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

Full Business Case

22 SEPTEMBER 2016

VERSION – V3 FINAL

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Abbreviations

BTA	Business Transfer Agreement	LINks	Local Involvement Networks
CCG	Clinical Commissioning Group	LTFM	Long Term Financial Model
CCS	Cambridgeshire Community Services	MDT	Multi-Disciplinary Team
CPCCG	Cambridgeshire and Peterborough Clinical Commissioning Group	MRI	Magnetic Resonance Imaging
CEO	Chief Executive Officer	NHS	National Health Service
CIP	Cost Improvement Plan	NHSE	NHS England
CMA	Competition and Markets Authority	NHS I	NHS Improvement
CQC	Care Quality Commission	NPV	Net Present Value
CRG	Clinical Reference Group	OBC	Outline Business Case
DGH	District General Hospital	OD	Organisational Development
EBITDA	Earnings Before Interest, Taxation, Depreciation and Amortisation	PALS	Patient Advice and Liaison Service
ED	Emergency Department	PACS	Picture Archiving and Communication System
FBC	Full Business Case	PAS	Patient Administration System
FRR	Financial Risk Rating	PFI	Private Finance Initiative
FT	Foundation Trust	PMO	Programme Management Office
FY	Financial Year e.g. 2014/15 = FY15	PSHFT	Peterborough and Stamford Hospitals NHS Foundation Trust
GP	General Practitioner	PTIIP	Post Transaction Integration and Implementation Plan
GRR	Governance Risk Rating	PWC	PriceWaterhouseCoopers
HHCT	Hinchingbrooke Health Care NHS Trust	QIPP	Quality, Innovation, Productivity and Prevention
HR	Human Resources	SLA	Service Level Agreement
IM&T	Information Management and Technology	SLCCG	South Lincolnshire Clinical Commissioning Group
IT	Information Technology	SNAP	Stroke National Audit Programme
JSNA	Joint Strategic Needs Assessment		
KPI	Key Performance Indicator	TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006
LHE	Local Health Economy	WTE	Whole Time Equivalent

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1. Executive summary

Merger of Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) and Hinchingbrooke Health Care NHS Trust (HHCT) will improve clinical and financial sustainability and provide exceptional opportunities to deliver a step change in the strength and depth of many of the patient services currently provided. These opportunities will arise as a combination of the increased catchment population and critical mass of clinical specialists.

The merged Trust will be significantly more attractive to prospective job applicants and clinical leaders which, in partnership with primary care, community and specialist partners will improve services for the catchment population.

The combined Trust will deliver sustainable clinical services which are currently unsustainable. People living in the HHCT area will have access to services which cannot be provided without merger.

Merger will deliver £9m efficiencies which will contribute to the required system wide savings. Reductions will be in back office and corporate costs although this will result in minimal redundancies.

For those services which will continue to provide 24/7 emergency cover and those where there are significant national recruitment challenges, there will initially be some opportunities to make improvement. Over time the services will benefit from an increase in team size which will further improve performance standards and overall quality from the current CQC 'Good' rating.

The first 18 months of the merger, while challenging, will be an exciting time in which to establish the level of ambition for the combined Trust. During that period, we will further develop the clinical vision described in chapter 5. The right culture will be fostered to provide clinical and managerial leaders and teams with sufficient autonomy and freedom to take advantage of the available opportunities.

Throughout this business case, the steps being proposed have been informed by the lessons learned and successes from previous NHS mergers.

1.1 Sustainability

PSHFT and HHCT are not sustainable in their current forms. Merger of the two trusts is the best way to create a combined, more sustainable Trust based on the best of both.

Throughout this business case there are references to sustainability. NHS Improvement assesses NHS Foundation Trust's sustainability under three headings: clinical, operational and financial.

1.1.1 Clinical sustainability

Clinical sustainability is determined by a trust's ability to deliver good clinical services, and whether this is likely to be maintained into the longer term, that is three to five years.

1.1.2 Operational sustainability

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

1.1.3 Financial sustainability

Financial sustainability is the demonstration that a trust:

- Has sufficient cash to meet its operating costs
- Can generate sufficient income to cover its financial obligations
- Is able to generate an operating surplus
- Delivers an agreed annual forward financial plan and its actual income and expenditure is in line with that plan

1.2 PSHFT is not financially sustainable in its current form

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

PSHFT's financial position on 31 March 2016, i.e. the end of financial year FY16, was a deficit of £37.1m. Despite achieving above average cost improvements for the last few years, PSHFT will not be able to deliver a balanced budget for the foreseeable future.

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

The Trust has a track record of delivering above average cost improvement for each of the past four years and so the required savings are achievable. External reviews have identified further savings, including the Lord Carter review which recommended reductions in bank and agency costs.

The LHE Strategic Outline Case in 2015 identified £10m potential joint savings from PSHFT working collaboratively with Hinchingbrooke through reducing back office and corporate costs.

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

Although financial sustainability is a key driver for PSHFT, in the medium and longer terms the drive for seven day services and national shortages of specialists in areas such as stroke, Care of the Elderly and neurology will result in future clinical sustainability challenges.

