategy



Trust reviews

The strategy reflects the reviews conducted during the past 18 months which were primarily in response to the financial challenges faced by the Trust (Figure 3).

Figure 3 – Internal and external reviews which contributed to the strategy



The financial challenges emerged following the move from the old Peterborough City Hospital site to the new PFI building in 2010 and resulted in intervention by Monitor, including the appointment of a contingency planning team.

Contingency Planning Team

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

The CPT produced an in depth analysis¹ of the Trust and concluded that, while clinically and operationally sustainable, Peterborough and Stamford Hospitals NHS Foundation Trust is not financially sustainable in its current form.

This was the result of the Trust's deficit in 2013/14 of approximately £40m and forecasts that showed that in its current form, the size of this deficit would remain for years to come.

Monitor subsequently asked the CPT to identify and evaluate options to address or reduce the Trust's financial deficit, and to recommend a sustainable approach for the delivery of

¹ PwC (2013) *Peterborough and Stamford Hospitals NHS Foundation Trust - Assessment of Sustainability*
<https://www.gov.uk/government/publications/peterborough-and-stamford-hospitals-nhs-foundation-trust-assessment-of-sustainability>

the services operated by the Trust – while keeping patients’ interests at the heart of the solution.

To deliver a sustainable solution, a four-part strategy was developed which requires contributions from all parts of the local health economy, including the taxpayer.

Tackling the inefficiency at the Trust

Implementing a comprehensive cost improvement programme within the Trust and the local health economy (LHE), and working with providers of community and social care to free up bed capacity;

Rapidly progressing joined-up working across the local health economy

Driving cross-health economy working on revised pathways of care, longer-term contracts, capitated budgets and staff incentives;

Making better use of the underutilised estate

Redesigning an element of the physical estate at Peterborough City Hospital to provide additional beds and clinical capacity, and launching a competitive tender designed to maximise the opportunity provided by the Trust’s assets; and

Seeking support from the Department of Health (DH) or other national stakeholders to bridge any residual deficit.

This strategy describes the significant progress in addressing these areas to date, and the future steps we will take to deliver a more financially sustainable Trust.

We will require support from the Department of Health for the foreseeable future, but a joined up approach in the local health economy is a key aspect of ours, and the LHE’s future sustainability.

Other internal reviews

The strategy is also informed by various quality reviews and initiatives, including the Keogh, Berwick and Francis reviews and the most recent CQC report.

National Audit Office

In 2012, the Committee of Public Accounts asked the National Audit Office to at the circumstances underlying the Trust’s serious financial difficulties.

Later that year, the report² was published which highlighted:

- The 2007 Trust board failed to recognise that the PFI scheme would place considerable strains on the Trust’s finances for many years to come.
- The Department evaluated the scheme but was not sceptical enough about its affordability.

² National Audit Office (2012) *Peterborough and Stamford Hospitals NHS Foundation Trust – Report by the Comptroller and Auditor General* Available www.nao.org.uk

- The Trust board and the Department failed to satisfy Monitor's concerns on affordability.
- Monitor, and the Trust board, did not adequately maintain focus on the Trust's financial performance as assumed in the business case, between scheme approval and opening the new hospital.
- The severity of the Trust's financial situation was compounded by weak financial management.
- In 2011-12 the Trust's operating costs were around £58 million (31 per cent) higher than predicted in the scheme's business case. There were three reasons for this:
 - The Trust failed to control its costs in the period following signing of the PFI contract.
 - The business case included unrealistic assumptions about the scope to control costs.
 - The annual payment to the contractor, at 20 per cent of turnover, is broadly in line with the business case, but in absolute terms the outlay is much greater than predicted, partly because the business case included associated cost reductions that have not transpired
- Between 2007 and 2011 the financial projections produced by the executive board proved to be inaccurate
- The Trust's main commissioner did not reimburse the Trust for the entire healthcare it is providing.

Action since the report

In light of the report, the Trust has appointed a new Board and made significant improvement in governance and financial control.

In relation to the contracting issue, the block contract in place in 2012/13 was intended to give both organisations the time and space to develop a more sustainable approach. However, activity was significantly over contracted levels, and the Trust was not being paid for all work undertaken. The National Audit Office report provided evidence that the Trust was being underpaid by £9 million.

When NHS Peterborough and NHS Cambridgeshire 'merged' to form Cambridge & Peterborough CCG, the new, much larger organisation benefitted from economies of scale, and also permitted some re-balancing of financial pressures across Cambridgeshire.

In 2013/14 further moves were made to ensure that the Trust is paid fairly for activity, while agreeing to engage with commissioners to ensure that we are only doing 'the right work'. The early agreement of a single set of 'Commissioning & Contracting Principles', between our Board of Directors, and the Boards of all three new commissioning organisations, has been key to moving this agenda forward.

As a consequence, the 'underpayment gap' was closed in the 13/14 contract, primarily through:

- Negotiating the move from a 'block' to a 'cost & volume' (PbR) contract with Cambridge & Peterborough CCG

- Implementing a standardised structure / hierarchy for pricing non-PbR activity (phased over three years,) again, uniformly applied to all three NHS contracts
Developing Activity Plans that are based on statistically evidenced activity run-rates, with adjustments then applied for population growth, Trust planned service changes, and commissioner QIPP schemes.

Care Quality Commission

The Care Quality Commission visited the Trust in March 2014 as part of the new inspection regime. They found many services which were rated as good, but that overall the Trust requires improvement. The areas for improvement were mainly in medical care and A&E (Figure 4).

Figure 4 - Trust CQC report 2014

Ratings:						
Location name:	Peterborough City Hospital					
	Safe	Effective	Caring	Responsive	Well led	Overall service
A&E	RI	NA	G	RI	G	RI
Medical care	RI	RI	RI	RI	RI	RI
Surgery	G	G	G	G	G	G
Intensive/Critical care	G	G	G	G	G	G
Maternity & Family Planning	G	G	G	G	G	G
Services for Children & Young People	G	G	G	RI	G	G
End of Life care	G	RI	G	G	G	G
Outpatients	G	NA	G	G	G	G
Overall domain	RI	RI	G	RI	G	n/a
Overall location	RI					

Location name:	Stanford Hospital					
	Safe	Effective	Caring	Responsive	Well led	Overall service
A&E	G	NA	G	G	G	G
Medical care	G	G	G	G	G	G
Surgery	G	G	G	G	G	G
Outpatients	G	NA	G	G	G	G
Overall domain	G	G	G	G	G	n/a
Overall location	Good					

Trust name:	Peterborough and Stamford Hospitals NHS FT				
	Safe	Effective	Caring	Responsive	Well led
Domains at trust	RI	RI	G	RI	G
Overall trust	RI				

Safety

Most Trust services are safe with systems to raise concerns and incidents, and staff know how to do this. Incidents are reviewed and lessons learned are shared with staff. The inspectors recognised that there are plans to provide dedicated space for children in A&E and they supported the implementation.

The hospitals are clean with good infection control in place, they recommended that we improve access to hand gels at Peterborough City Hospital.

One area the Trust has focused on is the reduction of falls which is linked to the high percentage of single rooms in the new building. The CQC acknowledged that falls are above the national average at Peterborough City Hospital and recommended that we continue work to reduce them.

Effectiveness

The trust uses a range of measures to ensure that patients receive good care including the Safety Thermometer and local monitoring of call bell response times. The findings of this monitoring are shared with staff and acted upon to improve care. The trust uses national guidance to improve patient care. Outcomes for patients are good in most areas apart from stroke care where improvements are needed. The trust needs to improve engagement in national clinical audits, and delays in providing pain relief at the end of life need to be reduced.

Caring

The review found that staff are very caring and involved patients in their care and in the care of loved ones. Generally, patients were treated with sensitivity and respect.

Responsive

Whilst most patients received care that met their needs once they had been admitted to the appropriate ward areas, a number of patients had to be admitted onto a ward that had a bed available rather than onto a ward that met the needs of the patient, resulting in delays in receiving the best care.

The four-hour wait target in the A&E department and target times for referral to treatment, are two areas for improvement. The hospital was in line with national expectations for the number of cancelled operations.

There was a backlog of complaints and we need to improve how we learn lessons from complaints.

Action has been taken to meet the mental health needs of patients; but this should be extended to include children and young people.

Well led

Trust values are visible in the actions and behaviour of staff, with caring staff who work efficiently together and with other stakeholders. There is a good awareness of risk and risk management.

The senior leadership team are visible and staff know who to report issues to. Most staff feel supported in raising issues although not always certain that action will be taken.

The trust uses the experience of external reviews to improve services for patients and staff. There is a quarterly 'Learning from Lessons' event for staff and the board members undertake the '15 Steps Challenge' and night visits to ward areas, with findings displayed on several wards.

Trust Board review of objectives 2014

The Trust Board review the Trust objectives in early 2014. Seven objectives were developed through engagement with senior clinical leaders, the Trust Board and the Council of Governors and are supported by directorate and specialty level plans. They are:

1. Be in the top quartile safest district general hospitals in England
2. Be in the top 20% of Trusts for patient care and experience
3. Be an effective Trust and meet performance standards
4. Have a productive workforce equipped, skilled and motivated to provide the highest quality care
5. Ensure that the Trust is well run and well led
6. Deliver our financial targets
7. Achieve all round 'sustainability' for PCH and Stamford Hospital

Five year plans of our local commissioners

We recognise that the challenges faced by the Trust and the wider health economies in which we operate can only be addressed through joint work involving all health and social care providers and commissioners in our local health economies.

We have worked with our main commissioners in developing their draft five year strategic plans (Figure 2), and the key assumptions and proposals are reflected in this strategy.

Market analysis

The population we serve

We provide a full range of District General Hospital (DGH) services and some regional specialties for a catchment area of just over 500,000 people living in Peterborough, North and East Cambridgeshire, South Lincolnshire, and East Leicestershire and Rutland (Figure 5).

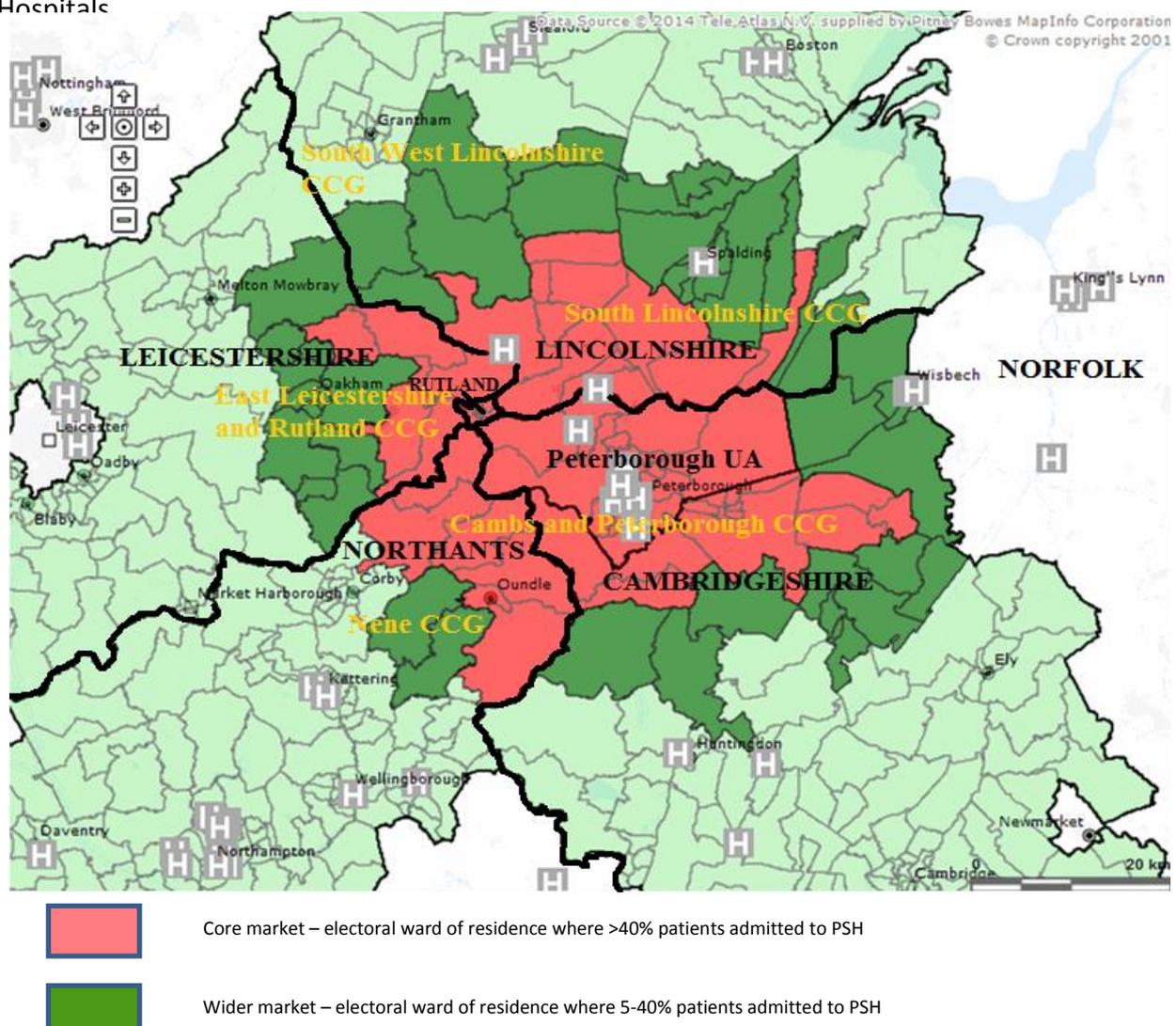
Figure 5 - Trust catchment population

2012 populations served by PSH	Cambridgeshire and Peterborough CCG	South Lincolnshire CCG	East Leicestershire and Rutland CCG	Total
Core area	257,713	66,375	13,523	337,611
Wider area	58,562	75,719	25,035	170,064

Our core and wider catchment areas are shown in Figure 6. These are defined by the number of people who were admitted as inpatients to our Trust during the past three years. In our core area, more than 40% of people from an electoral ward who needed inpatient treatment were cared for in our hospitals. In the wider area, between 5 and 40% of people were treated here rather than another Trust.

Figure 6 - Core and wider areas served by Peterborough and Stamford

Hospitals



Demographic profile

The population we serve has a varied demographic profile. Peterborough is predominantly urban with 26% of the population living in the most deprived areas in the country.

Deprivation in Cambridgeshire is lower than the national average and parts of South Kesteven have some of the least deprived populations.

Although Peterborough suffers more deprivation than Cambridgeshire there are significant areas of deprivation in Fenland, North East Cambridge and North Huntingdon. All three areas are served by the Trust.

Peterborough

Peterborough has a predominantly urban population with 26% of residents living in the most deprived areas in the country (Dogsthorpe and East Wards).

People living in Peterborough are generally in poorer health than the average English population (

Figure 7). Deprivation is higher than average and about 9,500 children live in poverty. Life expectancy for men is lower than average. Life expectancy is 9.4 years lower for men and 5.6 years lower for women in the most deprived areas of Peterborough than in the least deprived areas.

Over the last 10 years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen, but is still worse than average.

In school Year 6, 19.2% of children are classified as obese. Levels of teenage pregnancy, GCSE attainment and smoking in pregnancy are worse than average. The estimated level of adult smoking is worse than average as are rates of road injuries and deaths, and hospital stays for alcohol related harm.

The level of alcohol-specific hospital stays among those under 18 is better than average.

Priorities in Peterborough include reducing premature mortality, reducing inequalities in coronary heart disease and promoting healthy lifestyles.

Figure 7 - Peterborough health profile

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	62988	34.1	20.3	83.7	[Red dot]	0.0
	2 Proportion of children in poverty	9470	23.5	21.1	45.9	[Red dot]	6.2
	3 Statutory homelessness	267	3.7	2.3	9.7	[Red dot]	0.0
	4 GCSE achieved (5A*-C Inc. Eng & Maths)	1097	49.3	59.0	31.9	[Red dot]	81.0
	5 Violent crime	3403	19.6	13.6	32.7	[Red dot]	4.2
	6 Long term unemployment	1398	11.6	9.5	31.3	[Red dot]	1.2
Children's and young people's health	7 Smoking in pregnancy ‡	476	16.8	13.3	30.0	[Red dot]	2.9
	8 Starting breast feeding ‡	2109	74.5	74.8	41.8	[Yellow dot]	96.0
	9 Obese Children (Year 6) ‡	391	19.2	19.2	28.5	[Yellow dot]	10.3
	10 Alcohol-specific hospital stays (under 18)	14	35.5	61.8	154.9	[Green dot]	12.5
	11 Teenage pregnancy (under 18) ‡	153	44.5	34.0	58.5	[Red dot]	11.7
Adult health and lifestyle	12 Adults smoking	n/a	23.7	20.0	29.4	[Red dot]	8.2
	13 Increasing and higher risk drinking	n/a	21.0	22.3	25.1	[Yellow dot]	15.7
	14 Healthy eating adults	n/a	28.0	28.7	19.3	[Yellow dot]	47.8
	15 Physically active adults	n/a	56.6	56.0	43.8	[Yellow dot]	68.5
	16 Obese adults ‡	n/a	24.9	24.2	30.7	[Yellow dot]	13.9
Disease and poor health	17 Incidence of malignant melanoma	26	16.2	14.5	28.8	[Yellow dot]	3.2
	18 Hospital stays for self-harm	551	297.4	207.9	542.4	[Red dot]	51.2
	19 Hospital stays for alcohol related harm ‡	4310	2302	1895	3276	[Red dot]	910
	20 Drug misuse	1445	12.0	8.6	26.3	[Red dot]	0.8
	21 People diagnosed with diabetes	8413	5.9	5.8	8.4	[Red dot]	3.4
	22 New cases of tuberculosis	45	25.9	15.4	137.0	[Red dot]	0.0
	23 Acute sexually transmitted Infections	1463	793	804	3210	[Yellow dot]	162
	24 Hip fracture in 65s and over	180	538	457	621	[Yellow dot]	327
Life expectancy and causes of death	25 Excess winter deaths ‡	98	22.3	19.1	35.3	[Yellow dot]	-0.4
	26 Life expectancy – male	n/a	77.7	78.9	73.8	[Red dot]	83.0
	27 Life expectancy – female	n/a	82.6	82.9	79.3	[Yellow dot]	86.4
	28 Infant deaths	13	4.3	4.3	8.0	[Yellow dot]	1.1
	29 Smoking related deaths	238	208	201	356	[Yellow dot]	122
	30 Early deaths: heart disease and stroke	133	77.7	60.9	113.3	[Red dot]	29.2
	31 Early deaths: cancer	179	106.1	108.1	153.2	[Yellow dot]	77.7
	32 Road injuries and deaths	90	49.3	41.9	125.1	[Red dot]	13.1

‡ For comparison with PHOF Indicators, please go to the following link: www.healthprofiles.info/PHOF

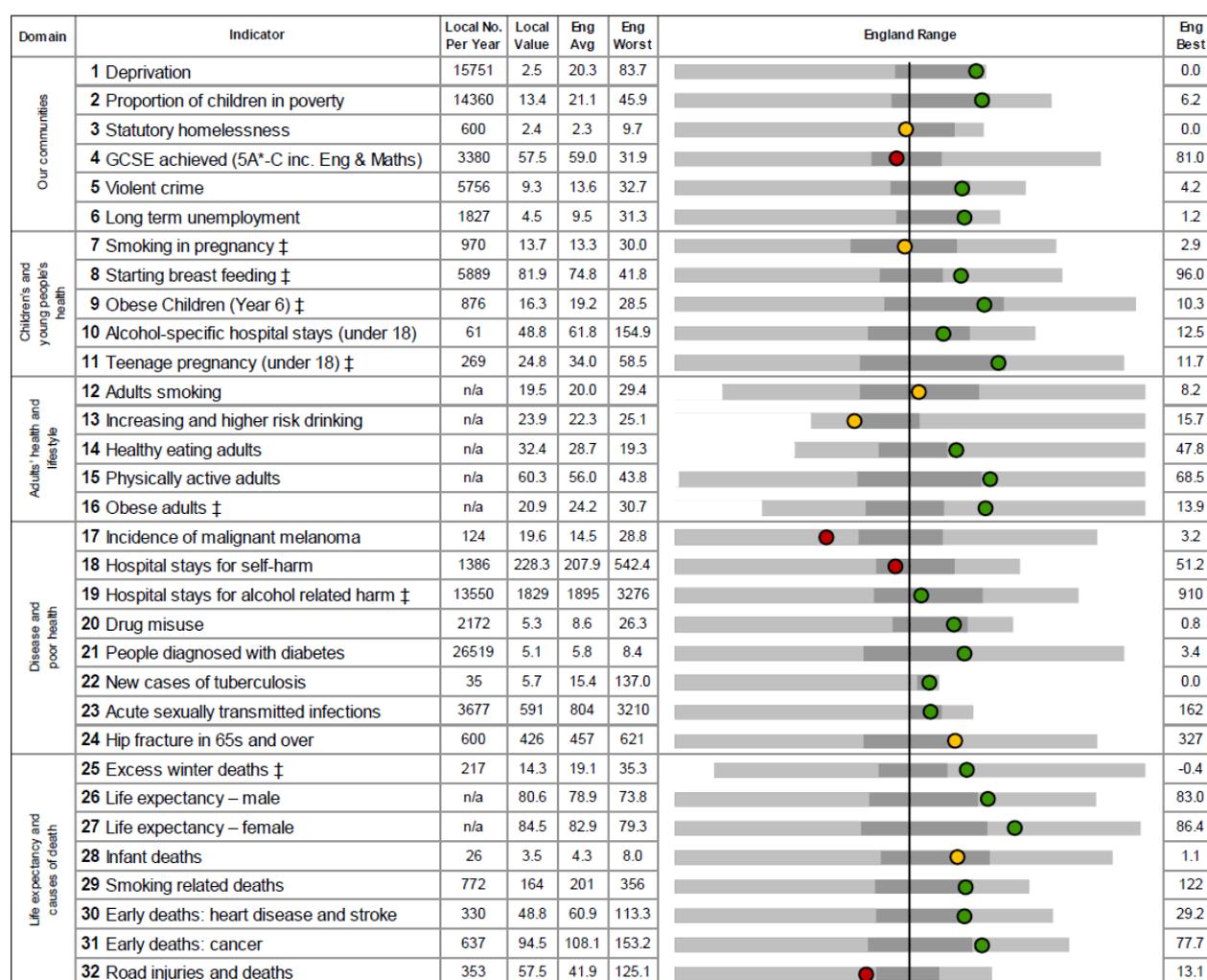
Cambridgeshire

The health of people in Cambridgeshire is generally better than the average for England. Deprivation is lower than average, however about 14,400 children live in poverty (Figure 8). Life expectancy for both men and women is higher than average. Life expectancy is 7.2 years lower for men and 5.3 years lower for women in the most deprived areas of Cambridgeshire than in the least deprived areas.

- Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than average
- In Year 6, 16.3% of children are classified as obese, better than the average.
- The level of GCSE attainment is worse than the England average
- Levels of teenage pregnancy, alcohol-specific hospital stays among those under 18 and breast feeding are better than average

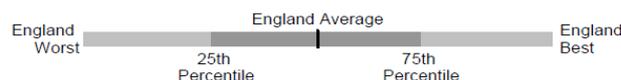
- Estimated levels of adult 'healthy eating', physical activity and obesity are better than average
- The rate of road injuries and deaths is worse than the England average
- Rates of sexually transmitted infections and smoking related deaths are better than average
- Rates of incidence of malignant melanoma and hospital stays for self-harm are worse than average

Figure 8 - Cambridgeshire health profile



‡ For comparison with PHOF Indicators, please go to the following link: www.healthprofiles.info/PHOF

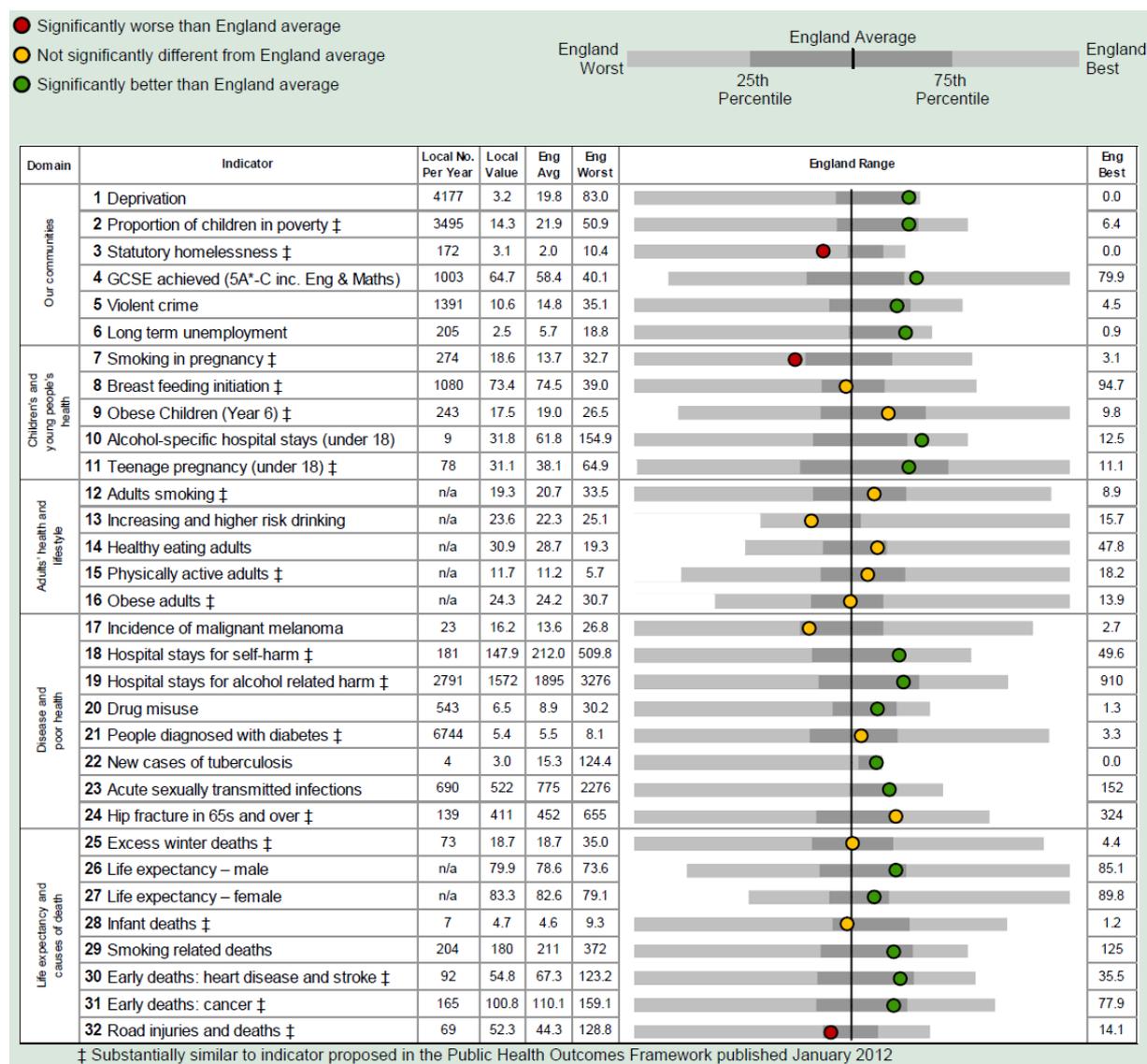
- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



South Kesteven

The health of people in South Kesteven is generally better than the English average (Figure 9). Deprivation is lower than average, although about 3,500 children live in poverty. Life expectancy for both men and women is higher than average.

Figure 9 - South Kesteven health profile



Life expectancy is 8.6 years lower for men and 5.0 years lower for women in the most deprived areas of South Kesteven when compared with the least deprived areas.

Over the last 10 years, all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and is better than average.

About 17.5% of Year 6 children are classified as obese. The level of smoking in pregnancy is worse than average and alcohol-specific hospital stays is better (lower) than average. Levels of teenage pregnancy, GCSE attainment and alcohol-specific hospital stays among those under 18 are better than average.

An estimated 19.3% of adults smoke and 24.3% are obese. The rate of road injuries and deaths is worse than average. Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are better than average. The rate of statutory homelessness is higher than average.

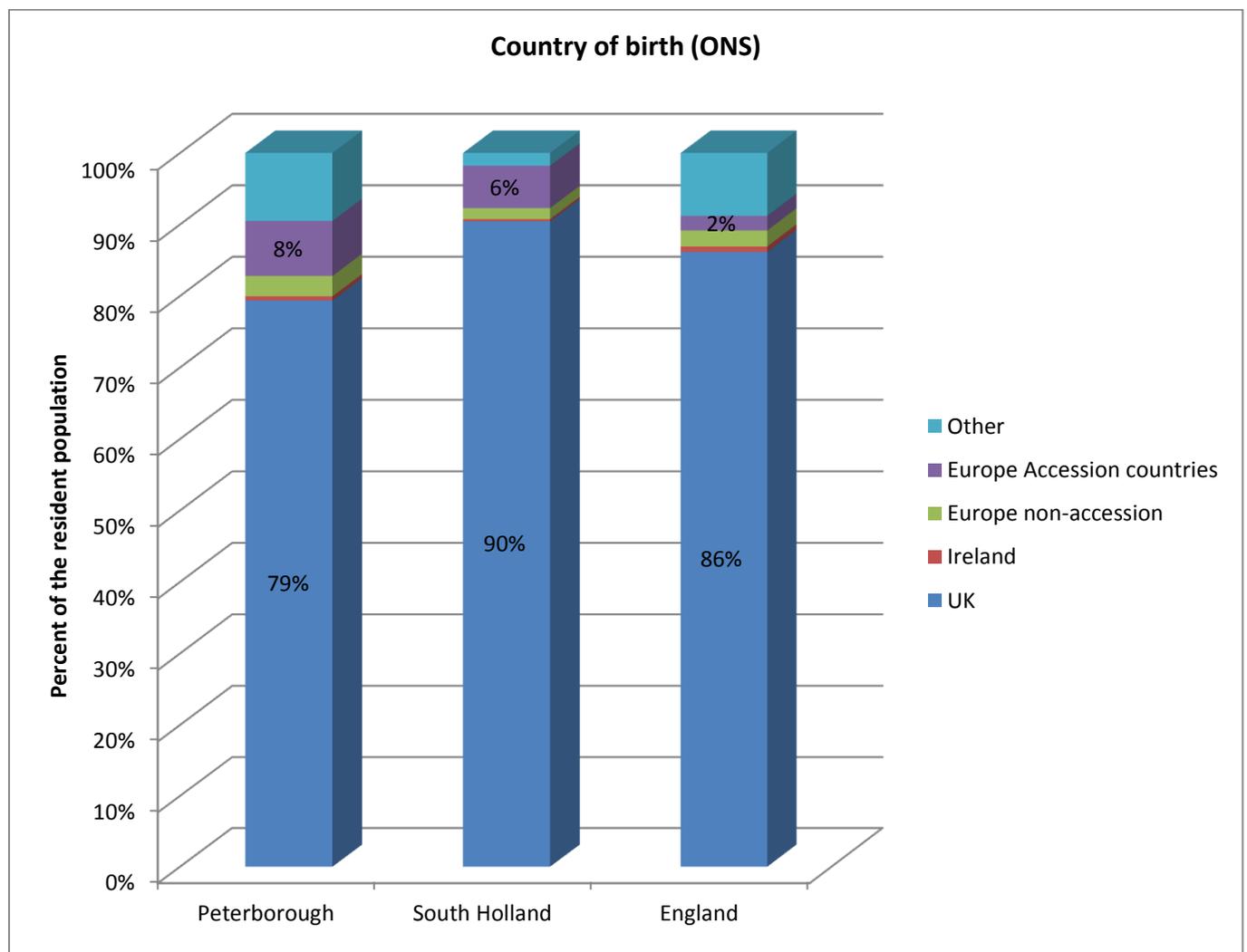
Priorities in South Kesteven include tackling alcohol and tobacco abuse, and obesity.

Migrant population

Changes in the migrant population add to the complexity of how services are provided. International migrants in Cambridgeshire and Peterborough come from all over the world and with different socio-economic backgrounds.

According to the Office for National Statistics (ONS), the most common countries of origin for migrant workers registering in Cambridgeshire and Peterborough in both 2010 and 2011 were Lithuania, Latvia, and Poland, three of the eight countries which acceded to the EU in 2004 (Figure 10). South Holland has three times the national average proportion of their population who were born in the accession countries.

Figure 10 - Country of birth for populations in Peterborough and South Holland



Population growth

The population in our core catchment will grow at a faster rate than the national average (Table 1). The Office for National Statistics forecasts growth of by 5.7% in the next five years compared with the national average of 5.1%, and 4.9% for the East of England.

Table 1 - Forecast population growth 2014 to 2019

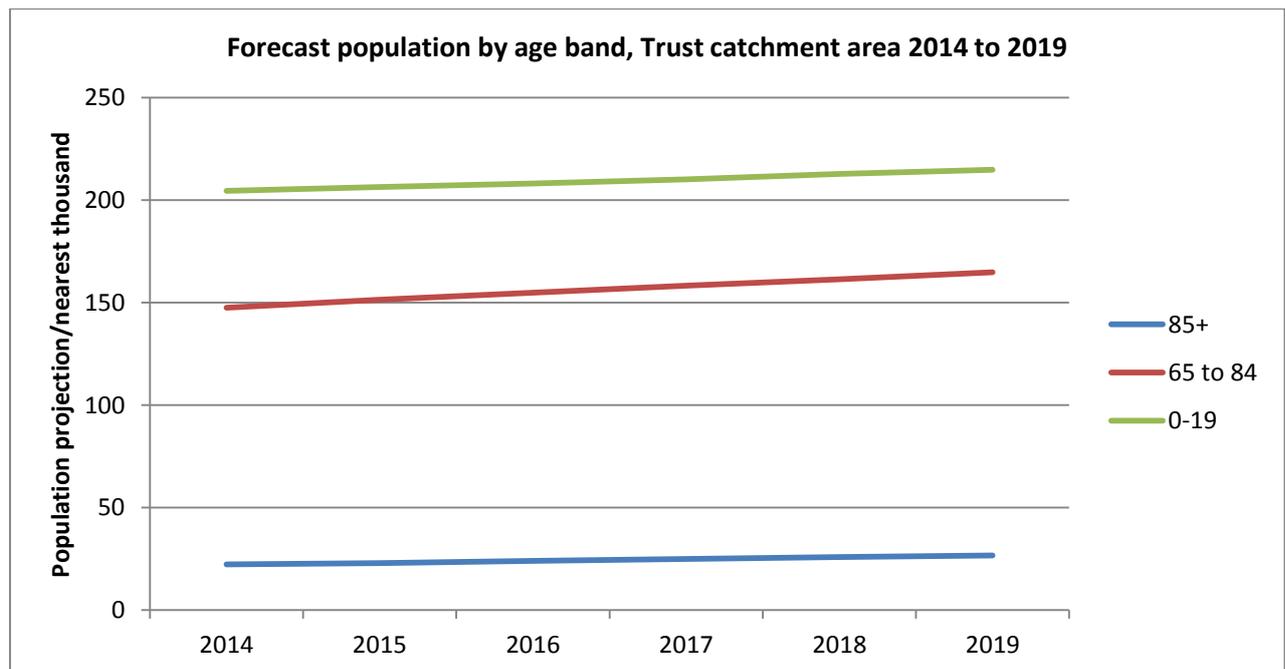
Area	Whole population/ '000s			Population forecast over 85/'000s		
	2014	2019	% change	2014	2019	% change
England	53,493	56,198	5.1%	1,221	1,506	23.3%
East of England	6,003	6,295	4.9%	161	192	18.7%
PASH catchment area	869	919	5.7%	22.3	26.7	19.7%

Peterborough’s population is younger than the national average and although we will experience significant growth in the population over the age of 85, we anticipate that this will be below the national average.

Based on ONS projections (Figure 11), in the next five years we will experience:

- Below average growth in the over 85 age group of just under 20% compared with the national average of over 23%
- Higher than average growth in the 65 to 84 age group, 17.3% compared with 14.6%; and
- Above average growth in the 0-19 age group, with an increase of 5% compared with the 3.5% national average

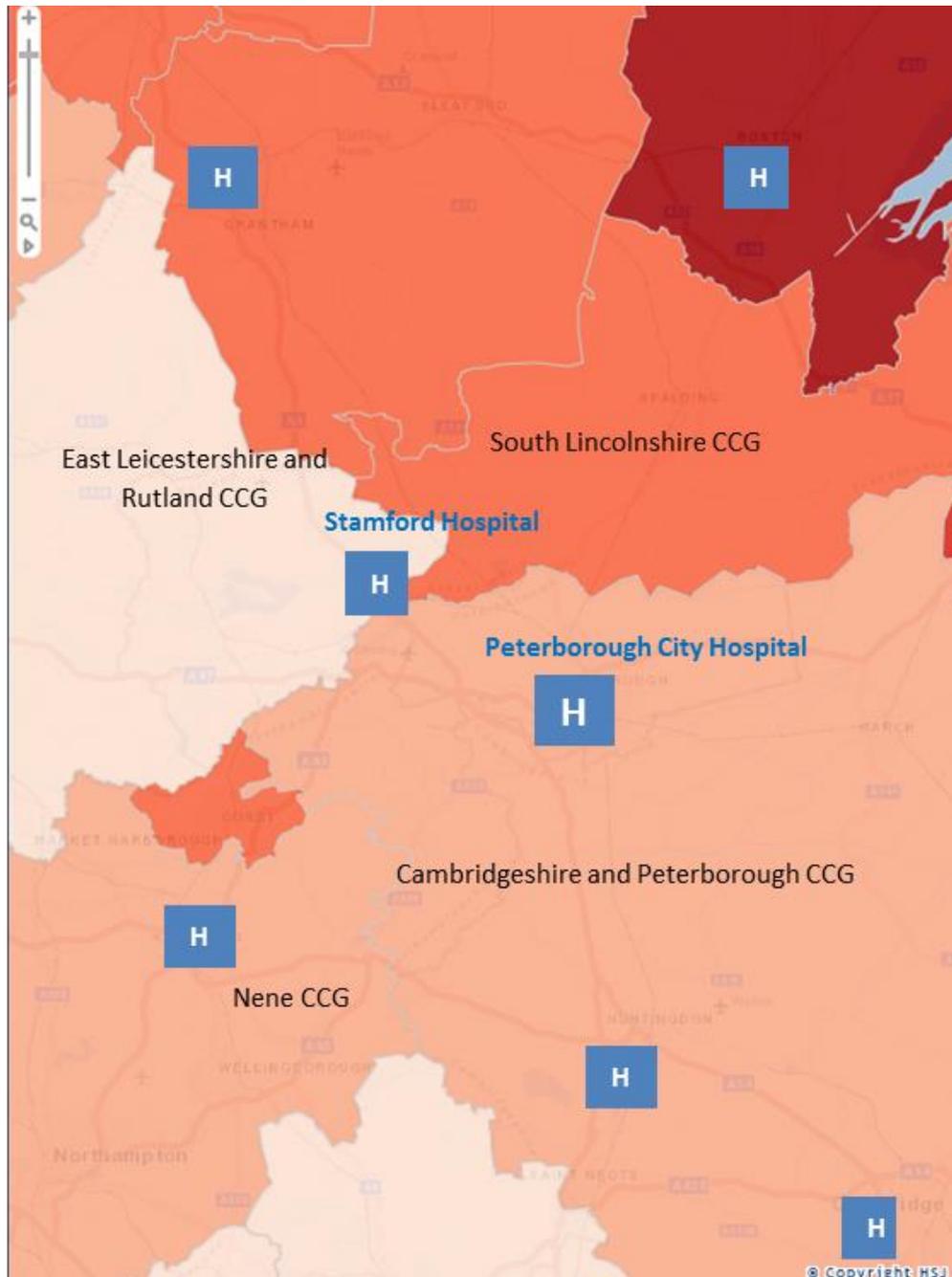
Figure 11 - ONS forecast population growth for Trust catchment area



Commissioners

Trust combined contract clinical income for 2014/15 is £205m. Our local clinical commissioning groups (CCG) are Cambridgeshire and Peterborough CCG, South Lincolnshire CCG, and East Leicestershire and Rutland CCG (Figure 12).

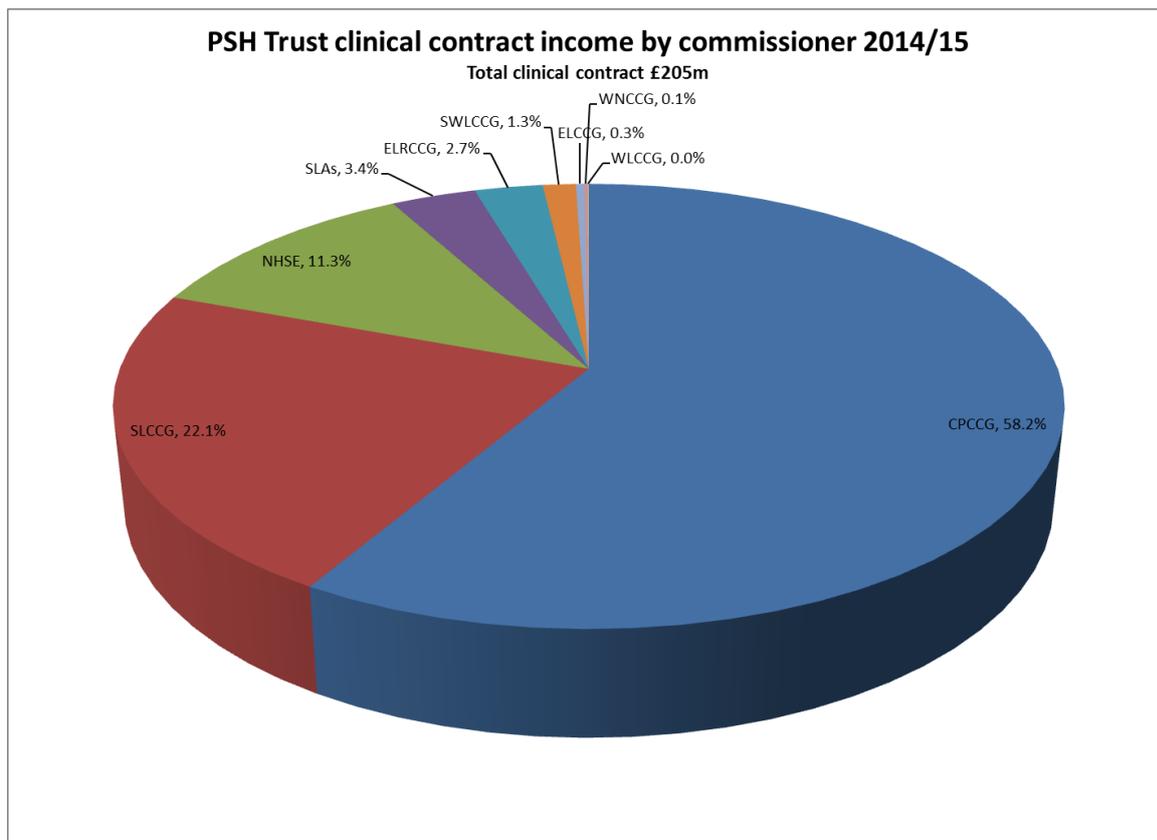
Figure 12 - Trust local commissioners



Our main commissioners are Cambridgeshire and Peterborough CCG with a total contract value of nearly £120m representing 58% of our clinical income (Figure 13).