1.3 HHCT is not clinically or financially sustainable

Hinchingbrooke Health Care NHS Trust (HHCT) is not sustainable in its current form, neither clinically or financially.

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

As a result of HHCT's size and case mix, it is likely to face further clinical service sustainability issues in the near future such as orthogeriatrics, neurology, cardiology and end of life care services which are significantly challenged due to the small size of the teams delivering the services.

HHCT's emergency department is the third smallest in the country and relies significantly on locum doctors to provide a safe service. This is not a sustainable option on clinical or financial grounds and presents a substantial risk to the future of the organisation.

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

The financial challenge at HHCT is also significant.

- At 16.8%, it has one of the largest financial deficits as a proportion of turnover in the country; a FY16 deficit of £18.8m on £112m turnover
- The recent national financial efficiency work led by Lord Carter, identified HHCT as being the second least financially efficient hospital in the country.
- HHCT annual reference costs are 14% greater than the average costs across the country of providing the same volume and case mix of activity.

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

1.4 The Local Health Economy (LHE) has a significant financial deficit and faces rising demand

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

The system has incurred a collective deficit of £150m in FY16, which is one of the highest per capita deficits in the country. The latest projections across Cambridgeshire and

Peterborough show that the financial deficit across the NHS providers and commissioners is likely to be £250m by FY21 if things continue as they have done in the recent past.

Meeting the future demands on services, while maintaining and improving clinical sustainability for patients within the tight financial envelope, means it is essential that NHS providers continue to find ways of working better together to remove organisational barriers and organise pathways around patients' needs.

1.5 LHEs must work together to make services sustainable

Cambridgeshire and Peterborough health and care statutory partners are working together closely to consider how to deliver improvements in services whilst reducing, and then eliminating, the collective health deficit which was already more than £150m at the end of financial year FY16 (2015/16). In line with all other LHE's nationally, they developed a Sustainability and Transformation Plan (STP) overseen by health Chief Executives, Local Authority Directors and senior clinical leaders who together comprise a Health and Care Executive (HACE).

In June 2016, Cambridgeshire and Peterborough CCG submitted the STP to the Department of Health. A summary is in Figure 1.

Figure 1 - Cambridgeshire and Peterborough CCG STP aims

Aim	Delivered through:
At home is best	People powered health and wellbeing
	Neighbourhood care tubs
Safe and effective hospital care, when needed	Responsive urgent and expert emergency care
	Systematic, standardised care
	Continued world renown through specialisation
We're only sustainable together	Formalised partnership working
Supported delivery	A culture of learning as a system
	Workforce: growing our own
	Streamlined estates
	Embedded digital technology

There has been a wide ranging review of clinical services led by clinicians, working with colleagues across Cambridgeshire and Peterborough. Their work has been overseen and reviewed by a Clinical Advisory Group which then reports to the HACE for ratification.

In relation to acute services: three key and linked services have been reviewed by the clinically-led groups as set out above. These are:

- 24/7 urgent care services
- Consultant-led obstetric services
- Consultant-led paediatric services

After careful consideration of national guidance, and the local need and population changes, it was agreed that all three services should remain at all three sites; Cambridge University Hospitals, Hinchingbrooke Hospital and Peterborough City Hospital. Ultimately any decision

to change services rests with the clinical commissioner, locally the Cambridgeshire and Peterborough Clinical Commissioning Group and would follow formal public consultation.

Both Hinchingbrooke Health Care Trust and Peterborough and Stamford Hospital NHS Foundation Trust Boards, through their Chief Executive Officers and lead directors, have been involved in the Sustainability and Transformation Plan process; and both organisations have supported the STP and continue to do so. Therefore both Boards reiterate their joint commitment to ensuring the ongoing provision of safe, sustainable core acute services at both Hinchingbrooke and Peterborough City Hospitals.

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

1.6 Collaboration will help both Trusts become more sustainable and a merger is the best way of maximising collaboration

The STP work has identified the benefits of closer collaborative working between HHCT and PSHFT. Our combined vision is to provide safe, sustainable clinical services, addressing services which are currently unsustainable.

There are 13 unsustainable services which will be significantly improved through integration of teams which will improve recruitment and retention of medical and nursing staff.

By focussing on six specialties initially, clinicians at the two trusts are working together to improve sustainability. For example, working in a single team will provide patients in HHCT catchment with full local access to all haematology services of the combined organisation. This will include more services than are currently available including the usual adult haematology services, a Teenager and Young Adult service, CLIC Sargent (childhood blood cancer and leukaemia services), and other haematology sub-specialties.

All clinical services from both sites have been engaged and have identified that merger will:

- Strengthen single handed sub-specialties and support services
- Improve access to emergency and 7 day services
- Formalise and expand training clinical rotations
- Take learning from best practice on both sites to improve services
- Increase resilience to meet requirements for rapid access to services, such as 2 week waits
- Enhance staff access to skills across all sites
- Expand clinical trials building on existing strengths
- Standardise the services commissioned across the area
- Strengthen working with community provider partners
- Joint recruitment to attract high quality staff
- Benefit from clinical leadership of colleagues in specific areas

The case also shows that merger as opposed to any alternative level of collaboration will deliver £9m in corporate and back office savings. These saving will be made as a result of

corporate and back office integration, which will generate efficiencies and support the merger of clinical services. They will also support delivery of the Lord Carter review recommendations.