South Lincolnshire CCG is our second largest commissioner. They commission services for people living in South Holland and South Kesteven, and the value represents 22% of Trust income.

Figure 13 - Trust clinical contract by commissioner



Specialised commissioning by NHS England includes:

- Specialised services £16.5m
- Dental services £3.6m
- MoD specialised services £1.6m
- Screening services £1.4m
- Prison services £0.17m

The Trust has service level agreements with various partners including local primary care and mental health providers, totalling nearly £7m. East Leicestershire and Rutland CCG commissions the Trust to provide around £1m of acute services for patients mainly living in the Rutland area.

As described in our strategy and the recommendations of the CPT, the future success of the Trust is intrinsically linked to the sustainable development of our commissioners. Alignment between the trust and commissioner strategies is essential.

Cambridgeshire and Peterborough five year strategic plan

The Trust has worked with the Cambridgeshire and Peterborough local health economy to develop a shared view of the challenges facing the area and agree the way forward. The CCG will consider the five year plan at their June board³.

The Trust has participated in, and continues to engage in shaping the local strategic plan through groups led by the commissioner and attended by senior managers and clinicians for all providers.

Challenged Health Economy

Recognising that certain health economies across England face particular financial challenges in the next five years, NHS England commissioned external support to work with eleven particularly challenged economies in for three months. Cambridgeshire and Peterborough was one of the eleven areas selected, with work commencing in April 2014, with full Trust support and engagement throughout the process.

The process produced a system-wide estimate of the financial challenge facing the economy, followed by “Care Design Groups” which took a clinically focussed approach to identify changes that could improve outcomes and the financial sustainability of the health system. The output of this work is a common agreement on the size of the financial challenge and an agreement to jointly support further work in 2014/15 to develop more detailed transformational plans.

Forecast demand for Cambridgeshire and Peterborough

The increasing demands on the Cambridgeshire and Peterborough health system are driven by a population that is increasing and as shown in Figure 11 above, a population that is ageing.

Figure 14 shows how projections of demographic changes might affect inpatient and outpatient activity between 2013 and 2021. The increase in activity is particularly marked in the age groups 60-75 and aged 75+.

³ Cambridgeshire and Peterborough CCG (2014) Cambridgeshire and Peterborough health system blueprint 2014/15 to 2018/19, available at <http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2014/05%20June/Agenda%20Item%202.2a%20-%20Appendix%20Blueprint.pdf>

Figure 14 - CPCCG forecast activity 2013 to 2021 based on demographic change

Current inpatient activity				Current AE activity		Current outpatient activity		
Age group	Urgent Care	Elective Care	Maternity & Paediatrics	Age group	Urgent Care	Age group	Elective Care	Maternity & Paediatrics
0 - 4	4,181	1,507	1,683	0 - 4	9,119	0 - 4	22,224	-
5 - 19	3,456	3,816	408	5 - 19	25,214	5 - 19	70,879	852
20 - 39	6,702	10,088	7,643	20 - 39	38,297	20 - 39	155,776	12,323
40 - 59	8,221	22,874	323	40 - 59	29,084	40 - 59	182,680	636
60 - 74	8,227	27,722	-	60 - 74	19,227	60 - 74	183,015	-
75+	13,059	20,776	-	75+	17,971	75+	118,485	1

Future inpatient activity (2021)				Future AE activity (2021)		Future outpatient activity (2021)		
Age group	Urgent Care	Elective Care	Maternity & Paediatrics	Age group	Urgent Care	Age group	Elective Care	Maternity & Paediatrics
0 - 4	4,648	1,675	1,871	0 - 4	10,138	0 - 4	24,708	-
5 - 19	3,889	4,294	459	5 - 19	28,374	5 - 19	79,763	959
20 - 39	6,890	10,371	7,858	20 - 39	39,372	20 - 39	160,148	12,669
40 - 59	8,849	24,621	348	40 - 59	31,306	40 - 59	196,634	685
60 - 74	9,656	32,537	-	60 - 74	22,566	60 - 74	214,802	-
75+	17,448	27,759	-	75+	24,011	75+	158,308	1

Source: Information from Hospital Episode Statistics ("HES")

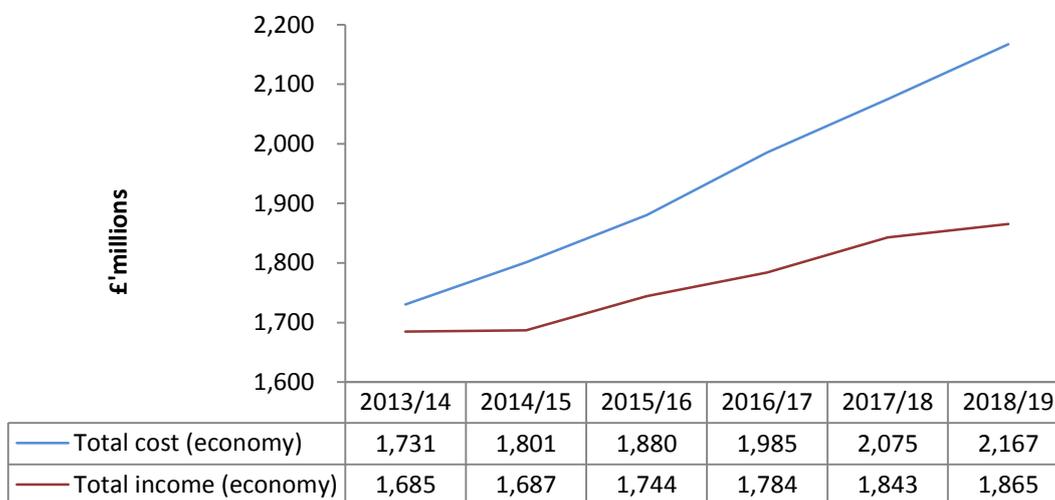
With these facts in mind three financial scenarios for the whole of the Cambridgeshire and Peterborough health system for 2014-2019 were modelled.

All of these models include mental health and community care. They also include the Better Care Fund. The total for the health system includes funding for adult social care, children’s social care and public health but these services are assumed in each case to be in neither deficit nor surplus. In other words the gap shown relates to gaps in funding of direct healthcare provision only.

Scenario 1: The “base case” scenario

In scenario 1 no provider savings are achieved i.e. there are no savings from cost improvement plans or target provider efficiencies. The financial gap across the health system widens to over £300m by 2018/19 (Figure 15).

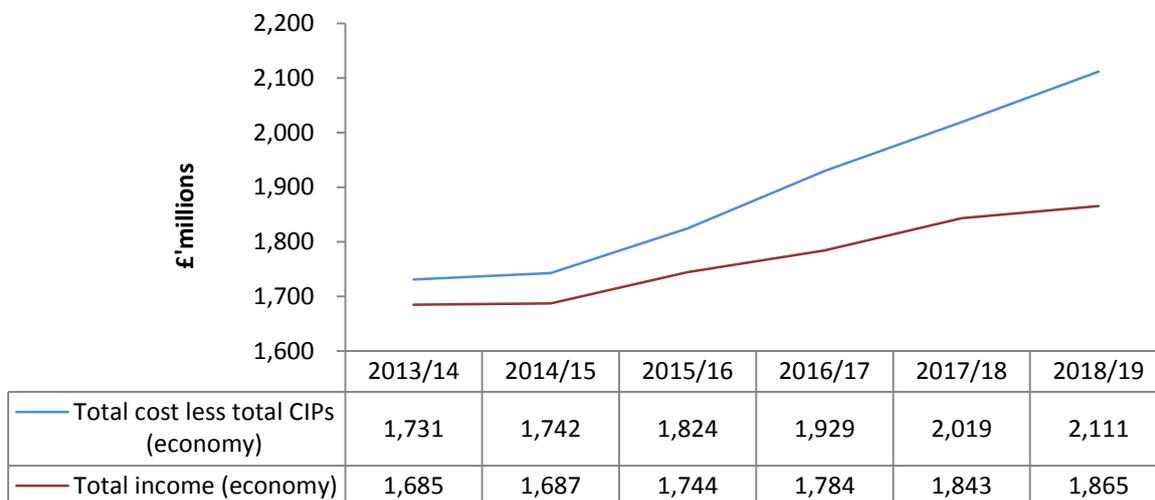
Figure 15 - Scenario 1 gap between funding and the cost of care on a ‘do nothing’ basis



Scenario 2: “Cost Improvement Plans achieved”

In scenario 2 the providers in the health system achieve their cost improvement plans. This lessens the financial gap in 2018/19 but it still remains at £250 m (Figure 16).

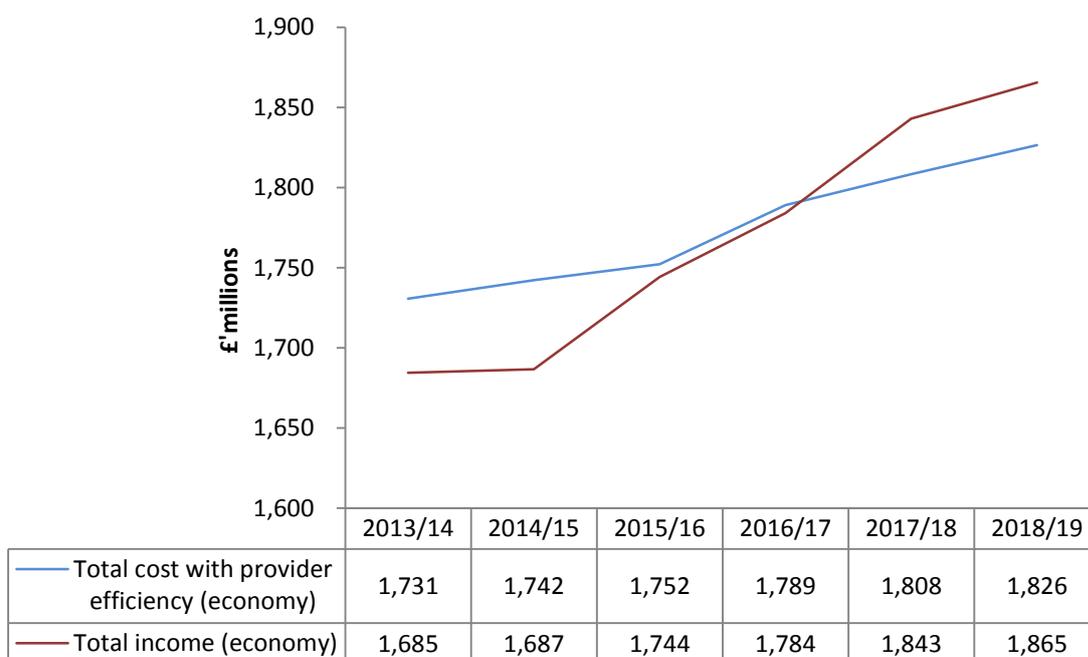
Figure 16 - Scenario 2 gap between funding and costs of care assuming provider CIP's are delivered



Scenario 3: “Year on year efficiency savings”

In this scenario each provider achieves a cumulative 4% efficiency saving year on year. This amounts to reducing their costs by over 19% over the 5 year time period from the 2013/2014 baseline. In this scenario, the overall health system breaks even in 2017 (Figure 17).

Figure 17 - Gap between funding and costs of care assuming a 4% cumulative efficiency saving



A summary of the funding gap for each scenario is shown in Table 2.

Table 2 - Scenario forecast funding gaps

Funding gap	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Scenario 1 – Do nothing	-46	-114	-136	-201	-232	-302
Scenario 2 – CIP only	-46	-55	-80	-145	-176	-246
Scenario 3 – 19% efficiency	-46	-55	-8	-5	35	39

In common with other providers and the commissioner, we have assumed that scenario 3, in which each provider reduces its cost base by 4% each year, is not likely. It is also unlikely that scenario 1 (no savings) will be made against cost improvement plans. Scenario 2 is therefore the most likely scenario for the Cambridgeshire and Peterborough health system.

This means that across Cambridgeshire and Peterborough, the health system will face an estimated deficit of at best £250m by 2019 unless there are changes to the activity and costs incurred by the system. The size of the gap is over 10% of the total health and social care spend. Even though there are some signs that the overall efficiency of the system is increasing, demand is being driven by demographic changes.

At present, along with other providers in the local health economy the Trust financial plan does not align with the forecasts of available funding. This means that the whole system needs more alignment to remain sustainable and we will need to work to reduce whole economy spending.

Achieving this alignment will involve several approaches:

- Continuing to increase the efficiency of the health system i.e. doing the same things in a more efficient way
- Transforming areas of the health system i.e. delivering health services differently
- Reducing demand for healthcare i.e. reducing the amount of healthcare that is needed by people by increasing health and wellbeing across the population. Delivery of Local Authority Health and Wellbeing strategies is outside the scope of this health system plan, but will be central to this.

The partner health and social care organisations recognise the scale of the financial challenge, and that the gap will not be solved through efficiency alone. The partners have agreed a concordat describing commitment to work together over the next 5 years. The redesign work will be led by a reference group of CEO's and directors to coordinate future work streams to redesign pathways for the future by June 2015.

The need to improve health outcomes whilst maintaining a financially sustainable system will build on transformational interventions that are ongoing already, notably the CCG's Older Peoples and Adult Community Services Procurement but will need to go further in the future.

Older People's and Adult Community Service Procurement

The CCG has embarked on an Older People and Adult Community Services (OPACS) procurement which is designed to achieve transformation beyond traditional organisational boundaries, and a new contracting approach which combines a capitated budget with Payment by Outcomes to enable a population approach to service delivery.

This is a 5 + 2 year contract term, to enable investment and transformation, which will be awarded to a lead provider responsible for the whole pathway, providing leadership and operational coordination.

To drive the process and leverage the best possible solutions, the CCG is using a two stage competitive dialogue procurement process. The total value of the contract over 5 years is in the order of £800m. Full solutions are due to be submitted at the end of July, with a decision on preferred bidder by the end of September 2014 and service commencement in early 2015.

The Trust is not bidding to provide this service, however it will be affected by the process in the following ways:

1. The aim of the service is to reduce hospital admissions for emergency care. At this stage it is estimated that this could be in the region of 10%, but could be as high as 30%. If this was to be achieved it would impact positively on Trust capacity, and finances. This is because the cost of unpredictable unplanned care is higher than the income earned due to:
 - a. 10% of 2013/14 urgent care inpatient tariff is paid at marginal rate
 - b. The cost of providing additional clinical cover to meet emergency demand is normally at a premium rate
 - c. Increased emergency demand results in failure to achieve emergency care standards, resulting in the imposition of fines
 - d. Emergency pressure is absorbed by displacing and cancelling elective activity which results in inconvenience for patients and administrative inefficiency associated with the booking and rebooking of operations
 - e. These delays in the elective pathway result in either outsourcing at premium cost to meet national performance standards, and/or imposition of additional fines for not meeting the 18 week performance standard, and/or the cancelled operation is then provided but not paid for by the commissioner
2. Whichever provider is awarded the contract, the Trust will be contracting with them rather than the commissioner for urgent care for patients over the age of 65.
3. The success of the new service model is reliant on fully integrated working between all health and social care providers to avoid hospital admission and reduce length of stay. The Trust has a key role in achieving this for patients in Peterborough and parts

of Cambridgeshire. This will be through senior decision making with the successful bidder, and individual clinicians working more closely with colleagues in primary and social care.

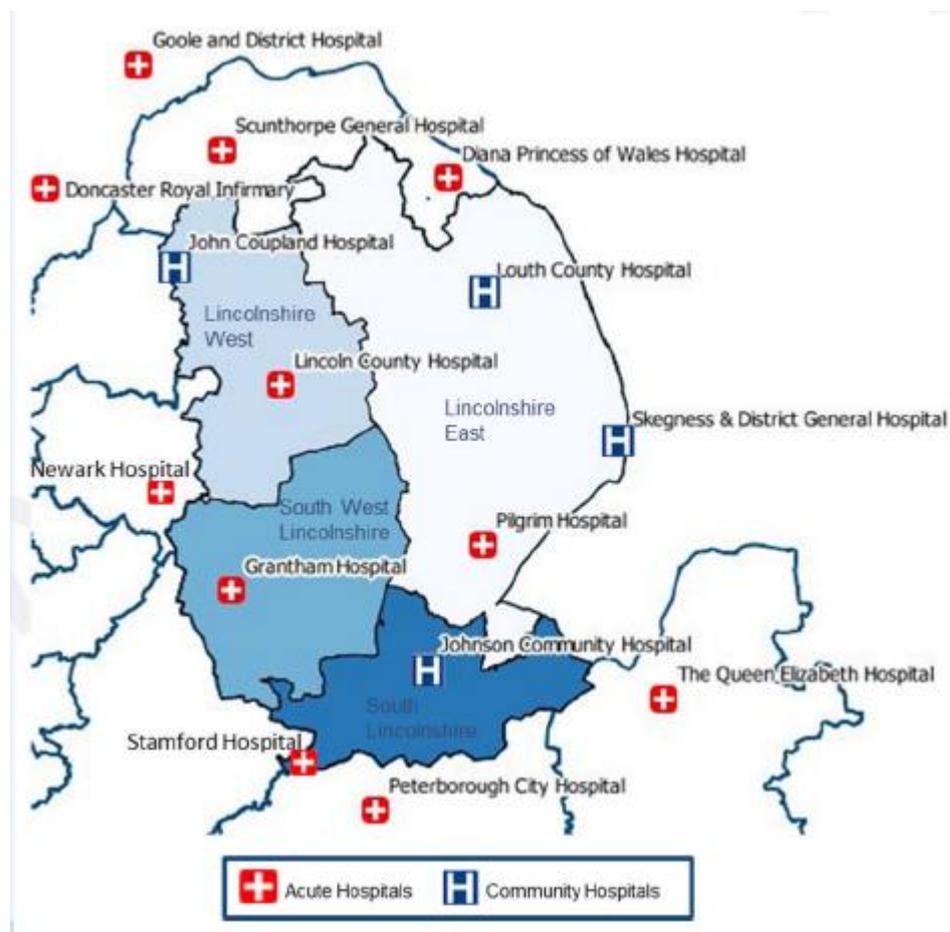
4. Information sharing is a key component and will be reliant on integration of IT systems, for example to share care plans and data to reduce hospital admissions and assess the relative outcomes of interventions.

The Trust has made assumptions in the financial plan that there will be a reduction in urgent care demand which will make a positive financial contribution to the Trust due to the reasons described above.

South Lincolnshire CCG's

South Lincolnshire CCG is one of four CCG's in the county of Lincolnshire (Figure 18), the others being South West Lincolnshire CCG, Lincolnshire West CCG and Lincolnshire East CCG. It was included as part of the Sustainable Lincolnshire Review into the safety and sustainability of services across the county.

Figure 18 - Lincolnshire CCG's



Sustainable Lincolnshire Review

The health and social care system in Lincolnshire faces significant challenges which addressed in the Sustainable Lincolnshire Review⁴.

The Keogh review identified areas of concern over the quality and safety of some services with particular patient outcome challenges in Reactive (Urgent) care. In addition, there is evidence:

- from patients and service users of services being fragmented;
- that service models do not reflect published clinical evidence that some elements of care can be better provided closer to home;
- that workforce structure, IM&T, incentive arrangements and other factors are not supporting transformational change.

Like many other Lincolnshire employers they find it difficult to recruit the workforce required. For services to be sustainable they need to change them to make recruitment easier, requiring increased flexibility of working approaches especially for senior clinical staff.

All four Lincolnshire CCGs have above average disease prevalence for the majority of the disease categories investigated. This coupled with the impact of growth in demand for services (growth in the elderly population and children) is outstripping growth in funding.

Increasing demand and expectations from patients; users and carers, and politicians around local access (made more complex by rurality) and time and type of care delivered, place additional pressures on this health and social care economy.