1.7 Collaboration will help both Trusts become more sustainable and a merger is the best way of maximising collaboration

This business case describes how collaboration will significantly reduce the clinical challenges faced by one or both trusts through integration of teams which will improve recruitment and retention of medical and nursing staff. It sets out the four options which have been considered and shows that merger provides the greatest opportunity to deliver a clinically and financially sustainable organisation.

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

1. Maintain or improve the sustainability of clinical services at HHCT
2. Improve the sustainability of clinical services at PSHFT
3. Enable more than £9m of financial benefits[1] to be achieved through the integration of back office functions for the benefit of taxpayers
4. Improve patient care and experience through recruitment and retention of high quality specialists with more realistic rotas, increased training and educational opportunities
5. Improve infrastructure for example through the single procurement and running of IT; greater flexibility of major equipment and more robust business continuity
6. Expand engagement out to the local community in Huntingdonshire. PSHFT has over 9,000 members with public and staff representation on the Council of Governors. The Council of Governors has responsibility for appointing Non-Executive Directors and holding the Board to account. This would be expanded to the population of Huntingdonshire and staff at HHCT as a part of a merged organisation.

1.8 Next steps

Following approval of the FBC the trusts will proceed towards merger. Timelines agreed by both boards and the regulator for the next steps are:

- Continued engagement with the public and staff
- Refer the FBC to Regulators for review
- Refer the FBC clinical chapter to the Clinical Senate, to ensure that the proposals are safe
- Complete a detailed implementation plan by November 2016
- In the November 2016 meetings, the Boards will review comments collected as part of the public engagement, and the findings of the Clinical Senate to ensure that they are reflected in the FBC and implementation plan, and ratify the FBC
- Subject to all necessary approvals, the merger will be transacted on 1 April 2017.

[1] Note Although Monitor (2015) suggested there were around £10m theoretical savings, this business case has so far identified £9m of clearly identified and quantified savings

- During the period between FBC approval and merger, both trusts will work together to provide safe sustainable services, particularly in those areas already identified as being unsustainable.

Benefits will be delivered through a merged organisation. Some will be achieved by April 2017 with others being realised in advance and the full benefits being delivered over a four year timetable, i.e. by autumn 2020.

1.9 The decision to be taken by Trust Boards in September 2016

The Boards are asked to approve the FBC for merger implementation on 1 April 2017. Approval is subject to the consideration of:

- **The output of the further staff and public engagement in October and early November 2016**
- **The output of the independent Clinical Senates review of the proposed way forward for the integration of clinical services (as set out in the Clinical Senate Terms of reference (Appendix 1)**
- **At their November 2016 Board meetings, both Boards expect to ratify the decision to merge having reviewed the above additional inputs.**
- **Following the September Board decision, the FBC will be submitted to NHS Improvement.**

2. Introduction

2.1 Purpose of this document

The purpose of this document is to provide a compelling case that merger of Hinchingbrooke Health Care NHS Trust (HHCT) with Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) will deliver:

1. Sustainable and safe clinical services
2. Savings through greater integration of back office and support functions

The above objectives will be delivered within the timescale of the Local Health Economy sustainability plan to address the clinical and financial sustainability challenges within the next three to five years.

2.2 The FBC and supporting documentation

PSHFT and HHCT deliver services which are highly valued by the communities they serve but between them, they face significant financial and clinical sustainability challenges in the immediate and medium term.

This business case describes how these financial and clinical sustainability challenges will be met through merger of the two organisations, subject to regulatory approval. It includes a high level implementation plan from approval through to the transaction date and beyond to the first two years post-merger. A more detailed post transaction implementation and integration plan is included as a supporting document.

This Full Business Case (FBC) proposes a merger of Hinchingbrooke Health Care NHS Trust (HHCT) with Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT). Although it describes a merger of the two trusts, legally because one is a Foundation Trust and the other is not, this will be achieved through the acquisition of HHCT by PSHFT.

The FBC describes the case for merger. Supporting documents which provide assurance and describe how the merger will be transacted include:

- External financial due diligence report
- External commercial and legal due diligence report
- IM&T due diligence report
- Well Led Governance Review

Other documents which will be obtained prior to the November Boards include:

- Clinical senate view on the clinical service proposals
- Business Transfer Agreement
- Signed Heads of Terms for the transaction
- Post transaction implementation and integration plan

2.3 Structure of this document

The structure of the case is described in Figure 2.