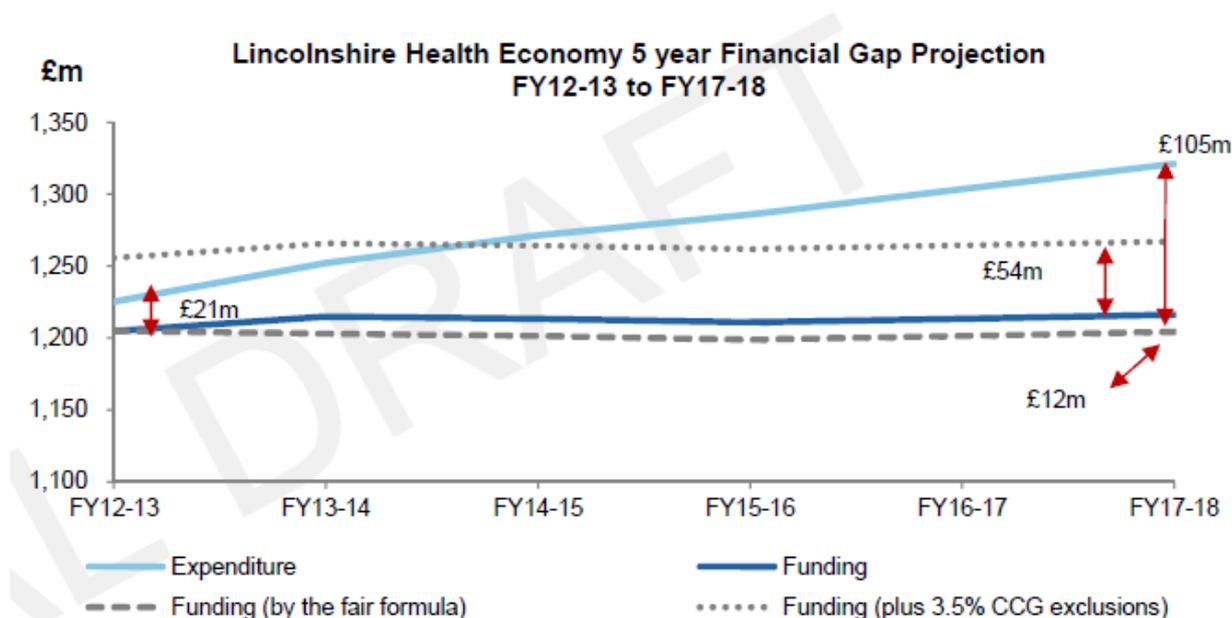
Lincolnshire demand forecast

The cost of making current services safe and viable would add to existing cost pressures. The system (health and social care) is already in a deficit position of £20.8 million. If current services were continued, Lincolnshire would have an annual overspend of just over £105 million in five years' time (

⁴ NHS Lincolnshire East Clinical Commissioning Group (2013) *Lincolnshire Sustainable Services Review - A Blueprint for Future Health and Care Services in Lincolnshire* available at http://www.ulh.nhs.uk/foundation_trust/members_portal/documents/LSSR_Draft_Blueprint.pdf

Figure 19). These issues can only be addressed by the whole health and social care community.

Figure 19 - Lincolnshire 5 year financial gap projection



Lincolnshire strategy impact on the Trust

Although the Trust was not included in the review, we were kept informed of progress and consulted at key points during the strategy development. As a significant provider of services for patients in South Lincolnshire, the Trust will provide improved access required to maintain safe services for patients in some of the rural areas in South Lincolnshire particularly through Stamford Hospital. This will have implications for the Trust clinical service strategies and where we locate services in the future.

Trust demand forecast

CCG activity forecasts do not provide an accurate picture for the Trust, given that 80% of Trust activity comes from parts of two CCG's. CCG populations served by the Trust are not accurately reflected in the CCG assumptions, for example, Peterborough has a much younger and generally more deprived population than the rest of CPCCG.

The Trust has assessed the future demand for services based on its catchment area rather than whole CCG's and as if there were no changes to care delivery.

Forecast activity from 2014/15 to 2019/20 was estimated from the 2013/14 activity outturn by specialty and point of delivery, and applying Office of National Statistics estimates of population growth at district level. This was adjusted to compensate for the difference between the GP registered population and the ONS estimate. Estimates are based on our catchment area, which accounts for any difference between the commissioners' growth estimates and the Trust's.

We will experience significant growth in most points of delivery (Figure 20).

The 1.6% growth in non-elective admissions is unsustainable, as the Trust already faces demand in excess of capacity and continues to fail to meet the four hour standard.

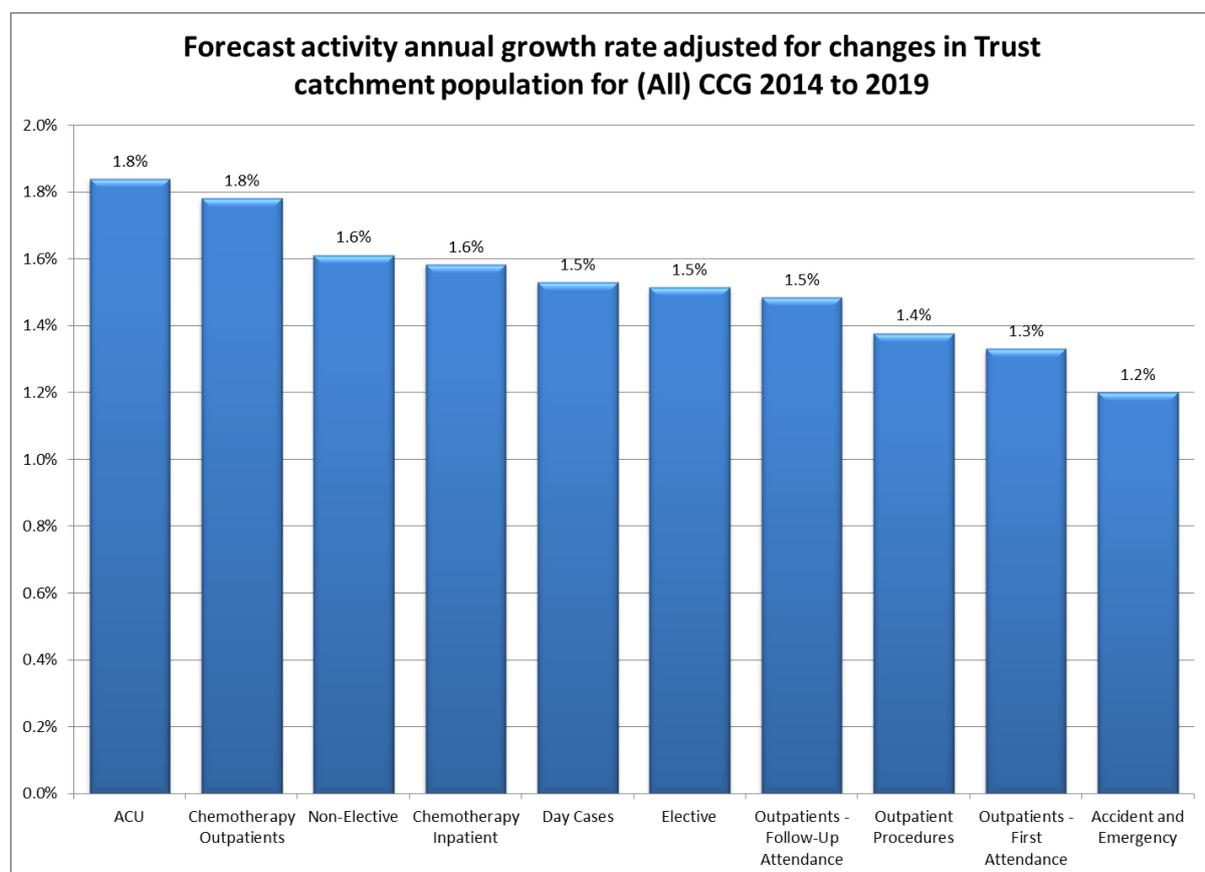
Although ED will experience lower growth than other points of delivery, a rise of 1.2% pa is unsustainable given the current demand and inability to achieve the four hour performance standard.

A rise in elective activity of 1.5% pa could reduce the Trust deficit, however lack of capacity for urgent care already in results in elective cancellations. It is also not clear how financially sustainable this rise will be for commissioners.

The 1.5% annual growth in day case may be beneficial to the Trust and commissioners if it replaces inpatient activity, and there is capacity to meet demand.

Outpatient activity will rise by around 1.2% pa.

Figure 20 - Forecast demand by point of delivery 2014 to 2019



Non-elective demand

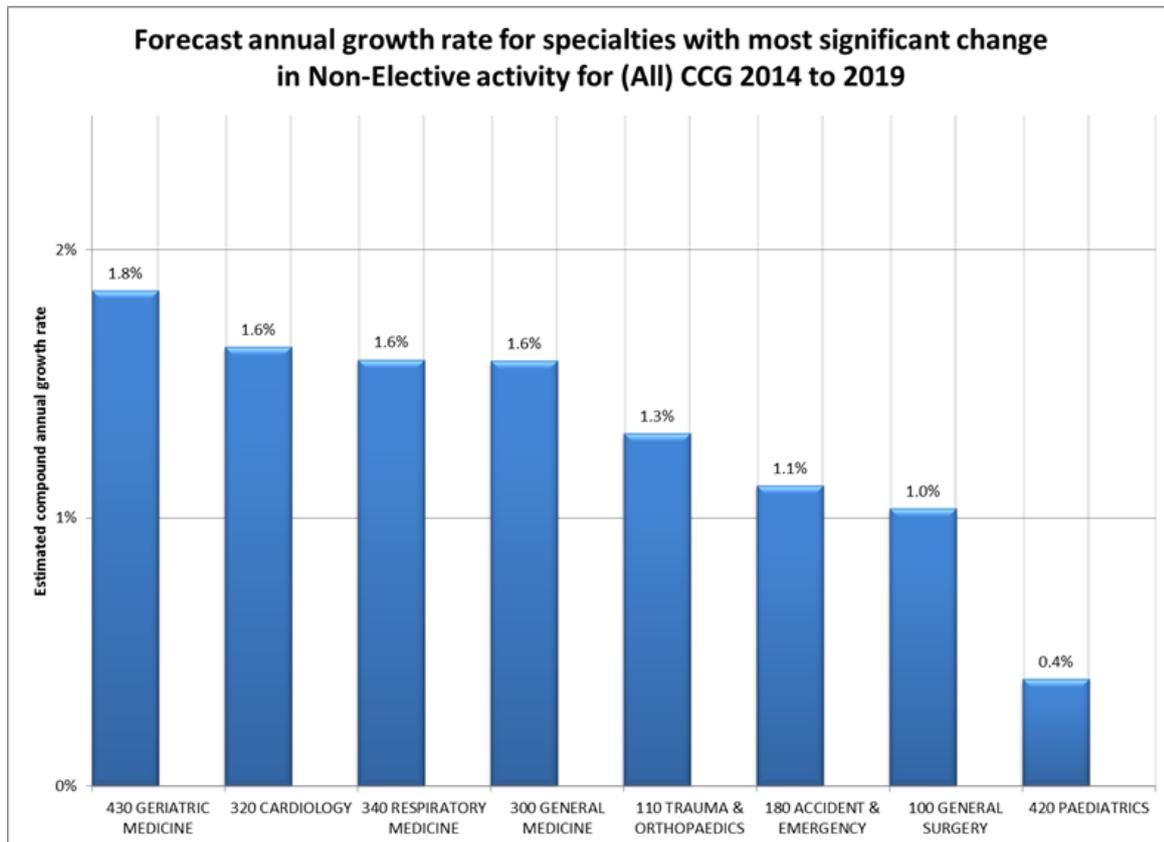
If there are no changes to reduce demand, we will experience 1.5% compound annual growth in non-elective activity (Figure 21).

Specialities associated with old age will continue to rise including **geriatric medicine** growing by 1.8% pa. **Cardiology** growth of 1.6% pa is against a backdrop of under capacity in this area. **Respiratory medicine** will grow by 1.6% pa. The effectiveness of any ambulatory care has not been factored into this estimate, but there is a significant challenge to reduce this level of demand in a high volume speciality.

The rise in surgical activity including **trauma and orthopaedics** and **general surgery** will place added pressure on elective capacity.

Emergency paediatric, forecast to grow by 0.4% pa is a specialty where a regional service review is required to match demand with capacity.

Figure 21 - Forecast Trust non-elective demand



Elective demand

Without a change of approach, we will experience 1.5% growth in demand for elective specialties. Individual specialties will experience growth above this rate (Figure 22).

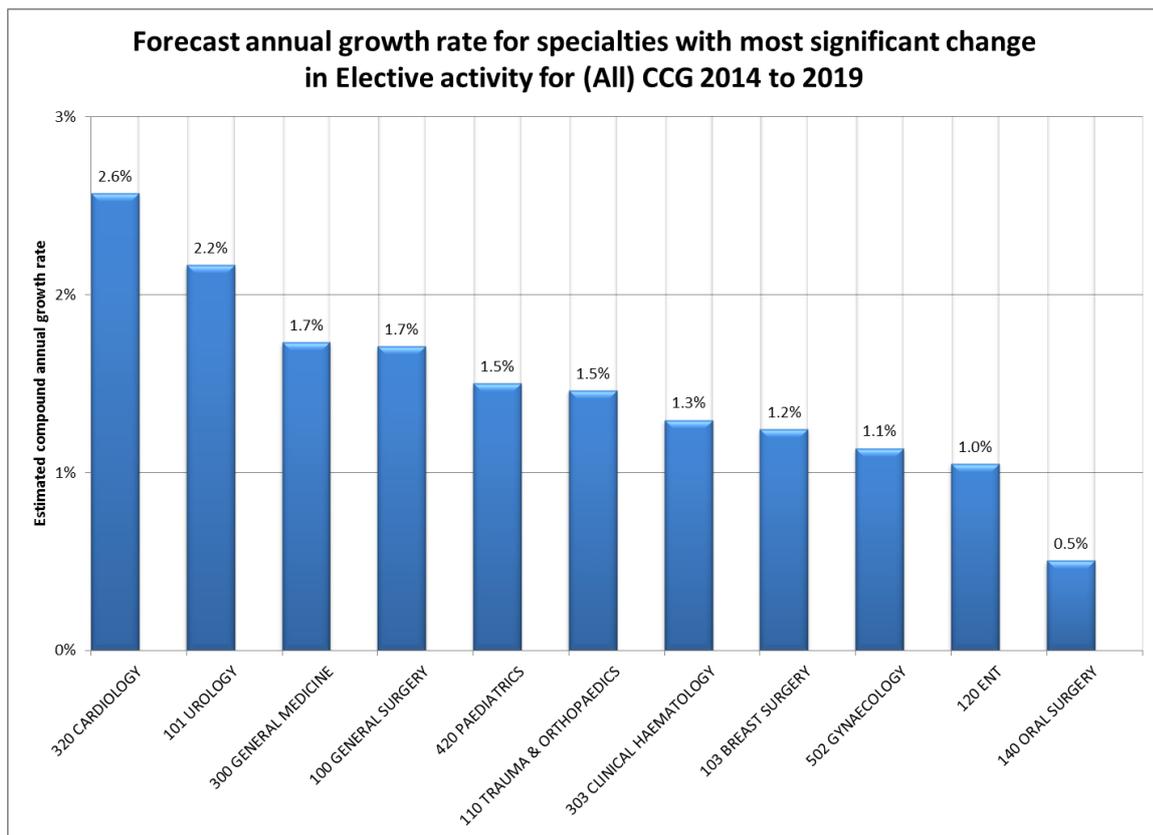
Cardiology growth of 2.6% does not take into account any transfer of elective activity from Papworth and is against a backdrop of under capacity in the Trust.

There will be significant growth in demand for surgical specialties led by **urology** at 2.2%, followed by **general surgery** (1.7%), **orthopaedics** (1.5%), **and breast** (1.2%) **ENT** (1.0%) and 0.5% in **oral and maxillo facial**.

Medical demand will increase by 1.7% in elective **general medicine** and 1.3% in **clinical haematology**.

Demand for elective **children services** will rise by 1.5%

Figure 22 - Forecast Trust elective demand



Day case demand

Without a change of approach, we will experience 1.5% annual growth in demand for day case surgery (

Figure 23). Some specialties will experience higher growth.

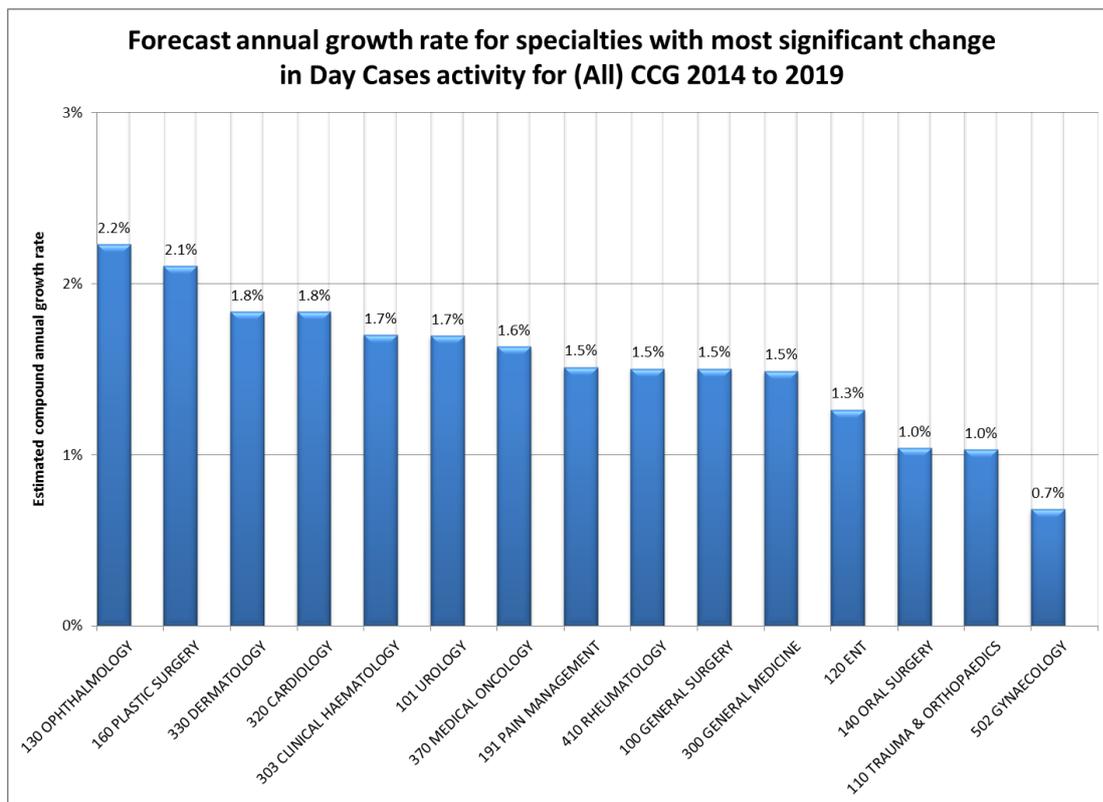
Ophthalmology growth of 2.2% is in an area where we already fail to achieve the 18 week standard.

Surgical specialties with above average growth include **plastic surgery** (2.1%), **dermatology** (1.8%) and **urology** (1.7%)

Medical demand will increase with a 1.8% increase in demand for **elective cardiology** and 1.7% **clinical haematology**.

Rising demand for cancer services will result in 1.6% rise in day case **medical oncology**.

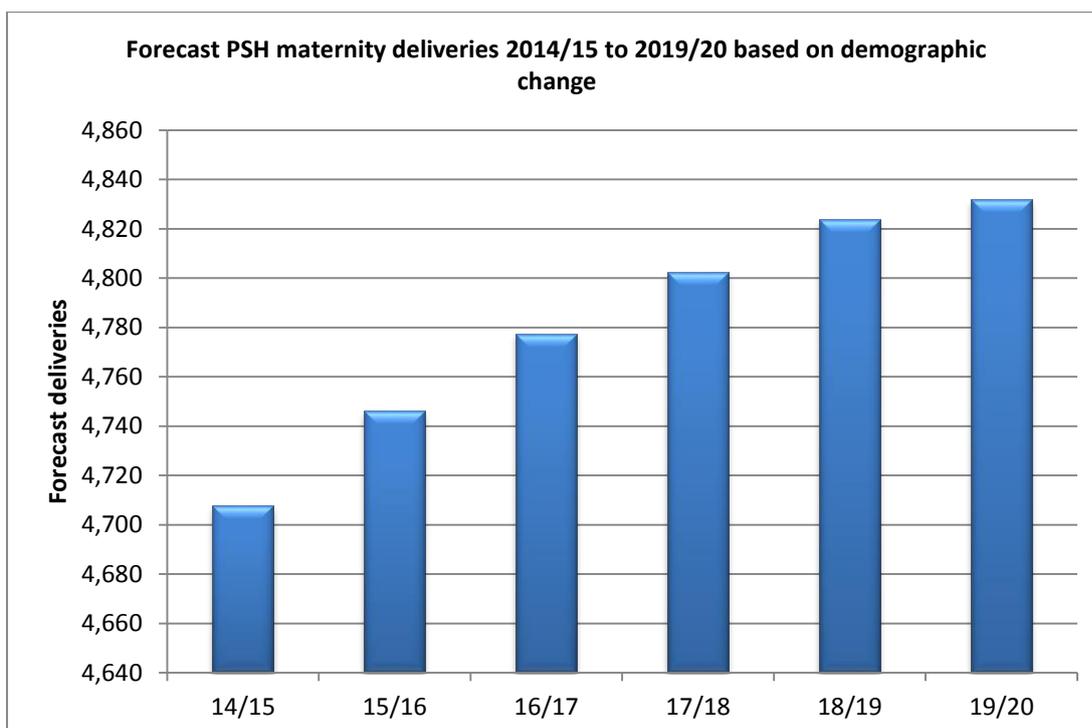
Figure 23 - Forecast Day case activity



Maternity

Based on ONS data, births in our catchment will rise to just under 5,000 per year (Figure 24), although slower rates of growth are forecast during the period and beyond.

Figure 24 - Forecast maternity growth rate



Summary of demand

We face growth in demand of 1.5% per year, with higher levels in some specialties. The Trust lacks capacity to support this, and it is financially unsustainable for commissioners. This leads to an over-riding need to reconfigure services so that they meet the needs of our local population in a clinically and financially sustainable way. We will work with the health economy to develop new ways of working which provide hospital care for those who need it, supported by community services which reduce the demand on hospital care.

Provider landscape

The Trust operates in a competitive market with a mix of both NHS and private providers. As a 'borderline' provider, i.e. operating across multiple health economies, competitors are located in different CCG's and regions.

Analysis of the local providers shows that there are a number of distressed Trusts. Whilst most NHS provided care is delivered by NHS organisations, there is increasing competition in the Peterborough area from private providers.

Appendix 1, competitor analysis gives more details on the position of each NHS provider.

Key providers operating in the Trust catchment area include:

Hinchingsbrooke Healthcare NHS Trust

The Trust is managed by Circle under a ten year management franchise agreement. They are looking to expand in orthopaedics, particularly joint services. As with all small Trusts, sustaining the proposed seven day working for urgent care will be a significant challenge.

The Trust continues to report a financial deficit, although this has improved from £3.5m in 2012/13 to a forecast £700k in 2013/14.

The Queen Elizabeth Hospital, Kings Lynn

The Trust is in breach of the terms of its authorisation and a Contingency Planning Team has been assigned to develop options for securing sustainable patient services.

The trust has been in breach of its operating conditions since January 2012 and was placed into special measures in October 2013. At the time, Monitor had concerns that it was providing poor quality care and had weak leadership.

An interim Chair, Chief Executive and Nursing Director have been appointed and progress has been made in accident and emergency. The trust is forecast to make a £13 million deficit in 2013-14.

United Lincolnshire Hospitals NHS Foundation Trust

United Lincolnshire Hospitals Trust plans to concentrate specialised urgent care on fewer sites and reduce hospital bed numbers as part of a strategy to fix problems identified in the Lincolnshire Sustainable Services review.

It was one of 14 trusts reviewed by Sir Bruce Keogh because of persistently high death rates.

It reported a deficit of £26m for 2013-14.

Cambridgeshire Community Services

In August 2012, the Trust was removed from the Trust Development Authority Foundation Trust pipeline which effectively ended the Trust's aspirations to remain an independent organisation. In 2013, the CCG announced the tender of community Older People's services, which represents a significant element of the trust's income. The Trust was prevented from bidding alone, and not shortlisted when it went into a public/private partnership with Capita and Circle.

The Trust forecast a £800k surplus for 2013/14.

Ramsay Healthcare (The Fitzwilliam Hospital)

Ramsay healthcare is an international private healthcare provider which provides inpatient and outpatient care in the UK, including Peterborough from the Fitzwilliam Hospital.

The Fitzwilliam hospital provided nearly £9m (£7m inpatient, £1.8m outpatient, based on PbR) of NHS commissioned services for patients living in the Trust catchment area in 2013/14⁵.

Directly commissioned activity in 2013/14 includes surgical outpatient clinics for orthopaedics, ENT, general surgery, and ophthalmology. Elective services included minor surgical procedures (ENT, cataracts, minor orthopaedics, endoscopy etc.) but also joint replacement. In addition, the Trust commissioned Ramsay to provide elective care during periods of excess urgent care demand, to ensure patients were treated within the 18 weeks RTT standard.

Market share

Market share has been assessed based on Hospital Episode Statistics (HES) data available on Dr Foster. Activity commissioned for NHS patients is converted into Payment by Results (PbR) tariff adjusted for the Market Forces Factor (MFF). Although it is based on the respective tariff for each year, as local tariffs are sometimes in use, it may not necessarily reflect what each provider was paid.

Market share has been calculated for the period 2011/12 to 2013/14 for all commissioners who commissioned activity for patients in the Trust catchment area. This is defined as the core and wider areas in Figure 6 and includes activity in Peterborough, parts of Cambridgeshire, South Lincolnshire, Rutland and East Leicestershire and East Northamptonshire.

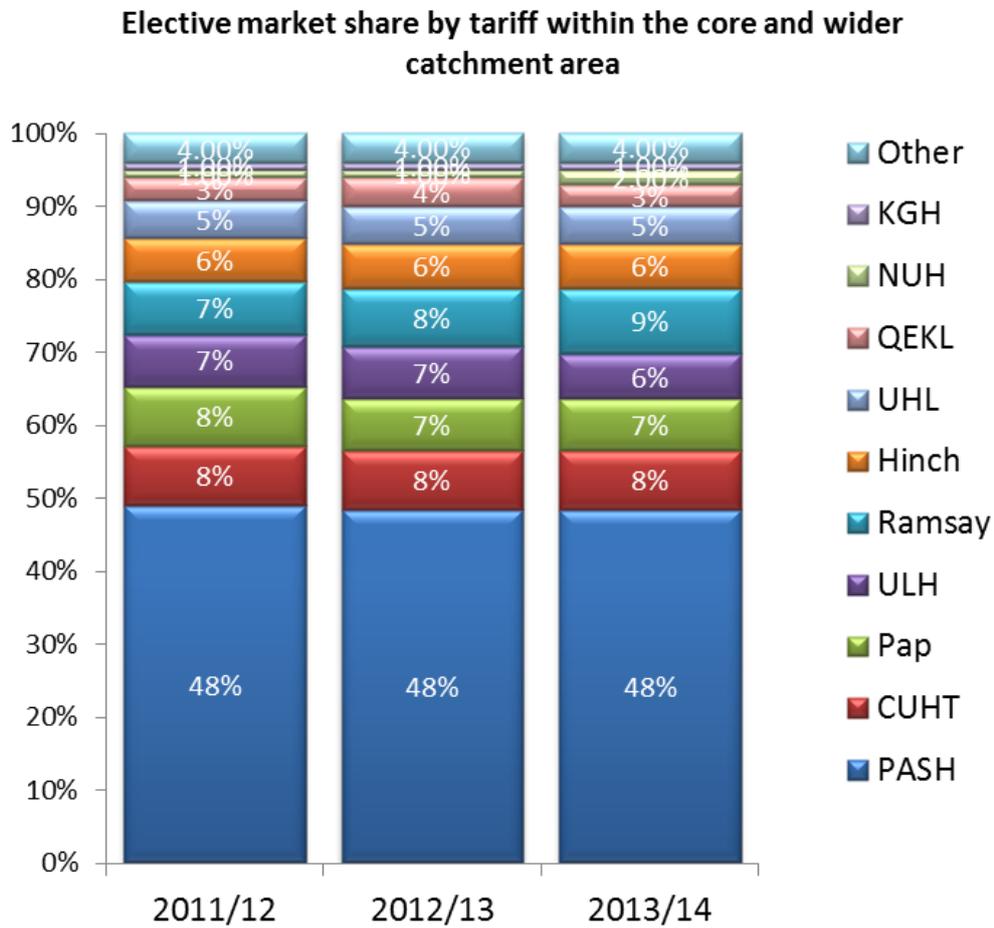
Elective market

The Trust maintained market share in a market which is shrinking (Figure 25). The main change in the market involves the move towards Ramsay (Fitzwilliam hospital) who have

⁵ Source: Dr Foster Hospital Marketing Manager, accessed May 2014

increased market share from 7% to 9% during the period. Papworth and United Lincolnshire Hospitals have lost 1% market share each.

Figure 25 - Elective market share



Annual growth rate for the Trust was -2.1%, better than the market rate of -2.6% (

Figure 26).

Figure 26 - Elective growth rates

	Tariff CAGR* '11-'13
Other	-5.6%
KGH	-8.3%
NUH	1.4%
QEKL	-2.1%
UHL	-8.7%
Hinch	-0.8%
Ramsay	8.2%
ULH	-9.3%
Pap	-4.5%
CUHT	-2.3%
PASH	-2.2%
Whole market	-2.6%

United Lincolnshire Hospitals negative growth of -9.3% can be compared with Ramsay's positive growth of 8.2% pa. Growth does not include activity which the Trust outsources to Ramsay due to under-capacity associated with emergency pressures, and so understates their market gain.

This growth in demand for elective activity (measured by activity rather than tariff) has been met by Ramsay instead of NHS providers due to lack of elective capacity due to increasing urgent care pressures.

Non-elective market

The Trust increased market share in a shrinking market (

Figure 27). Trust market share increased from 62% to 66% for the period 2011/12 to 2013/14.

United Lincolnshire Hospitals market share fell from 11% to 9% during the same period. Smaller DGH hospitals lost market share while the specialist and larger hospitals gained share. Peterborough gained market share from Lincoln hospitals, Queen Elizabeth at Kings Lynn and Leicester hospitals.

As described previously, this growth in non-elective market share has a significant performance and financial impact on the Trust associated with marginal tariff for emergency activity and the displacement of elective patients.

Figure 27 - Non elective market

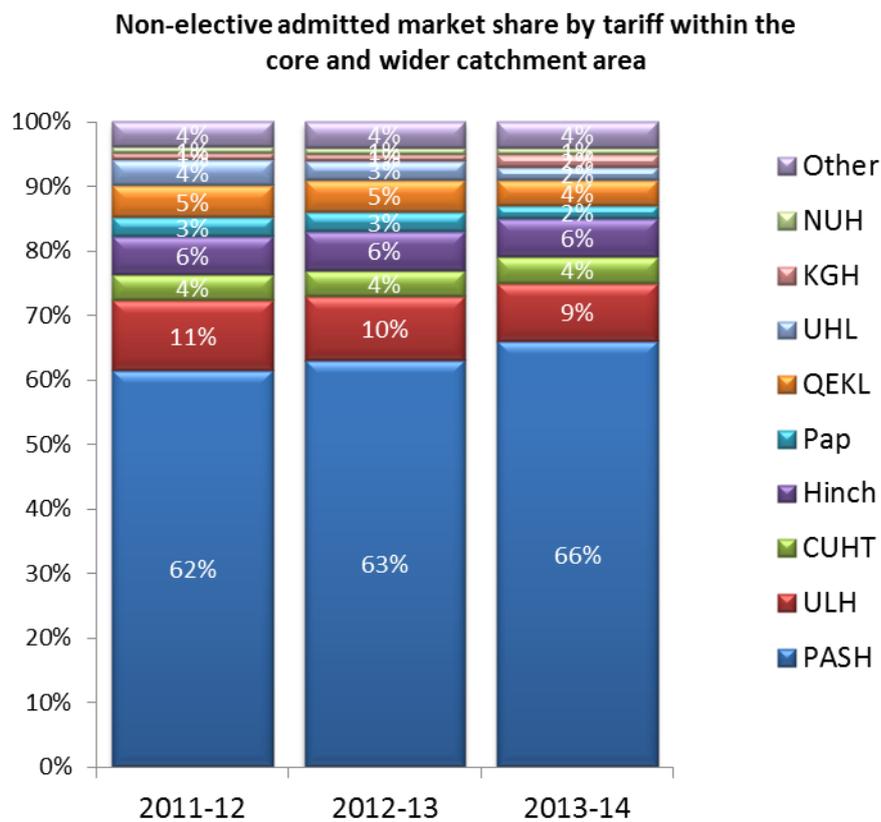


Figure 28 - Non-elective

	Tariff CAGR* '10-'13
Other	-3.1%
NUH	-10.5%
KGH	0.8%
UHL	-19.0%
QEKL	-5.1%
Pap	-7.0%
Hinch	-4.5%
CUHT	0.4%
ULH	-6.0%
PASH	-0.2%
Whole market	-2.2%

The market shrank by -2.2% per annum (Figure 28). The Trust experienced better than market negative growth of -0.2% pa whereas United Lincolnshire Hospitals experienced

negative growth of nearly three times the market rate (-6.0%). This could be explained by improved road access for patients living in South Lincolnshire which was recognised in contract negotiations by commissioners in 2013/14.

University Hospitals Leicester which serves populations in East Leicestershire and Rutland also experienced above market rate negative growth of -19.0%. More people appear to be travelling to Peterborough in an emergency from the East Leicestershire area since the opening of the new hospital.

Conclusions on market share

The Trust's main competitor in the elective market is the Fitzwilliam hospital operated by Ramsay healthcare. Although it is a competitor, it also provides additional capacity when the Trust faces higher demand for urgent care, at which times we outsource elective activity to prevent 18 week RTT breaches.

Perhaps as a result of the new premises, better road links and the new location on the edge of the city, we are attracting increasing levels of urgent care. Patients in South Lincolnshire now have much faster access and with concerns over the safety of some of the smaller DGH's, we are becoming a significant urgent care centre.

Risk to sustainability and strategic options

As part of the CPT review, the Trust had a comprehensive assessment of the future clinical, operational and financial sustainability. They concluded that, while clinically and operationally sustainable, Peterborough and Stamford Hospitals NHS Foundation Trust is not financially sustainable in its current form.

Operational sustainability

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

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

Key operational strengths and challenges identified from the review were:

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

Clinical sustainability

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

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

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

- Key Performance Indicators reviewed demonstrate that clinical quality is appropriate and, on the whole, the Trust operates within acceptable levels of performance;

- Trust mortality indices indicate acceptable clinical safety in comparison to national peers;
- The CQC inspection revealed areas for improvement, although the overall Quality and Risk Profile (QRP) indicated no high risks of non-compliance;
- The Trust has shown overall improvement in clinical quality in the last 12 months;
- The Trust has not consistently met the four-hour A&E target, and this is an area the Trust is currently focused on;
- The Trust's catchment population is within recommended limits for a District General Hospital (DGH) and, where the population for some services is too small, the Trust provides these as part of a wider network; and
- The Trust's clinical sustainability is partly dependent on commissioners' plans (such as demand management plans for A&E attendance).

Financial sustainability

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

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

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

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

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

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

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

- The level of the deficit in FY13 and for the next five years is very large relative to the income of the Trust;
- To eliminate the deficit by cost reduction alone will not be possible. The ongoing efficiency requirements in the NHS are c.4%-5% for the foreseeable future.
- The Trust has already forecast a challenging level of efficiencies that comprise the national targets and a degree of 'catch up' towards its peers' performance;
- The commissioners' intentions regarding the level of patient activity being directed to the Trust mean the Trust cannot 'grow' its way to reducing the deficit;

- If the CPT were to sensitise the Trust's forecasts the risks would be weighted to the downside, in recognition that the outer years of the forecast are reliant on local health economy strategies rather than the Trust acting in isolation; and
- None of the tests regarding financial sustainability are met by the Trust.

Causes of the deficit

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

Operational issues - £18m

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

Estate issues - £22m

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

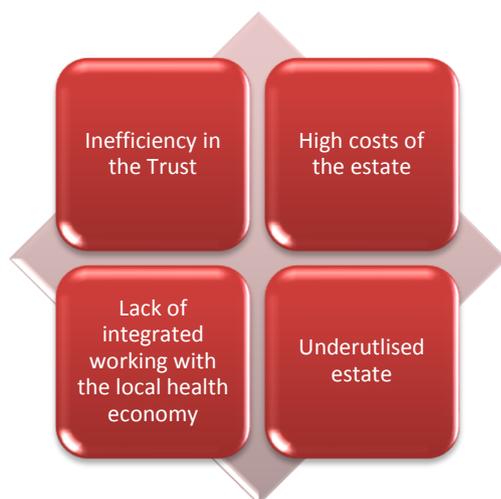
In addition, the CPT has considered the long-term (within the next 5 years) elements of the Trust's deficit. It noted that, in the absence of any corrective action, the Trust's deficit would deteriorate marginally every year as a result of the commissioners' plans to move activity away from an acute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

In the review of sustainability, the CPT identified a number of factors that have led to the financial challenges facing the Trust.

They are grouped into four areas in

Figure 29.

Figure 29 - Causes of the deficit



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

Operational issues

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

Estate issues

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

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

Location Specific Services

The CPT supported commissioners to identify services that must continue to be provided at the location of the Trust's sites in the event of its failure, due to the absence of suitable alternative provision. These are known as Location Specific Services (LSS). This concluded that over 60% of services currently provided on the Peterborough City hospital site must be provided from this location in future. This requirement has been considered in assessing the strategic options.

Strategic options

Developing the options

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

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

In considering the viable options the aim was to identify a way forward for the Trust that can:

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

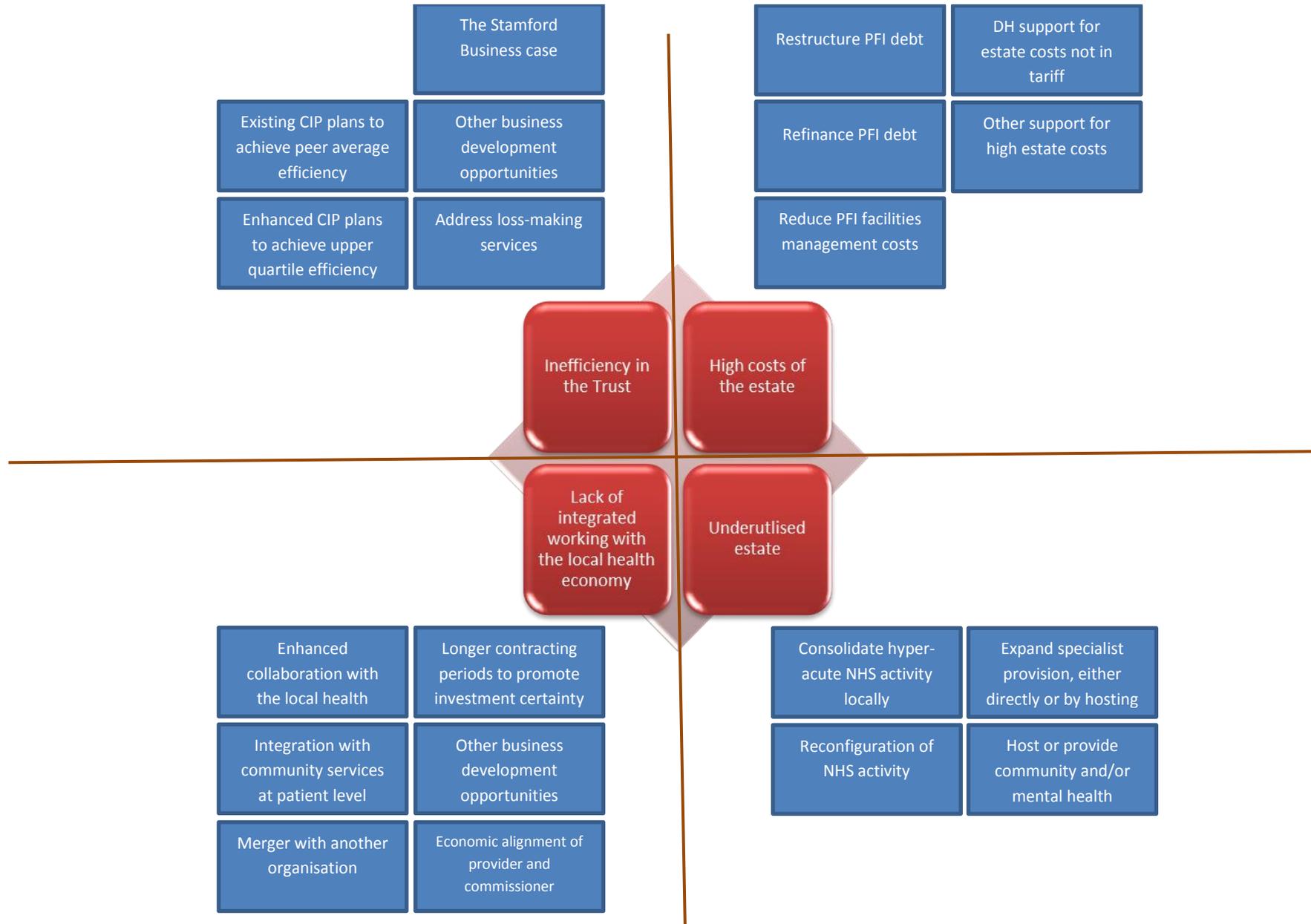
Key principles underpinning the development of the recommended options included:

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

The process for identifying options included one-to-one meetings with stakeholders, close working with three advisory groups comprising operational, financial and clinical representatives from local providers, commissioners and NHS England Area Teams, and with patient groups. It also included a review of previous reports about the Trust the wider local economy and the insight of the CPT members.

The following long list of options was developed against the four key challenges (Figure 30). Each option was then evaluated using a range of qualitative and quantitative measures.

Figure 30 - Long list of options



Option appraisal

Criteria for assessing the options were developed with the advisory groups. Each was evaluated against the following criteria.

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

The financial opportunity of each option was considered and each was evaluated against the appraisal criteria.

Addressing efficiency issues and delivery of CIPs

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

Over the next five years the Trust's CIPs target is £65m including circa £8m of 'catch up' to achieve average efficiency levels, with the balance representing the standard annual efficiency improvement requirement.