Figure 2 - Structure of the document

Chapter	Description
Chapter 3 – Background and case for change	This chapter describes the rationale for the merger of the two trusts including: An introduction to the two trusts and the local health economy The financial and clinical challenges faced by the trusts Progress towards the merger including the strategic outline case, outline business case within the context of the Sustainability and Transformation Plan
Chapter 4 – Options appraisal	The options for collaboration with an appraisal of how effective the different levels of collaboration will be in delivering the strategic aims of clinical and financial sustainability
Chapter 5 – Clinical vision	Sets out how quality will be improved across the new organisation, services reconfigured and better opportunities realised
Chapter 6 – Corporate services vision	Describes how corporate and back office services will be merged to support the integration of clinical services and deliver financial savings for reinvestment in clinical services
Chapter 7 – Workforce and OD	Explains how the workforce will transition to the merged organisation and how the combined trust will develop a high performing workforce operating across the enlarged trust.
Chapter 8 – Financial case	Sets out the actions which will make the organisation financially viable
Chapter 9 – Listening and feedback	Summarises the engagement which has taken place with key messages to date. It includes future engagement to ensure the merger is delivered in a sustainable way.
Chapter 10 – Moving forwards	This section describes: • The proposed governance • Timelines leading up to acquisition • Planning for integration • Governance of the integration • Benefits realisation • Risks associated with the merger

2.4 Independent assurance of business case

PA Consultancy Group (PA) have provided assurance to the boards that:

- The FBC has been completed to an acceptably robust and high standard,
- the due diligence processes undertaken have been adequate

PA recommendations were based on an earlier version of the FBC and were categorised as either ‘must-do’ or ‘should-do’ actions. PA concluded that nothing in their recommendations should prevent an FBC decision being made. Appendix 4 includes the full PA report. Their recommendations are reflected in this final version of the FBC or will be included in the implementation plan in November.

On the Trusts’ due diligence process they concluded that it comprehensively covers all the areas included in the NHS Improvement guidance and that if all external and internal due diligence work is delivered on time and with the specified content, there should be no items

outstanding that are likely to be material to the FBC decision. Following approval of the FBC in September, a plan for addressing all outstanding areas of due diligence will be developed for FBC ratification in November.

3. Background and the case for change

3.1 Background

This Full Business Case explores in greater detail the benefits of closer collaboration between Peterborough and Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Health Care NHS Trust identified in the Strategic Outline Case (SOC) and Outline Business Case (OBC).

The Cambridgeshire and Peterborough Local Health Economy views organisations working together more closely than before to tackle the underlying challenges facing the LHE to make:

- future improvements in the way care is provided; and
- the local health economy financially sustainable by collectively reducing back office costs

A December 2015 Strategic Outline Case concluded that the best way to achieve this in the long term is by acting like an Accountable Care Organisation (ACO) model. An ACO is a group of providers and commissioners who agree to take responsibility for providing all care for a given population for a defined period of time under a contractual commitment.

It was recommended that an incremental stepping stone approach was taken to creating an ACO. One of the stepping stones to creating this model is to explore options for closer working between HHCT and PSHFT.

In December 2015, both trusts signed a Memorandum of Understanding committing time and resource to exploring different types of collaboration. The findings were reported in an outline business case presented to the boards of both Trusts in May 2016 which recommended further exploration of the benefits and risks of a merger of the two trusts.

3.2 Lessons from other NHS mergers

Outside the NHS it is well known that up to 60% of all mergers fail to deliver the planned benefits. However, the odds of success for small to medium-sized enterprise acquisitions are higher on average (45%) when the target organisation is in the same or similar industry, and when it is smaller than its acquirer in terms of revenue.

NHS Improvement (2016)[2] report that the rationale for a merger needs to be based on a clear, objective appraisal of the financial and clinical benefits that the transaction would bring to the organisations or to the wider health economy. The literature states that the benefits sought from a merger should be clearly understood and used as a basis for integration

[2] NHS Improvement (2016) Mergers in the NHS: lessons learnt and recommendations May 2016 Available at https://improvement.nhs.uk/uploads/documents/Mergers_Cass_full_report.pdf

planning. This connection between the aims of the merger and the integration process has been linked to merger success.

Lessons from other NHS mergers have been used to inform this business case with a strong emphasis on the clinical case, and development of culture in the combined Trust.

3.3 HHCT drivers for change

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

HHCT's clinical and financial unsustainability is driven by the critical mass of the organisation and the size of its catchment population.

In the current configuration, HHCT is too small for the continued future provision of high quality sustainable modern healthcare to its local population.

Emergency Department: The emergency department is the third smallest in the country and relies significantly on locum doctors to provide a safe service. Other services such as **orthogeriatrics**, **neurology**, **cardiology, respiratory** and **end of life care** services are also significantly challenged due to the size of the teams delivering the services.

The HHCT catchment is not big enough to support more highly specialised emergency services, particularly given the proximity of Papworth and Addenbrooke's hospitals.

The future unsustainability of services at HHCT is not abstract or theoretical. Over recent years, the range of services provided at Hinchingbrooke has reduced, and the nature of the dependencies between them means that there is a consequent impact on other services.

The outpatient **pain** service at HHCT ceased in 2016 resulting in more referrals being diverted to pain services at PSHFT and Addenbrooke's, but has also impacting on the spinal service at HHCT contributing to the now unsustainable backlog and excessive waiting times for patients. Given the challenges of delivering waiting time standards, the impending retirement of the lead spinal surgeon, and the known national shortage of specialists meaning that recruiting a single handed successor was unlikely; the HHCT board decided earlier this year to close the service.

The **nuclear medicine** service at HHCT has recently stopped because of issues with specialist staff and equipment requirements. This service was stopped at the end of August 2016.

Dermatology is an outpatient service that has previously been provided at HHCT by Addenbrooke's. They served notice on HHCT for this service a year ago, and in the absence of an alternative model being commissioned, it is now no longer provided at HHCT.

Figure 3 shows examples of services that are not provided at HHCT.

Figure 3 - Services not provided at HHCT – Summary of key issues

Emergency / Urgent Care	Elective & Outpatients	Diagnostics
In line with many small DGHs, ambulances divert to other hospitals for emergency patients with: • Trauma (level 2 & 3) • Stroke • Heart Attack	The following services have are no longer available at HHCT (last 12-months): • ***Pain*** • ***Dermatology*** • ****Spinal**** now closed to new referrals	The following diagnostic services are no longer available at HHCT (last 12-months): • ***Nuclear medicine***
No substantive specialty consultants (inpatient cover provided by general medical physicians): • Stroke rehabilitation • Haematology Limited consultant cover for: • Cardiology • Respiratory • Neurology	The following services are not available at HHCT currently, but are an opportunity post-merger. Sub-speciality Cardiology e.g. • rapid access chest pain • heart failure clinics Sub-speciality respiratory e.g. • Oxygen Therapy	The following services are not available at HHCT currently, but are an opportunity post-merger. • Bronchoscopies • Sleep studies • Nuclear medicine

Bold services have ended in the past 12 months

Spinal service is a sub-specialty of orthopaedics not currently provided by PSHFT either.

The financial challenge at HHCT is also significant.

- At 16.8%, it has one of the largest financial deficits as a proportion of turnover in the country; a FY16 deficit of £18.8m on £112m turnover
- The recent national financial efficiency work led by Lord Carter, identified HHCT as being the second most financially inefficient hospital in the country.
- HHCT annual reference costs are 14% greater than the average costs across the country of providing the same volume and case mix of activity.

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

3.4 PSHFT drivers for change

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

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

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

There are four areas at PSHFT where current clinical service models are not sustainable in the medium term for the reasons set out in Figure 4.

Figure 4 - PSHFT clinical services at risk in the medium term

	Unsustainable		Comments
	Now	Medium-term	
Acute Medicine	x	✓	Both trusts unable to fill all consultant posts.
Diagnostic imaging / Interventional radiology	x	✓	
Gastroenterology	x	✓	No 7-day gastro bleed rota service at PSHFT
Ortho-Geriatrics (part of orthopaedics)	x	✓	Single-handed service risk

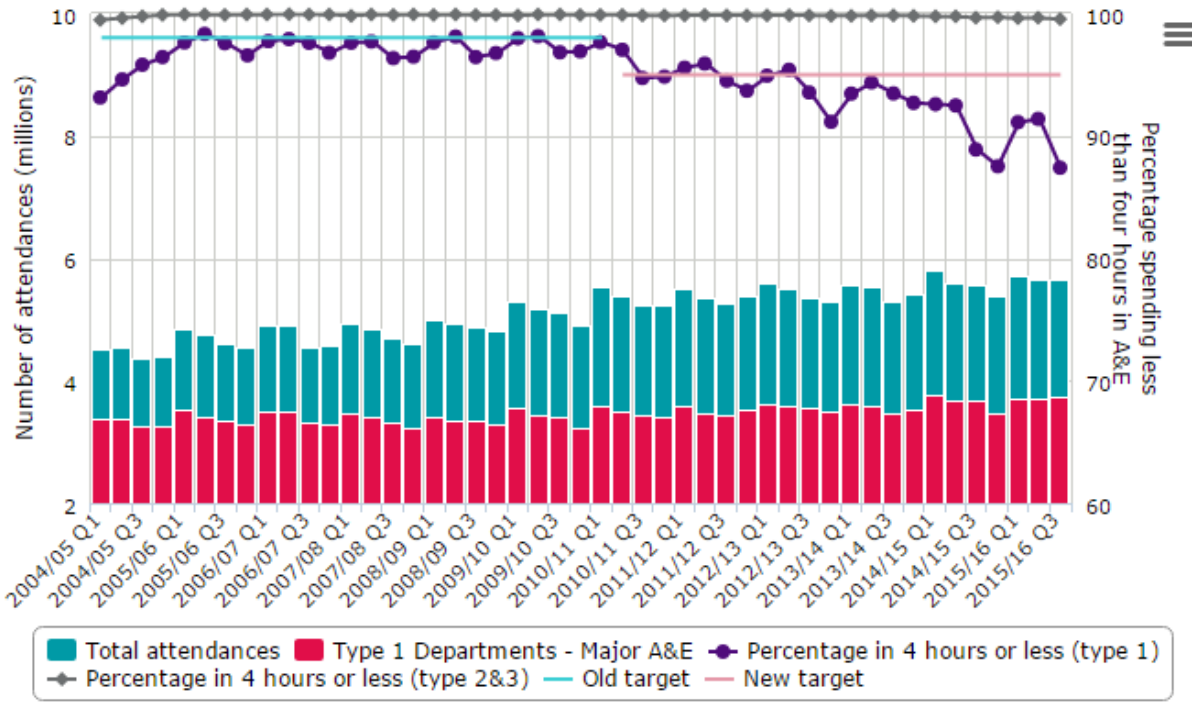
Note: for comparison with HHCT summary in Figure 3, PSHFT do not take major trauma patients, and do not provide an orthopaedic spine service.