Despite this urgent need, delivering these CIPs will be challenging. The Trust has delivered over £26.2m of CIP in the past two years through productivity gains in cancer and diagnostic services, and direct access therapies.

Delivering CIP targets in years three to five are likely to require significant co-working with commissioners. Historically, cooperative working with CCGs has proven challenging due to failings on both sides, however given the concordat and the new collaborative approach in Cambridgeshire and Peterborough, we can be cautiously optimistic that these savings can be delivered.

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

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

An extensive efficiency programme has been implemented to address the gap in CIP delivery identified in the sustainability report. This should make progress in:

1. Improving efficiency to top quartile performance, although this will be dependent on significant reduction in emergency demand;
2. Repatriating work outsourced to private providers;
3. Implementing the proposed Stamford Business Case;
4. Driving a number of business development opportunities; and

- Further integrating health and social care service for patients to ensure that they are treated in the right place at the right time.

CIP themes identified in the CPT report are shown in Figure 31.

Figure 31 - CIP themes

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

Closer working with other parts of the local health economy

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

As described previously the Trust and other parts of the local health economy have started to work better together to address the rise in A&E and urgent care attendances, especially amongst the frail and elderly, and will engage in further work in the next 9-12 months to develop a plan for sustainable services.

We have planned for a reduction in emergency admissions which will have a positive financial impact on the Trust. But reducing unplanned care could have negative financial consequences for the Trust if another use for the estate cannot be found and related staff costs are not reduced in the longer term.

More efficient use of the Stamford site

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

Discontinuing loss-making services

There is an opportunity for the Trust to review whether it can discontinue loss-making, clinically necessary services in order to free capacity at the Trust's sites to perform more profitable activity. The Trust will do this in collaboration with commissioners to make sure

suitable alternative provision exists for these services. The Trust has some financial information to undertake this exercise which will develop over the coming 12 months as part of the clinical service strategy work.

Impact of the efficiency programme

The Trust has set out in its Long Term Financial Model (LTFM) £65m of efficiencies over five years that comprises the national efficiency requirement as well as additional efficiency as the Trust seeks to ‘catch up’ with most other foundation trusts. The efficiencies are a key area of opportunity for the Trust.

All who are involved in developing cost improvement proposals are clear about the quality goals of the Trust. Each proposal has an individual quality impact assessment authorised by the Chief Nurse and Medical Director before any proposed change is accepted as a potential CIP.

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

The Trust is looking to capitalise on a range of business and service development opportunities. It has prudently only assumed the provision of these services in its LTFM where there is an approved business case. The estimated contribution from radiotherapy and staff accommodation is c.£0.1m in year 1 and £0.8m in year 2, shown in the table below in Table 3. This has been added to the CIP efficiency challenge.

Table 3 - Cost improvement plan

Cost Improvements, Savings, and Incomes	2014/15	2015/16	2016/17	2017/18	2018/19
CIP / efficiencies (R)	£13m	£13m	£13m	£13m	£13m
Business Development benefits (R)	£0.1m	£0.8m	£0.1m	0	0

R – Recurrent, NR – Non-recurrent income/expenditure

Making better use of the Estate

There is a range of ways to increase the number of elective beds at the Peterborough Hospital site.

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

Additional beds could be generated at the PCH site primarily through conversion of the 4th floor (up to 116 beds) of the main building. A further option would include improved availability of existing beds through reduction in length of stay and the commissioners’ plans to shift activity into a community setting (98 beds).

Finally, the estate has the ability to sustain further beds (estimated at 87 beds) which would provide an ideal environment for elective care.

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

The Trust with the CPT calculated an indicative cost of £20.1m for the structural works and fit-out requirements based on seven wards, converting four wards on the 4th floor of PCH and other ways to increase bed estate. The building work would likely take c.6 months for the increases to bed estate and in excess of one year for the adjustments to the 4th floor. The additional capacity identified by the CPT (especially on the 4th floor) represents a significant opportunity for the Trust, as the fixed costs of operating the facilities (i.e. unitary charge and some facilities management costs) are being incurred, even though there is little revenue generating activity taking place from these facilities. This means that any additional revenue generated is likely to result in a significant contribution to the bottom line. The exact amount of contribution towards the Trust's deficit depends on the type of activity provided in the area.

Sources of additional activity at Trust sites

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

Securing additional NHS activity

Options to increase NHS activity are unrealistic given the scale of the challenge faced by the local health economies and commissioner intentions to shift activity away from acute settings towards community settings. Unless there was significant reconfiguration of services across the health economy, increasing market share in a market that is not growing would have an adverse impact on other local providers, a number of whom already face financial challenges.

Identifying NHS activity that could be hosted at the Trust's sites

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

Four alternative sources of NHS activity were considered, as well as the various ways in which these activities could be delivered at the Trust.

Consolidation of DGH providers

DGH activity could be increased through either the consolidation of a number of acute services across the local health economy at the Trust's sites; or the reallocation of services between the Trust and another DGH. This would secure clinically sustainability at both Trusts. This could result in the other DGH becoming a 'cold site' focusing on the delivery of outpatient and diagnostic services and elective care.

Hosting specialist NHS activity

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

Mental health activity

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

Community activity

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

Conclusion on increased NHS use of the estate

Each of the options for transferring NHS activity to the Trust presents its own benefits and challenges. Specialist activity would bring the greatest contribution per bed; however, there are limited opportunities for the Trust to capture specialist activity within the current structure of the local health economy and given NHS England lack of appetite to extend specialised commissioning.

As a result, redirecting patient flows from other DGH sites to the PCH site is likely to make the greatest contribution to the financial deficit. The Trust will work with the local health economy to recommend the maximisation of the spare capacity and bring as much additional activity on site as possible in the longer term, as the planned non-elective activity reduction facilitates movement to better length of stay and frees up capacity.

Conclusions on making better use of the Estate

The transfer of NHS activity from existing providers to the Trust provides an opportunity to generate additional revenues for the Trust and it is the option that has the biggest potential to deliver financial improvements at the Trust. However, it is contingent on being able to work with commissioners and other providers to establish solution which meets the needs of the local population whilst not destabilising other providers.

The local private health hospital is increasing local market share, which although it has been gained from Lincoln, is an opportunity lost to the Trust. The Trust also outsources capacity to the same private provider. The Trust will consider whether there is an option to expand capacity through efficiency and potentially construction of additional space to take market share from the private provider.

Improving integration across the health economy

Effective cross-health working

The CPT report and the work with the local health economy, including the Challenged Economy report, make it very clear that any sustainable solution to address the deficit at the Trust and deliver quality services to local patients requires support and buy-in across the local health economy. Without this, there is a real risk that the sustainability of the Trust could be undermined.

The Trust will adopt the following approaches to maximise the opportunity for integration:

- Collaboration on care pathways, with special attention to urgent care and long term conditions;
- Playing a full role in developing new services with commissioners as part of the Older Peoples care procurement; and
- Considering models that allow staff to be deployed more flexibly across the local health economy

The Trust has already engaged with the bidders for the Older People's programme and offered support in ensuring that it is successful, not least for the financial benefits to the Trust from reducing urgent care demand discussed previously.

The Trust will fully support the Cambridgeshire and Peterborough proposal to develop a more detailed plan over the coming 9-12 months through the concordat and programme management office.

Exploring how staff terms and conditions could support integrated working

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

Nearly 70% of the Trust's cost base is staff-related.

The Trust has considered the following options to create a more agile and flexible workforce:

- A range of enablers (e.g. mobile/remote working technology, outcome-based performance management, cultural shift);

- An investment in local health economy-wide workforce planning to ensure that each provider has the right skills mix to meet future demand;
- A joint approach to recruitment and retention among all providers in order to avoid competing for skills within the locality (which could drive up costs and negatively impact patient outcomes);
- A joint approach amongst all providers to local human resources (HR) policies, procedures and protocols to ensure equity and flexibility within joint/integrated teams; and
- Opportunities for more integrated (and lower cost) support functions across the local health economy, e.g. learning and development.

Conclusion on improved integration across the health economy

The local health economy alignment exercise, encompassing the options described, is about to commence. The Trust will encourage other partners to consider these options as part of the five year plan to be developed by June 2015 for the whole health economy.

Supporting the high cost of the Estate

Opportunity to address the high costs of the estate

A significant portion, around 50%, of the Trust's ongoing financial deficit can be attributed to the cost of the PFI at PCH. The PFI cost for FY13 was £40.4m and this will inflate in line with the RPI. As a percentage of turnover, the Trust's estate costs are high (at 22%) and £22.2m above the DH's current 'approval threshold' benchmark.

Four possible options by which the financial burden of the Trust's facilities could be reduced were considered by the CPT.

Restructuring the PFI debt

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

The PFI financial review concluded that all forms of refinancing the PFI are unfeasible due to current financial market conditions and the prohibitively expensive costs of restructuring.

Reducing facilities management costs

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

The Trust has already worked with the PFI contractor to reduce these costs by altering the services obtained from the contractor. Further work in this area is included in the CIP plans.

Commissioner support

The CPT considered whether the Trust's commissioners might be prepared to make contributions to cover the disproportionately high estate costs, given the benefits to local

patients of the high-quality facilities provided in Peterborough through the PFI build. Given the current financial deficit in the local health economies, this is not a viable option.

Department of Health support

The Trust receives cash to support its deficit but no PFI premium cost subsidy.

Conclusion on addressing the high cost of the Estate

The relatively high costs of the estate as a result of the PFI contract account for a significant proportion of the Trust's deficit. This, combined with the likely range of financial contributions from the options described in this report, mean that some form of permanent top-up is likely to be required above national tariff.

SWOT analysis

The above analysis has been summarised into a Trust SWOT analysis in Table 4.

Table 4 - SWOT analysis

<u>STRENGTHS</u>	<u>WEAKNESSES</u>
<p>New, high quality premises on the PCH site</p> <p>Premises at two health economies spreads Trust involvement and influence</p> <p>Some high performing specialties including orthopaedics</p> <p>Better than average mortality rates</p> <p>Good patient experience</p> <p>Good staff experience</p>	<p>Significant financial deficit</p> <p>Failure to meet ED four hour standard</p> <p>18 week performance</p> <p>Clinical leadership not yet in place for some areas</p> <p>CQC concerns regarding urgent care</p> <p>Higher than expected rate of falls, sepsis and C Diff</p>
<u>OPPORTUNITIES</u>	<u>THREATS</u>
<p>Older People’s service has the potential to reduce urgent care demand:</p> <ul style="list-style-type: none"> • Improve performance against ED standard • Reduce cancelled operations and improve 18 week performance • Increase hospital elective capacity • Reduce premium pay and outsourcing of elective activity • Reduce fines • Potential for reconfiguration across the health economy provides opportunities to better utilise the Trust estate • Maternity reconfiguration in Lincolnshire may provide opportunities to grow • Commissioning strategy for Lincolnshire provides new uses for Stamford hospital site 	<p>Health economy inability to meet rising cost associated with demographic growth</p> <p>Financial and clinical instability of local providers</p> <p>Measures to reduce urgent care demand fail to deliver sufficient extra capacity</p> <p>Business development opportunities fail to materialise</p>

Trust strategy

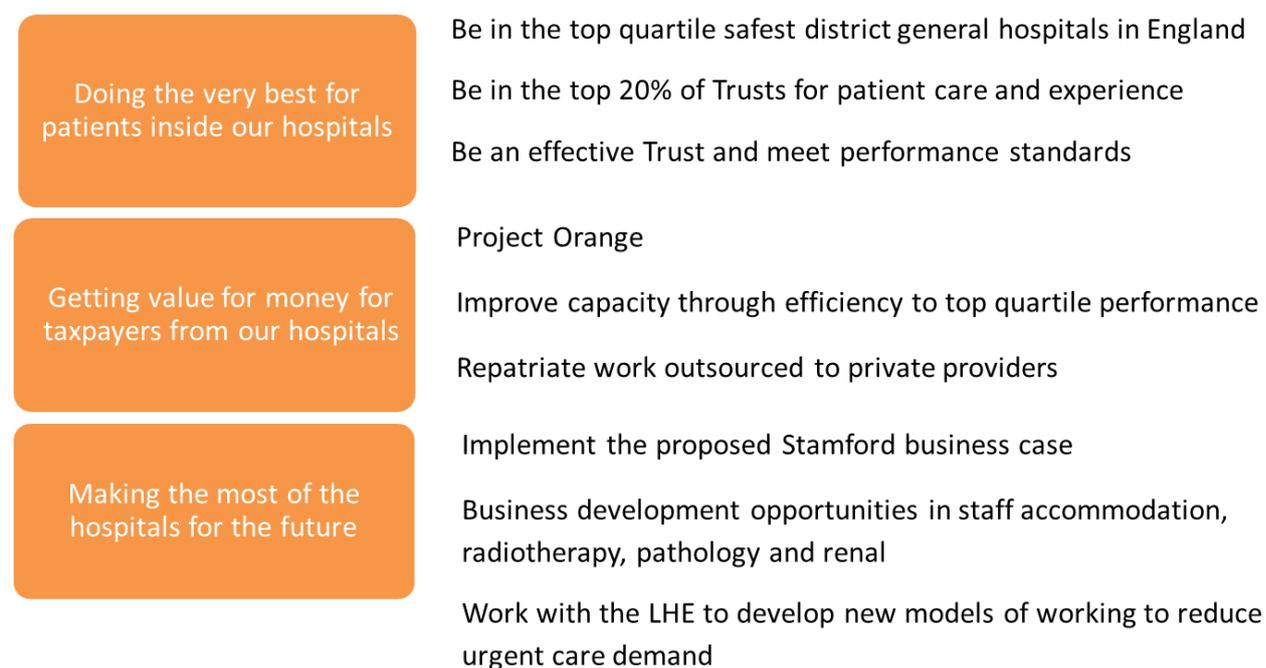
The size of the financial problem at the Trust is such that no one single solution is likely to generate a sufficient contribution to address the Trust's financial deficit. The financial potential of each area is different, as is the risk of delivery.

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

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

The Trust strategy is summarised in Figure 32 - Summary Trust strategy

Figure 32 - Summary Trust strategy



Addressing the causes of inefficiency

An extensive efficiency programme has been implemented at the Trust to address the gap in CIP delivery identified in the Sustainability Report. This programme aims to deliver £13m cost improvement each year for the next five years through:

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

Cost Improvement Plan

The Trust plans to deliver £13m cost improvement for each year of the five year plan. While detailed plans are only in place to the end of 2014/15, themes developed as part of the McKinsey review will deliver the greatest percentage of savings:

- Medical pay: £8m made up of productivity and pay level drivers
- Drugs, clinical supplies and services: £8m-11m
- Nursing, ST&T and non-clinical pay: Opportunities only possible by matching top quartile on each metric and then in each case approx. £4m-5m

Pay cost improvement of £6.5m will be achieved through reduced medical and dental locum expenditure, supported by recruitment to substantive posts. Medical agency provision will be reviewed to improve value for money. We will review senior management posts in corporate functions and throughout the Trust.

£1.5m health care provider costs will be reduced through repatriation of surgical activity outsourced to private providers due to lack of capacity within the Trust as we increase elective capacity. The Urgent Care Programme Board will be instrumental in delivering greater efficiency for urgent care with the corresponding increase in elective capacity.

Income related CIP schemes of £2.6m include the protection of elective activity, improved efficiency in the pathology service to increase capacity for direct access testing and increased critical care capacity with a resulting increase in income for the Trust.

We will adopt 'lean' methodology across the Trust to deliver improvement in the way we work. Front line staff will be trained in recognised tools and techniques such as structured problem solving to help identify ways of working more efficiently whilst maintaining our focus on patient care. These teams of front line staff will be supported by the Business Transformation Team (BTT) to deliver improvement in their local areas, whilst Trust wide transformation will be facilitated by the BTT who will focus on high value schemes worth £200K or more.

Making better use of the estate

A competitive tender process under the banner of Project Orange has commenced to offer the additional clinical space at PCH to interested parties.

Project Orange

Project Orange is a key requirement for the all-round sustainability for the Trust and could have a significant positive impact on the local health economy. The project has eight objectives:

1. Maintain or improve quality for patients
2. Maintain or improve clinical and operational sustainability of our hospitals.
3. Maximise the use of our hospitals estate.
4. The Trust is able to retain and recruit staff of the necessary calibre to deliver quality services.

5. Contribute to the financial sustainability of our hospitals and minimises DH/NHS England financial support.
6. Deliver value for money such that the contribution to future financial sustainability exceeds what could be delivered by the Trust acting alone and significantly exceeds the costs of the tender exercise.
7. Contribute to the development of health and social care service delivery and the long term financial sustainability of the local health economy.
8. Deliver a solution that has the flexibility to facilitate the future development of health and social care services in the health economy and allow it to respond effectively to future service and financial challenges.

In 2014/15 the tender will be developed and advertised in the Official Journal of the EU (OJEU) and potential bidders taken through the pre-qualification and competitive dialogue stages, with the intention to select the preferred bidder after July 2015. In 2015/16 the Trust will prepare a full business case including assessment of any competition issues and then complete detailed contract negotiations prior to seeking final approvals in the final quarter of 2015/16.

Supporting sustainability via local health economy working

Whilst the franchise option may contribute to delivering financial sustainability, the solution to the Trust deficit is to be found in the wider health economy, working with partners to deliver new models of care which deliver clinically and financially sustainable services.

Challenged Health Economy

To drive sustainability and to enhance the likelihood of options implementation, organisations from across the local health economy have agreed to jointly resource the next stage of the Local health Economy work. To date we have jointly:

1. Established appropriate governance arrangements to oversee local health economy change;
2. Agreed resources from the Trust which will support the next stage of the LHE work and will identify appropriate secondments from the Trust
3. Made some progress on pathway design in urgent and elective care;

We will build on this to:

4. Continue to support the pathway design work
5. Consider economic incentives to integrated working;
6. Review how staff across the local health economy are incentivised to support the delivery of sustainable and integrated services

Addressing the high costs of the estate

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

Business development

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

The business development opportunities being pursued by the Trust include:

- Radiotherapy expansion
- Staff accommodation
- Stamford hospital redevelopment
- Renal dialysis
- Pathology expansion

Radiotherapy

Our radiotherapy capacity will expand to meet growing demand for cancer treatment (Table 5). Capacity in our cancer network is inadequate to meet demand in 2016/17 and will require an additional Linear Accelerator in the Trust.

Table 5 - Radiotherapy business development

Provider	LINACS	Required fractions	Planned capacity 87% utilisation ⁶		Planned capacity 100% utilisation	
			Maximum fractions	Shortfall / Surplus	Maximum fractions	Shortfall / Surplus
Cambridge	7 + 1	66,973	51,378	15,235	59,055	7,918
Ipswich	3	21,497	23,584	-2,087	27,108	-5,611
Norwich	5 + 1	48,861	48,002	859	55,175	-6,314
PSHFT	2	15,655	11,755	3,900	13,512	2,143

The new LINAC will open in June 2015 and generate an additional £600k contribution to overhead per annum (£400k part year effect in 2015/16). Project management arrangements are in place to deliver the business plan.

Staff accommodation

New staff accommodation will be built on the Peterborough City Hospital to replace and improve existing provision on the old hospital site, reducing running costs whilst attracting higher rents due to the improved provision.

⁶ National Radiotherapy Advisory Group recommendation that LINACS are run at 87% of capacity

Construction of the accommodation is underway and is due to be completed by July 2014 with occupation from August.

Stamford hospital

Stamford hospital redevelopment will increase market share in the South Lincolnshire and Rutland areas and meet rising demand. Population in the area is forecast to grow at 1.1% and 1.0% pa respectively from 2014 to 2019 compared with the national average of 1.0%, with growth in the population aged over 85 growing faster than the national average.

Clinical services to be delivered from the site will be agreed with the South Lincolnshire CCG in September 2014, when further analysis of overall contribution will be assessed.

Renal dialysis

Renal dialysis is provided by the University Hospitals Leicester at Peterborough City Hospital. There are capacity issues facing Peterborough and the wider network which results in delays to patients receiving dialysis. In Peterborough the problem is particularly acute and results in patients being displaced to Corby and a subsequent break in the continuity of consultant care, and inconvenience to patients and family due to the increase travel time. We have met with UHL and agreed that we need to make a decision on the way forward as quickly as possible particularly as the Northamptonshire capacity which is out for tender will leave Peterborough 20 spaces short in April 2015.

Options are being considered with UHL including a development on the Stamford site. PSH aims to incrementally move towards more financial equity between the partners on profit and loss over the next three years.

The Trust plans to develop a strategic outline case for the service by Summer 2014 before further engagement with UHL to consider whether there is a role for Stamford hospital in the future development of this service.

Pathology

The Trust is working with Pathlinks to maintain clinical sustainability and improve productivity. However, the service model will also deliver scale to facilitate additional income from other organisations across the region (NHS and non-NHS) through joint bids for direct access tenders.

We plan to develop the first joint clinical strategy across Path Links in 2014/15, with a business case and related project plans and operational detail by June 2015.

Implementation over the following months will be reviewed in December 2015 when progress will be reviewed and consideration given to implementing further strategies.

Elective activity

The Trust has maintained market share in a shrinking elective market. We will compete with the private sector which could soon take 10% of the elective market in our area. We will achieve this through improving access times to services through controlling urgent care demand with our partners in the community.

Trust two year plan

The significant part of the Trust strategy relates to Project Orange, which is planned to deliver an outcome by 2015/16. The Trust has a two year plan to focusing on other improvements during that time in the Trust two year operational plan.