Nationally, it is hard to recruit to four areas including acute medicine, diagnostic imaging, gastroenterology and care of the elderly specialties, especially orthogeriatricians. In the medium term and with the drive for seven day services, PSHFT will face clinical sustainability challenges in these specialties.

3.5 National context

Nationally there are drivers to meet increasing demand with less resource, whilst improving quality. The demand for NHS services continues to rise. For example attendance at A&E have increased by 35 per cent between FY04 and FY16 to 22.3 million (Figure 5).

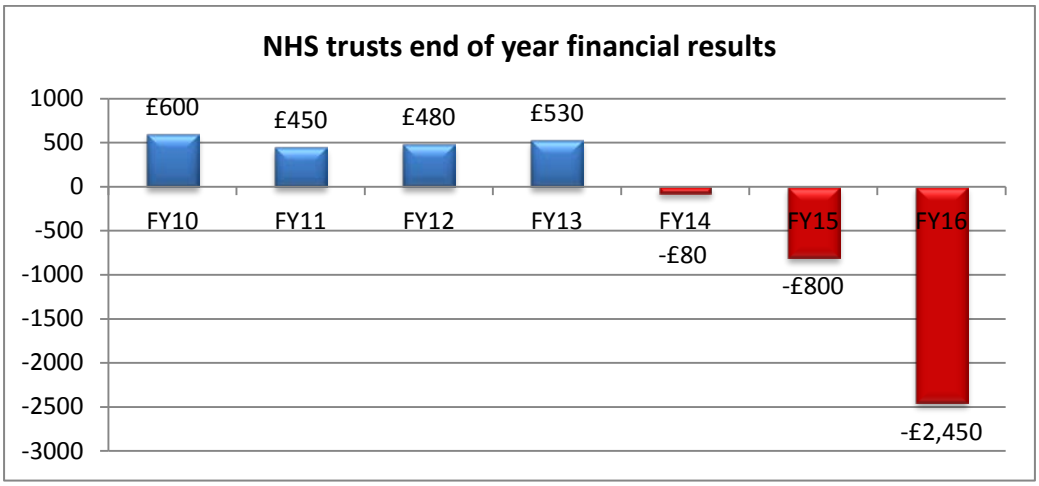
Figure 5 – NHS A&E performance FY04 to FY16



This and other measures of demand related to the ageing population are placing significant pressure on the health service nationally and locally.

The rising demand for services with an above average efficiency requirement since 2009 has resulted in significant financial challenges across the NHS. This has become increasingly apparent since FY14 when the NHS reported its first deficit. The combined NHS Trusts deficit for FY16 was £2.45bn (Figure 6), with 89% of acute trusts currently in deficit.

Figure 6 - NHS trusts end of year financial results FY10 to FY16



Taxpayers pay £101.3bn[3] to fund the NHS in England and there is rightly an ever increasing scrutiny of Trusts, hospitals and individual healthcare professionals over how this funding is spent. Care Quality Commission inspections, the Francis and Keogh report and the drive for seven day services are increasing pressure to maintain high standards at all times, requiring changes to working practices and the culture across the NHS.

Whilst the overall quality of services in the NHS has been maintained, well publicised examples where this has not been the case have highlighted the pressures to balance quality, access and financial pressures within the system. In 2012, the CQC reported concerns in less than 23% of inspected hospital services, which includes acute, mental health and community hospitals. By FY15, 57 per cent required improvement and 11 per cent were rated inadequate.

There has been much debate around the size an acute trust needs to be in order to achieve clinical and financial sustainability. The Royal Colleges, Improving Outcomes Guidance, Clinical Networks and NHS national guidelines are increasingly relating patient outcomes to population size and a need for a critical mass of procedures or patients to be treated per annum. Studies on hospital volume report statistically significant associations between higher volumes and better outcomes.

Further specialist centralisation will place increased pressure on both our trusts from rising clinical thresholds, minimum staffing levels and eventually potential loss of income for some specialties.

Collaboration must show how quality will be maintained in the face of growing demand while the available funding grows at a slower rate.

3.6 Local health economy context

The two trusts serve a diverse and growing population of around 700,000 people some of whom live in the most deprived areas of the country, including some wards in Peterborough. Some areas are forecast to experience significant growth in the over 65 age profile (Huntingdonshire and Rutland).

Specialist services such as cancer surgery, major trauma and specialist paediatrics are mainly provided by Addenbrooke's hospital in the south and when Papworth moves to the Addenbrooke's site in 2018, the heart attack centre will move with it.

District General Hospital (DGH) services are provided at PSHFT, HHCT and also at Addenbrooke's.

The challenges facing the NHS nationally are being replicated locally within the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and the South Lincolnshire CCG. The total population in Cambridgeshire and Peterborough CCG is forecast to grow by 10% between 2016 and 2021, with Peterborough growing by 11% and

[3] NHS budget for England 2015/16, *The NHS in England 2016* NHS England (2016)

Huntingdon over 65 age group growing by 17%. As people age, they are progressively more likely to live with multiple illnesses, disability and frailty, and therefore we can expect increased pressure and demand for services and care at HHCT and PSHFT in the future.

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

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

3.7 Local sustainability plans

Across the country, all commissioners including our local CCGs have developed Sustainability and Transformation Plans (STP) to address the clinical and financial challenges. The Cambridgeshire and Peterborough CCG plan, 'Fit for the Future'[4] includes themes shown in Figure 7**.** CPCCG recognise that hospitals need to work in partnership and that clinical and financial sustainability could be secured through potential merger of HHCT with PSHFT.

Figure 7 – Cambs and Peterborough CCG Fit for the Future

Fit for the Future programme	
At home is best	People powered health and wellbeing
	Neighbourhood care hubs
Safe and effective hospital care, when needed	Responsive urgent and expert emergency care including maintenance of 24/7 urgent care services at Addenbrooke's, Hinchingbrooke and Peterborough
	Systematic and standardised care including obstetric led maternity services at Addenbrooke's, Hinchingbrooke and Peterborough
	Continued world-famous research and services
We're only sustainable together	Partnership working with increased working across NHS and local authority social care boundaries; hospital and GP care, and physical and mental health
Supported delivery	A culture of learning as a system with increased sharing of education, training and research
	Workforce: growing our own
	Using our land and buildings better
	Using technology to modernise health

[4] Cambridgeshire and Peterborough CCG (2016) Fit for the Future available at http://www.fitforfuture.org.uk/fit-for-the-future

When CCGs have consulted with the local population on how their plans will impact on individual health providers, it is not possible to ascertain the direct impact on our Trusts, particularly Peterborough, but this should become clearer prior to merger.

Lincolnshire CCGs, local authorities and health providers have together developed a plan[5] to deliver sustainable services in the future which is summarised in Figure 8.

Figure 8 - Lincolnshire Health and Care - Case for Change

Lincolnshire Health and Care Case for Change	
Increased provision locally	Better use of buildings
	Increased one-stop shop
	Increased use of technology
	Support for patients to manage their own care
Improve emergency care and reduce use of A&E	Community crisis response
	Bring community services together
	Increase walk-in Urgent Care Centres across the county staffed by GP's and nurses
Centres of excellence	Specialist centres with one stop service for mental health, cancer, stroke and vascular
Maternity and children's services	Improve women's choice and provide more consistent support for midwife led births
	Ante natal and postnatal care closer to home
	Midwife-led maternity units
	Review of neonatal and consultant-led maternity services
	Review of children's emergency services

This collaboration must meet the requirements of both CPCCG and SLCCG, maintaining safe clinical services which are close to home wherever possible while delivering safe and effective hospital care where needed.

3.8 The two trusts in their current form

HHCT and PSHFT provide services to a combined population of around 700,000 people living predominantly in Cambridgeshire, Peterborough and South Lincolnshire (Figure 9). Their FY16 combined income was £372m with a combined forecast deficit of £54.8m. Between them, they employ 5,572 WTE employees.

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

[5] Lincolnshire Health and Care Case for Change (June 2016)

Figure 9 - Trusts at a glance

	HHCT	PSHFT
Main commissioners	Cambridgeshire and Peterborough CCG	Cambridgeshire and Peterborough CCG
		South Lincolnshire CCG
Populations served	193,000	507,000
Main commissioners	CPCCG	CPCCG 57%
	NHS England	SLCCG 22%
		NHS England 10%
		Others 11%
Turnover FY16	£112.3m	£260.8m
Surplus/deficit FY16	-£18.8m	-£37.1m
Surplus as % of turnover	-16.7%	-14.2%
Number of sites	1	2
Number of beds	235 + 21 day case in Treatment Centre	611 + 22 intermediate care at Stamford
Staff WTE	1,553	3,665
CQC overall rating	Good	Good

3.8.1 Trust services

Both trusts are district general hospitals; PSHFT is the larger of the two with a broader range of clinical services (Figure 10), with most of the inpatient services on the Peterborough City Hospital site, and predominantly outpatient services on the Stamford site, for example the pain management service based there is one of the largest in the region.

As with all trusts across the NHS, they face the ever increasing drive for efficiency whilst delivering service improvements, seven day services and the requirement to meet service standards contained within national reviews.

As is best practice, both trusts work closely with neighbouring teaching hospitals to provide specialist services through in-reach and shared staff. The main providers are Papworth, Addenbrooke's and University Hospitals Leicester. Examples include cancer services and major trauma at Addenbrooke's, cardio-thoracic at Papworth, and paediatric surgery and renal at Leicester and Addenbrooke's.