These seven objectives are summarised in Figure 33, and described in more detail in the Trust Operational Plan 2014/15 to 2015/16.⁷

⁷ Trust website available at <http://www.peterboroughandstamford.nhs.uk/page/?title=About+Us&pid=13>

Figure 33 - Trust two year objectives

Trust Objectives	Measure	Due date
1. Be in the top quartile safest district general hospitals in England	DGH mortality rates (HSMR and SHMI) in England in top quartile	Mar 2016
	Top quartile DGH hospital score for patients receiving harm free inpatient care (Patient Safety Thermometer)	Mar 2016
	Achieve 90% CQUIN targets	Mar 2015
	Seven day working:	
	<ul style="list-style-type: none"> Baseline assessment and implementation plan Seven day radiology reporting Urgent care consultant presence 0900-1700 seven days per week 	Mar 2015 Mar 2016 Mar 2016
2. Be in the top 20% of Trusts for patient care and experience	Trust Friends and Family Test average annual scores in the top 20% of all Trusts for combined ED, inpatient and maternity surveys	Mar 2015
	No final response to a complaint takes more than 30 days without complainant agreement	Apr 2015
	Top 20% scores in national patient surveys for:	
	<ul style="list-style-type: none"> Inpatient (six areas) Outpatient (eight areas) Maternity (three areas) 	Mar 2016 Mar 2016 Mar 2016
3. Be an effective Trust and meet performance standards	Achieve ED 4 hour standard every quarter for 2014/15	Mar 2015
	Each speciality achieves national 18 week wait standard for admitted and non-admitted patients each month for 2014/15	Mar 2015
	Achieve Monitor national Cancer Waiting Times every quarter in particular:	
	<ul style="list-style-type: none"> 62 day cancer standards Cancer patients not treated within 62 days because of non-patient choice diagnostic delay: <ul style="list-style-type: none"> Less than 25% Less than 10% 	Mar 2015 Mar 2015 Mar 2016 Mar 2015
	80% of stroke care provided in dedicated stroke facilities for 90% of their care	
4. Have a productive workforce equipped, skilled and motivated to provide the highest quality care	Staff engagement score of 4 in the national staff survey	Dec 2014
	Vacancy rate a maximum of 10% for nursing and 5% non-nursing	Oct 2014
	Reduce locum and agency spend:	
	<ul style="list-style-type: none"> 25% of 2013/14 outturn 50% of 2013/14 outturn 	Mar 2015 Mar 2016
	Questions related to Trust values (Caring Creative Community) included in:	
	<ul style="list-style-type: none"> 80% of all recruitment interviews 100% of all recruitment interviews 	Mar 2015 Mar 2016
	Staff appraisal rate of 90%	Mar 2015
Staff 12 month sickness rate of 3%	Mar 2015	
90% staff attend mandatory training in the previous 13 months	Mar 2015	
5. Ensure that the Trust is well run and well led	Audit of Board governance and Membership reports substantial assurance	Mar 2015
	'Have your say' internal staff survey, for each question:	
	<ul style="list-style-type: none"> Score 80% Score 85% 	Mar 2015 Mar 2016
	Agreed complement of senior staff in post	Jun 2014
	Revised integrated performance scorecards from ward to board level	Jun 2014
	Audit of directorate and corporate team governance and performance management:	
	<ul style="list-style-type: none"> Baseline audit Audit report assurance improves by one level for all directorates and teams 	Mar 2015 Mar 2016
35 clinical services strategies completed	Mar 2016	
6. Deliver our financial targets	Deliver income and expenditure plan	Mar 2015
	Deliver the capital programme	Mar 2015
	Deliver £16m CIP programme	Mar 2015
	Develop improved access and efficiency through IM and T:	
	<ul style="list-style-type: none"> Electronic document management Maternity system replacement Clinical notes and eForms PACS reprourement 	Mar 2015 Dec 2014 Oct 2015 Jul 2015
Achieve all round 'sustainability' for PCH and Stamford Hospital	Competitive tender process delivered to plan	Jun 2015
	Work with the health and social care economy to develop a joint five year strategic plan	
	Stamford hospital major redevelopment	2015/16
	Business development plan to deliver a £2m recurrent annual contribution:	
	<ul style="list-style-type: none"> Radiotherapy Pathology Renal dialysis 	Mar 2016 Jun 2015 Mar 2015 Mar 2015
Develop our academic potential in medical and non-medical education, and research and education	Mar 2015	

Enablers

Financial plan

The Trust has a Board approved plan which underpins this strategy. A prudent approach has been taken to planning with assumptions which align with national guidance and local commissioners where these are known. All benefits associated with the reconfiguration of the local health economy and the results from implementing recommendations from Project Orange have been excluded from this plan.

Key Principles and Assumptions

Key planning principles and assumptions are summarised in Table 6.

Table 6 - Key financial planning assumptions

	2014/15	2015/16	2016/17	2017/18	2018/19
<u>Inflationary and Growth Factors</u>					
Demographic increase	1.8%	1.8%	1.8%	1.8%	1.8%
Tariff deflator	1.5%	1.5%	1.5%	1.5%	1.5%
Pay inflation	1.0%	2.0%	2.0%	2.0%	2.0%
Drug cost inflation	3.0%	3.0%	3.0%	3.0%	3.0%
Non-clinical supplies consumable cost inflation	2.0%	2.0%	2.0%	2.0%	2.0%
CNST	9.6%	2.0%	2.0%	2.0%	2.0%
PFI	2.0%	2.0%	2.0%	2.0%	2.0%
<u>Income and Expenditure Account Impact</u>					
<u>Cost Improvements, Savings, and Incomes</u>					
CIP / efficiencies (R)	£13m	£13m	£13m	£13m	£13m
MRET reinvestment -Winter Pressure (NR)	£1.5m	£1.5m	£1.5m	£1.5m	£1.5m
MRET reinvestment – General (NR)	£1.0m	£1.0m	£1.0m	0	0
Business Development benefits (R)	£0.1m	£0.8m	£0.1m	0	0
<u>Investments and other costs</u>					
Penalties (R)	£1.5m	0	0	0	0
Severance costs (NR)	£1.3m	£1.3m	£1.3m	£1.3m	£1.3m
PMO costs (NR)	£2.1m	£2.1m	£2.1m	£2.1m	£2.1m
Project Orange (incl PRSG) (NR)	£2.2m	£0.4m	0	0	0
Contingency/general reserve (R)	£1.7m	£1.7m	£1.7m	£1.7m	£1.7m
Winter Pressure (offset above) (NR)	£1.5m	£1.5m	£1.5m	£1.5m	£1.5m
Cleaning (R)	£0.8m	0	0	0	0
7 day working (R)	£0.3m	£1.7m	0	0	0
CQIUN (R)	£0.2m	0	0	0	0
MOD withdrawal (R)	£1.0m	0	0	0	0

(R) – recurrent income/expenditure (NR) – non recurrent income/expenditure

Income and Expenditure Surplus/(Deficit) for each year of the strategic plan

The Trust is forecasting a gradually reducing deficit (before impairment costs) from £(45.0)m for FY15 to £(31.7)m in FY19 (Table 7). The improvement is driven by £13m year on year cost improvement plans and QIPP plans that result in the Trust achieving activity levels in 2017/18 that entirely eliminate the “MRET” discount levy on income. These benefits absorb inflationary pressure and deliver a strong improvement to the bottom line over the five year period.

A downside plan (not included below) based on failure to deliver QIPP will result in deterioration of the financial position by £5.5m progressively from FY17, resulting from the continued payment of MRET discount to commissioners.

Table 7 - Revenue income and expenditure plan

All figures £m	Budget		Plan		
	2014/15	2015/16	2016/17	2017/18	2018/19
Income					
NHS clinical income	213.3	215.1	212.8	212.6	212.6
Other income	20.1	20.1	20.2	20.2	20.3
Total income	233.4	235.2	233.0	232.8	232.9
Expenditure					
Pay	159.9	161.0	160.4	161.3	162.2
Consumables	65.3	64.7	63.0	62.1	61.4
Private Finance Initiative	19.3	19.8	20.3	20.8	21.3
Total expenditure	244.5	245.5	243.7	244.2	244.9
EBITDA	(11.1)	(11.1)	(6.3)	(3.8)	(0.4)
Depreciation	13.9	14.4	14.4	14.4	14.4
Interest	12.7	13.0	13.2	13.3	13.5
Loss on assets disposed	0.0	0.0	0.0	0.0	0.0
Deficit from operations	(37.7)	(38.5)	(33.9)	(31.5)	(28.3)
Restructuring costs	1.3	1.3	1.3	1.3	1.3
PMO costs	2.1	2.1	2.1	2.1	2.1
Project Orange costs	2.2	0.4	0.0	0.0	0.0
Deficit before impairment	(43.3)	(42.3)	(37.3)	(34.9)	(31.7)
Impairment costs	1.7	0.0	0.0	0.0	0.0
Retained deficit	(45.0)	(42.3)	(37.3)	(34.9)	(31.7)

Contribution by business development opportunities is forecast in FY16. Radiotherapy Expansion, Residential Accommodation, Maternity IT system, and Stamford Hospital Redevelopment are included in this plan. All future unquantified business developments have been excluded.

Increased costs in FY15 are due to Project Orange delivery costs of £2.2m, £1.0m of additional costs/lost income relating to the MOD exit, and £1.3m for the provision of restructuring costs. In addition, pay and benefit costs are budgeted to increase by £5.0m in 2014/15 compared with 2013/14.

Capital plan

Capital expenditure planned to support the strategy is shown in Table 8. The Trust plans to spend £13.3m in FY15 on the developments described previously in the plan. This is funded by Public Dividend Capital (PDC) and the Department of Health. Future capital expenditure is limited to £5m each year except FY18, with investment mainly in the Stamford Hospital redevelopment, medical equipment and IT.

Table 8 - Trust capital plan

Capital Expenditure £m	2014/15	2015/16	2016/17	2017/18	2018/19
Medical Equipment	2.0	2.0	2.0	2.0	2.0
IT strategy	2.9	-	-	-	-
Stamford Redevelopment	1.0	2.0	2.0	3.0	2.9
Radiotherapy expansion	5.4	-	-	-	-
PCH Residential accommodation	2.0	1.0	1.0	1.0	0.1
Total Capital Request	13.3	5.0	5.0	6.0	5.0
Funded by:		-	-	-	-
PDC funding	7.4	-	-	-	-
Stamford Land Sale Proceeds	-	-	-	1.0	-
Safer Hospitals, Safer Wards Technology Funding (DoH)	0.9	-	-	-	-
Total Capital Envelope	5.0	5.0	5.0	5.0	5.0
Savings needed to meet IT Strategic Plan	(1.5)	(6.9)	(4.8)	(0.5)	

It should be noted that the IM and T strategy is currently underfunded and cannot be entirely delivered without additional sources of capital.

Quality strategy

A more detailed quality strategy is available on the Intranet. Below is a summary

Quality goals

In our Trust, the delivery of patient centred and high quality care is “everyone’s business”. Delivery is dependent on three quality domains being in place at all times; namely, safety, clinical effectiveness and patient experience. Activities required of all staff to achieve the Quality Strategy objectives are summarised as ‘Right care; first time; every time.’

Quality priorities

Our quality priorities are reflected in the first two Trust objectives to be in the top 25% of District General Hospitals in England for mortality rates and harm free care measured on the Patient Safety Thermometer; and to be in the top 20% of Trusts for patient experience as measured by the Friends and Family Test and national patient survey data. Achieving this will be challenging, and as other Trusts make incremental improvement, we will need to improve at a faster than average rate.

We will further reduce the number of avoidable deaths through focus on areas where mortality data suggests a review would be appropriate, and by increasing emergency and radiology medical cover at weekends. In 2014/15 we will conduct a baseline of medical cover provided currently, and make recommendations for change. New working arrangements in emergency teams and radiology will be in place for the following year.

Increasing harm free patient care will focus on:

- Reducing the four harms monitored via the Safety Thermometer i.e. falls, pressure ulcers, venous thrombo-embolism and catheter associated urinary tract infection.
- Reduce the number of avoidable Clostridium difficile infections acquired in hospital
- Reduction in risks associated with medicines particularly prescribing errors
- Full use of the ‘Sepsis 6’
- Improve response to Early Warning Signs when the condition of a patient is deteriorating

Existing quality concerns

The Care Quality Commission completed an inspection of the Trust in March this year, as part of their new regime. We will update our plan to reflect any issues identified during the inspection when we receive the report in May 2014.

Board quality assurance

The Quality Governance Framework sets out the Trust’s framework around strategy, risk, capability, culture, structures and processes and measurement. Members of the Board of Directors have recently assessed their knowledge and performance around quality governance using the Monitor toolkit which demonstrated improvement compared with 2012/13.

Assurance for the Board is provided by the Quality Assurance sub-committee whose membership includes three non-executive directors, four executive directors and key external stakeholders including a public governor, a local GP and the chair of Healthwatch Peterborough.

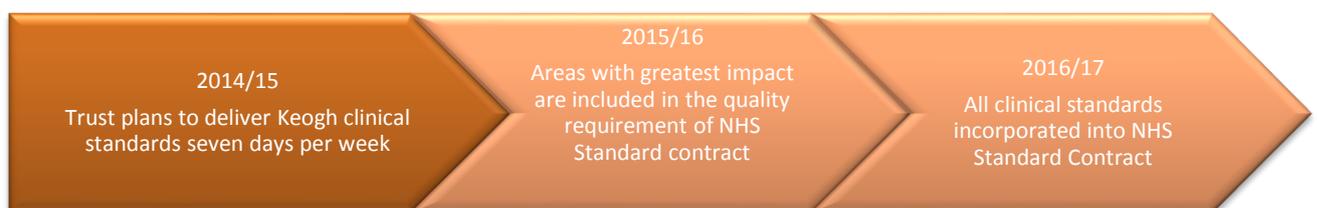
Quality and the workforce

We have reviewed the Francis report and the Government’s response to it and have a series of action plans in place to address relevant recommendations. This review has included the related reports (e.g. Berwick, Keogh, Cavendish and Clwyd and Hart) and has wide ranging requirements for development including workforce implications particularly relating to the National Quality board paper relating to staffing levels and skill mix. Where appropriate, we have aligned these recommendations to existing work plans, for example, complaints quality improvement plan, action plan to improve the management of deteriorating patients.

Seven day working and CQUIN

The delivery of seven day services is a priority for NHS England and the NHS Improving Quality (NHS IQ) partnership. In December 2013, NHS England’s national medical director Sir Bruce Keogh set out a plan to drive seven-day services across the NHS over the next three years. The aim is to move the NHS towards routine services being available seven days a week, to offer a much more patient-focused service and the opportunity to improve clinical outcomes and reduce costs. In the NHS England⁸ paper launching the project, a year by year plan was defined (Figure 34).

Figure 34 - Seven day working national timetable



⁸ NHS England (December 2013) NHS England’s Sir Bruce Keogh sets out plan to drive seven-day services across the NHS available at <http://www.england.nhs.uk/2013/12/15/sir-bruce-keogh-7ds/>

Year 1 (2014/15) - local contracts should include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan Section.

Use of local CQUIN schemes should be encouraged, based on the clinical standard for time from arrival to initial consultant assessment.

Year 2 (2015/16) - those clinical standards which will have the greatest impact should move into the national quality requirements section of the NHS Standard Contract.

Year 3 (2016/17) - all clinical standards should be incorporated into the national quality requirements section of the NHS Standard Contract with appropriate contractual sanctions in place for non-compliance, as is the case with other high priority service requirements.

The Trust has established a programme board of clinical directors, general managers, transformation, nursing leads, HR and finance to look at the requirements for seven-day services. The board has started discussions on what is needed to enable the Trust to meet the 10 clinical standards for seven-day services, with the initial focus on diagnostics and urgent and emergency care pathways.

One of the Trusts Commissioning for Quality and Innovation (CQUIN) targets for 2014/15, agreed with both leading commissioners, is on seven-day services. This scheme has a value of £1.7m of income this year.

In 2014/15, the Deputy Medical Director will prepare a seven day service specification in line with the East Midlands Provider Collaborative Seven Day Services project, supported by local specialty and directorate plans.

Our baseline assessment of current provision will be used to develop an implementation plan including an outline of the requirements and investment proposals for the required medical cover. By 2015/16, we will increase urgent care consultant presence to 0900 to 1700 hours seven days per week, and increase radiology reporting at weekends.

Workforce strategy

The Trust workforce strategy supports the delivery of the Trust vision and supporting strategy. It is summarised below, the full version is available online⁹.

The strategy has three **strategic areas**;

1. **Culture** – putting patients at the heart of what we do. A great place to work, creating the right organisation, embedding the right values and behaviours to deliver our vision. Supporting directorates to become the main drivers of quality, efficiency and effectiveness in our hospitals.
2. **Leadership, Education and Training** – right people, right skills, now and in the future.
3. **Performance and Innovation** - People in the right roles achieving excellence in quality improvement and cost reduction. Delivering the right care, first time, every time.

Strategic areas and work-streams



Culture

Values and behaviours

Following their introduction in 2009, the Trust values; caring, creative and community are well recognised across the organisation and shared through our Living Our Values themed activities such as induction and staff awards. A behavioural framework has been developed which identifies the supporting and unacceptable behaviours corresponding to each value.

⁹ PSHFT (2013) *Workforce and Organisational Development Strategy* Approved by Trust Management Board May 2013 Available within the Trust as <http://sharepoint01/C14/10Strategies/default.aspx>

This work stream will revisit the behavioural framework to assess its relevance and ensure that the 6Cs are carefully captured and sufficiently emphasised with patients placed at the heart of what we do.

We also recognise the need to share our expectations with our overall workforce and support behavioural change, including those staff working in our partner PFI organisations and our volunteers. In order to ensure that we provide a consistent positive patient experience, we will work with our PFI partner organisations to enable these staff to embed our values in the way they deliver care for patients in our hospitals.

In particular, assessment against our behavioural framework will become a mandatory element of appraisal, with the introduction of values-based recruitment across the organisation. In addition, the 15 Steps Challenge programme will be rolled out, to provide a consistent framework within which visitors and staff can observe, assess and enhance standards of care across our hospitals ensuring we deliver quality from a patient's perspective. For non-front line staff, introduction of this approach as part of their development will provide them with critical but supported insights about the issues which their front line colleagues face in delivering care to our patients on a daily basis with a view to streamlining administrative processes to free up time to increase direct care.

The Francis Report which was an outcome of a public inquiry into one organisation, highlighted whole system failures which have resulted in recommendations to re-emphasise what is important and to ensure such failings never happen again. The Trust is committed to supporting our staff to work together to learn all we can from the Francis Report. This will include the introduction of the 'duty of candour' meaning that if patient safety has been compromised we will say so, apologise and make sure that we learn lessons so that errors are not repeated; additionally our Whistleblowing policy and practice encourages our staff to speak out when something has gone wrong and learn lessons.

The Proud to Care work which seeks to build a culture of compassion on our wards including all members of our multidisciplinary teams will be rolled out across the Trust. The Steering Group will be enhanced, with a wider mandate to champion the values based approach.

The Trust's Quality Strategy is pivotal to embedding our values and behaviours and it is clear that the delivery of patient centred and high quality care is everyone's business in the Trust. The delivery of this care is dependent on all three quality domains being in place at all times, that is, safety, clinical effectiveness and patient experience. The Quality Strategy introduces the concept of *Right care; first time; every time*; focussing staff on providing care well at the outset and improving quality for patients, driving improved efficiency and reducing cost.

Staff engagement and recognition

The annual staff survey gives staff the opportunity to respond to questions regarding staff engagement. A long term communication and engagement programme to enable the culture change required to achieve our vision is an important and central element to encourage staff to be open and share ideas about how they can contribute to "delivering

excellence in care, in the most efficient way in hospitals where it is great to work” in their areas and how colleagues across the organisation can support them. The team briefing will be strengthened in directorates and supported by a programme of events which will enable staff to actively participate in developing key Trust work streams to help shape our future.

Celebrating success is vital and the Trust will do more to recognise and share excellence across the organisation internally and externally, and take pride in its staff, services and facilities. This will be used as a spring board to highlight opportunities to put patients at the heart of what we do, enhance practice and support learning to meet our current objectives and future needs.

Building on feedback from the annual staff survey results, work streams will target key areas to increase staff satisfaction. The introduction of a cultural barometer, supported through a 2013/14 CQUIN programme, will provide more frequent assessment of progress and enable the Trust to drive improvement against the friends and family test.

Organisational design

The Trust has made a number of structural changes over the last 2 years, including changes to the configuration of the directorates and the introduction of three Associate Medical Directors, who each support one of the 3 quality domains. Most significant however is the introduction of a Clinical Director model, which places clinicians at the heart of leading the clinical directorates a substantial change in approach compared with the previous management-led model.

Whilst this structural change has been implemented and Clinical Directors appointed, the benefits of this change in organisational model as laid out in the consultation paper are yet to be realised. Developing and strengthening our clinical directorates so that they become the main drivers of quality, efficiency and effectiveness in our hospitals is a key priority for the Trust over the coming five years.

A number of elements are required under this work stream including: the development of a programme of education and training for the directorate leadership teams; a review of their internal structures and governance frameworks to support delivery within directorates; a review of support functions to ensure effective alignment to support the clinical leadership model in practice. This will include introducing integrated performance frameworks across the organisation to ensure that ownership and accountability is clear at every level of the organisation. Through directorates, corporate colleagues and teams, the organisation will optimise effectiveness through this clinical model.

Over the next two years, the Trust will review and develop clinical service strategies for each area, supported by integrated workforce and organisational plans and ensure moreover that the overall organisational design and infrastructure remains fit for purpose and our workforce are supported to deliver excellence across the fields in which they work, ultimately continuously improving the quality of care for our patients now and in the future.

Health and wellbeing

We already undertake activities to provide a safe and secure workplace for our staff and support their improved health and wellbeing through provision of and access to occupational health services, flu immunisations, smoking cessation, physical challenges and a cycle to work scheme.

We will develop plans to increase our focus further on the health and wellbeing of our workforce. We will encourage our staff to become health ambassadors supporting them to lead and promote healthy lives and provide excellent role models for our patients. In particular we will work with our PFI partners to introduce healthier food options in our staff restaurants and address health issues in the workplace. Alongside these activities we will ensure our employment policies support staff in their work-place as well as providing training and guidance on the management of issues which support individuals and the organisation.

We will measure the impact of this through a number of measures including levels of absence, occupational health support and staff surveys.

Leadership, Education and Training

Leadership, talent management and succession planning

The Trust has developed leadership programmes in line with the NHS Leadership competency framework to provide a consistent approach to development throughout their careers. Currently the Trust is running a series of programmes for bands 7 & 8, in addition support for a number of internal staff to benefit from programmes run in association with the NHS Leadership Academy.

Talent management processes will be developed in line with the national and regional framework to provide additional consistency and the ability to more easily map roles and individuals onto external and internal programmes.

Education, Training and Development

We will support our doctors, nurses and health professionals in the revalidation process and ensure that non-medical staff are able to continually meet their professional registration requirements. Supporting appraisal and continuous professional development is an important element of ensuring a safe and effective workforce to meet our needs.

We will build strong relationships with our Local Education and Training Boards (LETB) and Health Education England (HEE) and working with health, local authority and local, regional and national education partners, the Trust will continue to support and influence the shape of education and training programmes to meet future needs, to meet the imperative of commissioning and delivering education and training to achieve a future workforce which is fit for purpose.

This work stream also includes National Vocational Qualifications at levels 2- 4 within and outside the Trust, covering a wide range of areas including: Business and Administration

and Customer Services as well as those with a clinical focus such as Health, Pharmacy, Pathology, Decontamination, Endoscopy, Perioperative Support, and Allied Health Professional. Assessor and Verifier awards are also offered to help encourage and increase learning support on-site. At present over 200 candidates are undertaking NVQs.

Apprenticeships offer a supported route into employment for individuals seeking to enhance their skills whilst working and provide an effective means to target individuals from within the local labour market. We receive funding for all apprentices and are committed to extending this provision further in future years.

A major area of focus is the delivery of mandatory training requirements to our staff and steps to drive increased compliance.

We will continue to develop our Library services, maximise the use of our outstanding learning facilities and resources and will seek to further enhance our range and quality of programmes to increase our brand reputation as a provider of high quality education and training. This will in turn help us attract and retain a high calibre workforce and scarce resource.

Performance and Innovation

Workforce productivity

External high level and detailed benchmarking has identified that there is an opportunity for the organisation to increase our workforce productivity and organisational performance relative to peers and we are taking steps to improve our comparative performance, increasing our focus in four key areas; price (the cost of the workforce), volume (the size of the workforce), mix (the shape of the workforce) and controls (governance requirements) to ensure the right staff in the right place at the right cost to meet current and future service requirements.

All pay cost improvement schemes are subject to the quality impact assessment process to ensure risks to delivery of high quality care are properly assessed and mitigated prior to the implementation and monitored to ensure continued compliance with quality outcomes and patient experience.

We recognise that there can be risks to continuity of employment for staff when changing workforce profile and composition and we are committed to working with our staff, staff side representatives and staff Governors to ensure that staff are aware of and have an opportunity to influence change and are supported throughout. We will use natural turnover and redeployment where possible to safeguard employment in the context of our overall aim; to make the Trust a great place to work.

Pay policy

Almost all eligible Trust staff are on the national Agenda for Change terms and conditions. This framework provides some opportunities for pay and performance optimisation for example supporting skills acquisition in the transition through gateways and providing for

consideration to be given to local arrangements in difficult to recruit areas. In line with the recent national pay settlement, the Trust will determine the nature of its local arrangements following consultation with staff and involvement of the staff side, and ensure that we optimize our position regarding pay.

We will continue to strive to be a great place to work, ensuring fairness and equity in our approach to pay and conditions and the Trust is committed to achieving the effective rollout of pension auto-enrolment in line with national expectations.

Workforce planning and resourcing

We will continue to build strong relationships with our Local Education and Training Board (LETB), Health Education England (HEE) and other health and relevant partner organisations. Working with our partners we will take active steps to shape and influence the nature of the future labour market and to develop and deliver a viable workforce proposition.

Emphasis remains on ensuring the Trust can meet its workforce needs in light of the demographic profile, shortage occupations and changes in employee expectations and education, particularly aiming to reduce significant reliance on premium based agency staff.

This will include; measures to secure registered and un-registered nursing staff, improve the conversion rate for application to appointment, decrease time to hire and improve retention in key areas. Over-reliance on premium rate agency must be reversed, to build more effective teams, improve continuity of care and reduce our cost base. By sourcing staff through alternative routes, the Trust will aim to increase the quality of its workforce whilst developing in-built flexibility to meet changes in demand and priorities and deliver high quality patient care. It is very important to gain a clear understanding of why people are leaving the Trust. If the Trust is to maintain good employees it is crucial that existing staff feel valued and supported at work and to this end we need to work hard to understand why staff decide to leave our organisation.

In addition, more detailed assessment of the local labour market will be used to determine additional steps that could be taken to secure employment for local people, whilst reducing our need for premium agency staff and providing continuity of care for our patients.

Recent service developments have highlighted that there is a limited pool of some people in the right professions, making successful recruitment increasingly difficult. These hard to recruit groups include

- registered nurses;
- medics; and
- radiographers

These groups will be given priority when recruitment campaigns are being conducted, with the full involvement of the clinical stakeholders.

Service Transformation and innovation

The Trust will continue to explore best practice in other organisations and support key staff to visit other organisations to learn from others, stimulating changes in practice, learning from the experience of others and applying tried and tested approaches where appropriate to change models of care within our hospitals to meet current and future needs.

In line with the Francis Report and the subsequent review undertaken by Sir Bruce Keogh, public sharing of information regarding consultant level outcomes (including mortality rates) will be introduced nationally. We will work with our consultants ensuring the provision of accurate, useful and relevant information to drive improvement in quality and service development.

Implementation

The strategy will be shared with our workforce to provide opportunities for them to contribute to the progress of the work-streams and to ensure the approach remains relevant to them in their roles.

The strategy will be led by the Workforce and Organisational Development Directorate but will involve partnership working across all directorates and CBUs for implementation. The role of the Workforce and Organisational Development team is primarily a facilitative approach in providing the organisation with the information and tools to make change or implement new practices; the strategy therefore needs to be owned by the organisation and the success will be determined by the actions of everyone.

IM&T strategy

The IM&T strategy supports delivery of the Trust five year strategy. It is summarised below, the full strategy is available on the Trust intranet site¹⁰.

Vision

The Trust considers accurate timely information, delivered by secure electronic communication and associated technologies, as enablers to improved safety, quality, effectiveness, efficiency and transparency.

Patients, clinicians, support staff, partner organisations, commissioners, government and the public are all recipients and users of the Trust's information. The Trust will encourage a culture of secure information sharing using appropriate technology across all stakeholder groups. The Trust aims to use appropriate technology to deliver information in a format that is easy to use via devices, media and delivery channels that enables recipients of the information to make best use of it while ensuring that those without access to technology will not be disadvantaged, while maintaining a high degree of confidentiality, integrity and availability.

The Trust's vision for IM&T (Information Management & Technology) is:

Providing the Right Information to the Right People at the Right Time

This Strategy:

- is a 4 year strategy, designed to support the Trust's vision of delivering the **Right Information** to the **Right People** at the **Right Time**
- will be supported by a 4 year programme plan and capital investment plan
- will support the Trust to implement Electronic Patient Records by 2018 and other Government information-related requirements
- reflects a requirement to further increase the involvement of the Trust's clinical staff and patients in the development of systems which empower them to use information and technology to support continual improvement in care quality and efficiency
- complements the Trust's overall strategy and expectation for continued productivity and efficiency gain
- supports a managed change (not a big bang approach) which will reflect the capacity of the organisation to accommodate change
- will give the Trust the flexibility to adopt best-of-breed clinical systems integrated into a core Patient Administration System
- is designed to be very flexible, reflecting the fast-moving environment and uncertain financial outlook for the NHS and the Trust
- The following headline projects will be delivered during the life of the strategy:

¹⁰ PSHFT (2014) *Information Management, Communications and Technology Strategy* Approved at the January 2014 Trust Board. Available within the Trust at <http://sharepoint01/C14/10Strategies/default.aspx>

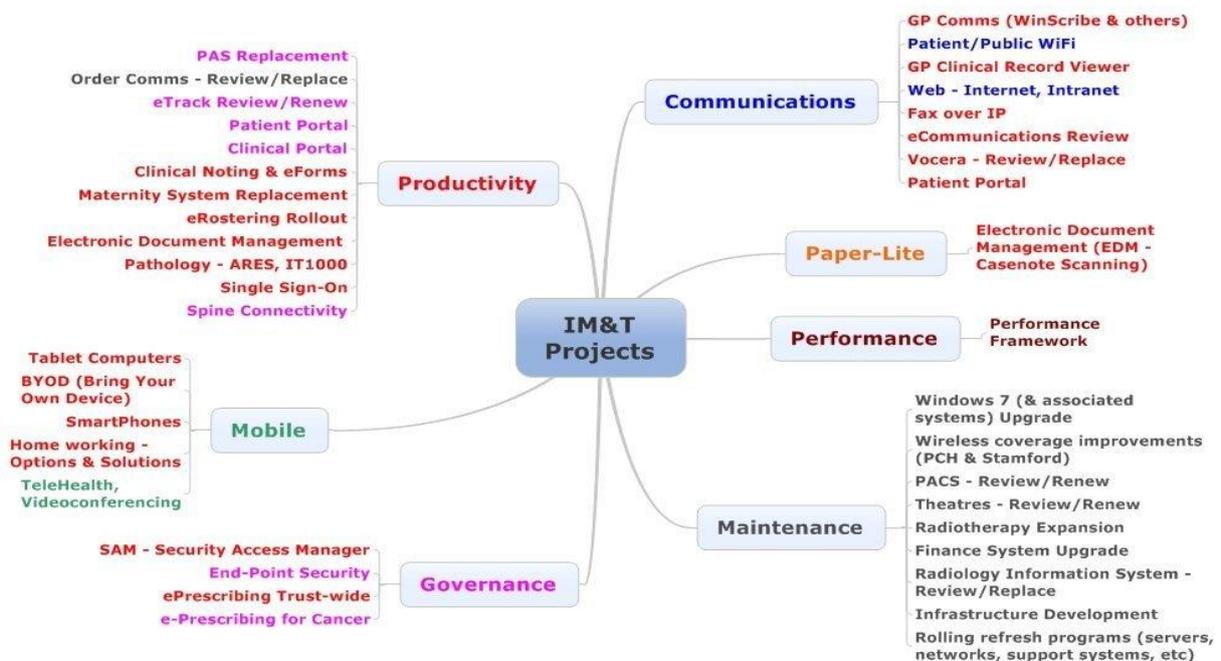
- introduction of Electronic Document Management (EDM – case note scanning and electronic retrieval/viewing)
- development or replacement of the clinical portal (eTrack)
- development of a patient portal providing secure communications between patients and clinical or admin staff and providing online booking
- redesign of the Trust’s Internet site
- review/replace the Patient Administration System (PAS), Order Communications System, Theatre system, and others
- further development of secure data networking, data processing, data storage and telecommunications infrastructure
- implementation of a new Performance Framework
- continual improvement of Information Governance standards and awareness

Goals

Work plan

In summary, the programme of work outlines the activities to move the hospital to a “Paper-Lite” way of working. It is accepted that “Paper-Free” is not yet an achievable goal for the Trust, but that moving as much activity from our paper-based system to electronic systems will improve efficiency and reduce the opportunities for errors. The main deliverables over the next three to five years are shown in Figure 35.

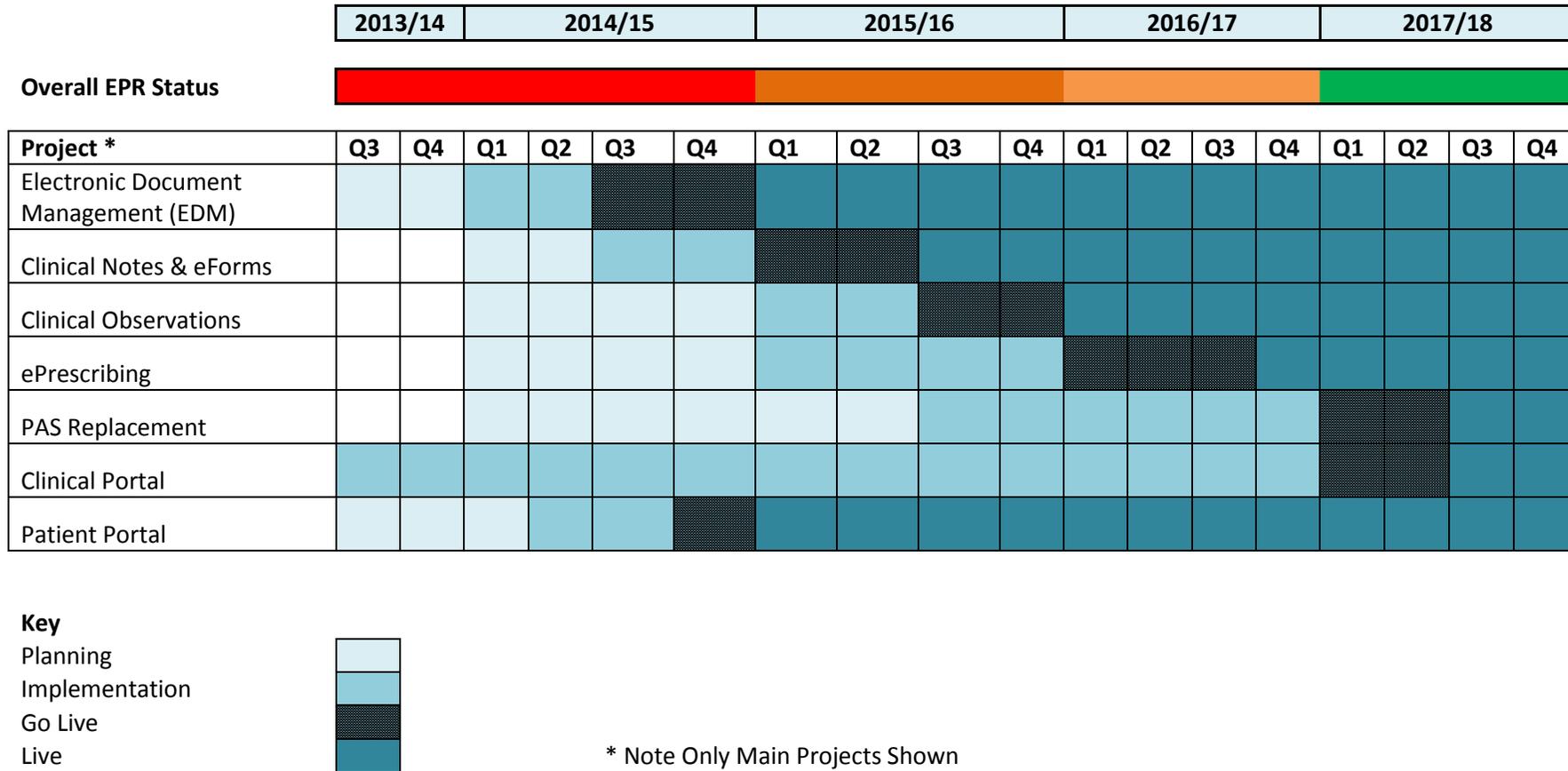
Figure 35 - Main IM&T deliverables



Text colour denotes secondary category

A plan for delivery of the main work programmes is shown in Figure 36, indicating the progress in achieving an electronic patient record (EPR).

Figure 36- IM&T work plan



Appendices

Competitor analysis

	Size and specialism	CQC	Monitor	Other
Cambridge University Hospitals NHS FT	Turnover: £617m DGH and national centre for specialist treatment and biomedical research	Compliant at last inspection published December 2012)	The Trust is in breach of its licence for persistent failure of the 62 day cancer, referral to treatment, A&E targets and poor financial performance and governance.	World-class reputation as a medical teaching and cancer centre. The Trust plans significant expansion of routine secondary activity, of its specialist activity, and of biomedical research
Hinchingbrooke	Turnover: £107m DGH covering a population of 160,000 in western Cambridgeshire	Compliant at last inspection (published December 2012).		Positive patient satisfaction survey results reported since the Circle franchise began in 2012. The first Trust whose management functions are delegated to the private sector. Circle took over a ten-year franchise and offers a growing number of joint consultant appointments to expand services.
Kettering General Hospital	Turnover: £190m DGH covering a population of 300,000 in north Northamptonshire	Non-compliant (published August 2013) regarding regulations 9 (care and welfare), against which a Warning Notice was issued and remains in place, and 11 (safeguarding people from abuse)	The Trust is in breach of its licence for persistent failure to meet the four hour A&E target and poor financial performance and governance	The Trust is increasing its co-working with Northampton General Hospital NHS Trust. Its current business plan is 'to consolidate and develop' its position as the 'secondary care provider of choice' in its area.
Papworth	Turnover: £129m UK's largest specialist cardiothoracic hospital and main heart and lung transplant centre	Complaint at last inspection (published December 2012)		The Trust is moving to a 310-bed, £165 million PFI on the Cambridge Biomedical Campus, with increased clinical and research integration with CUHFT. International reputation for cardiothoracic services and related clinical research.
QE Kings Lynn	Turnover: £165m DGH covering a population of 250,000 primarily in West Norfolk	Non-compliant (published August 2013) regarding nine regulations: 9 (care and welfare); 10 (assessing and monitoring); 13 (management of medicines); 17 (respecting and involving people); 18 (consent to care and treatment); 20 (records); 22 (staffing); 23 (supporting workers); and 24 (cooperating with other providers).	The Trust is in breach of its licence for poor financial performance, failure to demonstrate how the Trust could return to financial sustainability and potential quality governance concerns.	
United Lincolnshire Hospitals NHS Trust	Turnover: £408m Three main hospital sites covering a population of 700,000 across Lincolnshire	Non-compliant at 3 locations: Lincoln County Hospital (published January 2013) regarding regulation 22 (staffing); Pilgrim Hospital (published February 2013) regarding regulations 9 (care and welfare) and 22 (staffing); and Grantham and District Hospital (published April 2013) regarding regulations 22 (staffing) and 23 (supporting workers).		In July 2013 the NHS Trust Development Authority ("TDA") confirmed that five trusts, including ULHT, will be placed into special measures.
Cambridgeshire Community Services NHS Trust	Turnover: £158m Comprehensive health and social care across Cambridgeshire, plus other services in Luton, Peterborough and Suffolk	Non-compliant at two locations: Hinchingbrooke Hospital Holly Ward (published April 2013) regulations 9 (care and welfare) and 15 (safety and suitability of premises); and the Priory (published April 2013) regarding regulations 10 (assessing and monitoring the quality of provision) and 22 (staffing).		In October 2012, NHS Midlands and East concluded the Trust would not continue its journey to become an FT. The Trust Development Authority will lead the process to identify a sustainable future for the trust.

	Size and specialism	CQC	Monitor	Other
Cambridgeshire and Peterborough NHS Foundation Trust	<p>Turnover: £164m</p> <p>Mental health and specialist learning disability services across Cambridgeshire and Peterborough, and children's community services in Peterborough</p>	<p>Non-compliant: MH Services (CPFT) at Addenbrookes (published August 2013) regarding regulations 11 (safeguarding people who use services from abuse) and 22 (staffing).</p>		<p>The Trust's vision sees it becoming an integrated mental health and long-term conditions organisation and a major provider of 'out of hospital' care in the East of England.</p> <p>Increased collaborative work with the region's acute trusts is envisaged.</p>
Lincolnshire Community Services Trust	<p>Turnover: £109m</p> <p>Comprehensive health and social care across Lincolnshire</p>	<p>Complaint at last inspection (published April 2013)</p>		<p>The Trust's strategic objectives relate largely to consolidation: providing high quality services, improving the patient experience, a quality-driven financial strategy and community engagement.</p>
Lincolnshire Partnership NHS Foundation Trust	<p>Turnover: £98m</p> <p>Specialist health services for people in Lincolnshire with learning disabilities and mental health, drug, or alcohol problems</p>	<p>Complaint at last inspection (published August 2013)</p>		<p>The Trust's current business plan focuses on developing an innovative clinical strategy and new models of care, an internal organisational development and people plan, and a business development strategy to support the Trust's growth and market positioning.</p>