Figure 10 - Clinical services by trust

Service	HHCT	PSHFT	Service	HHCT	PSHFT
Accident & Emergency	✓	✓	Obstetrics	✓	✓
Acute Medicine	✓	✓	Oncology	✓**	✓
Ambulatory Care	✓	✓	Ophthalmology	✓	✓
Audiology	✓	✓	Oral and maxillofacial		✓
Breast Surgery	✓	✓	Pain		✓
Cardiology	✓	✓	Paediatrics	✓***	✓
Clinical haematology	✓	✓	Palliative care	✓	✓
Dermatology		✓	Pathology	✓	✓
Diabetes and Endocrinology	✓	✓	Plastics and dermatology	✓	✓
Diagnostic imaging	✓	✓	Radiotherapy		✓
Ear, Nose and Throat	✓	✓	Renal	✓**	✓
Endoscopy	✓	✓	Respiratory	✓	✓
Gastroenterology	✓	✓	Rheumatology	✓	✓
General Medicine	✓	✓	Stroke	✓****	✓
General Surgery	✓	✓	Therapy services	✓	✓
Geriatric Medicine	✓	✓	Thoracic Medicine		✓
Gynaecology	✓	✓	Trauma and Orthopaedics	✓	✓
Lower GI	✓	✓	Upper GI	✓	✓
Lymphoedema		✓	Urology	✓	✓
MacMillan centre	✓	✓	Vascular	✓*	✓*
Neonatal	✓***	✓			

*Networked service provided by Addenbrooke's
**Outpatient service only
***Provided on the HHCT site by Cambridgeshire Community Services
****Stroke provide acute but not hyper acute service

3.8.2 Quality

Following revisits by the Care Quality Commission both trusts have been rated overall as 'Good'.

PSHFT had a CQC revisit in May 2015 to review identified areas following the main trust inspection in May 2014. The final report was received and published in July 2015 giving an overall trust rating of 'Good'. A summary of their findings based on the initial inspection in 2014, with the updated scores for the areas they re-inspected in 2015 is shown in Figure 11.

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

Figure 11 - CQC ratings of PCH from inspections in Mar 2014 and May 2015

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

HHCT was revisited by the CQC in May 2016, following their earlier inspections in October 2015 and September 2014. On re-inspection, the overall rating was 'Good' and, based on the findings of the inspection; it was recommended that the Trust be removed from special measures with ongoing support continued during the period of transition.

The CQC noted outstanding practice including in areas of dementia; and partnership working between the hospital consultants and a local prison for end of life care. Areas for improvement include care delivery in the Emergency Department. The summary report is shown in Figure 12.

Figure 12 - HHCT CQC ratings August 2016

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

3.8.3 National performance standards

Figure 13 - Better Care Better Value performance Q3 FY16

Q3 FY16	Nat avg	HHCT	Rank[1]	PSHFT	Rank
Reducing length of stay[2]	13.91%	12.5%	20	12.9%	28
Emergency readmission (14 day)	5.4%	5.25%	65	6.47%	146
First to follow up ratio	1.97	1.57	18	1.74	46
Pre-procedure non elective bed days	1.6	1.24	46	2.13	136
Outpatient DNA	8.04%	5.49%	29	6.18%	36
Day case rate	78.72%	78.52%	109	77.24%	87
Pre-procedure elective bed days	0.25	0.04	54	0.12	46

[1] Ranked against all NHS organisations included in the indicator

[2] This indicator shows a percentage bed day saving and associated financial productivity opportunity to be realised (Lower is better).

Operating performance across both trusts is shown in Figure 13. *Better Care Better Value* benchmarking indicators are compiled by NHS Quality Improvement, and are used to identify potential areas for improvement in efficiency[6].

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

- length of stay,
- outpatient first to follow up ratios and 'Did not attend' rates,
- and pre-procedure elective bed days.

Pre procedure non-elective days and day case rates are both worse than average and the PSHFT readmission rate and the time patients are in hospital before an emergency operation (pre-procedure non elective bed days) are in the worst quartile nationally. The HHCT day case rate is also in the worst quartile.

As well as efficiency measures, all trusts must meet national performance standards, with sustainability and transformation funding being withheld from trusts which fail to perform. Both PSHFT and HHCT met all the national performance standards for the 12 months to July 2016 with the exception of the A&E four hour standard and the 62 day cancer target (Figure 14 and Figure 15).

Figure 14 - PSHFT performance against national standards July 2016

	Target		Previous year			Current year		
	Full Year	YTD	Q2	Q3	Q4	Q1	Jul	YTD
RTT - % Incomplete Pathways within 18 weeks	90%	92%	95.5%	94.6%	93.6%	94.2%	95.5%	94.6%
All Cancers - 2 Week Wait	93%	93%	94.7%	96.4%	96.7%	97.2%	96.3%	97.0%
All Cancers - 31 day wait from referral to treatment	96%	96%	100.0%	99.4%	99.1%	100%	99.1%	99.8%
All Cancers - 62 day wait from referral to treatment	85%	85%	88.3%	87.9%	80.4%	82.5%	77.2%	81.6%
All Cancers - 62 day screening	90%	90%	97.2%	93.1%	89.1%	92.5%	90.9%	92.2%
All Cancers - Subsequent Treatment - Drugs	98%	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
All Cancers - Subsequent Treatment - Surgery	94%	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
All Cancers - Subsequent Treatment - Radiotherapy	94%	94%	100.0%	94.3%	99.5%	100.0%	100.0%	100.0%
All Cancers - Subsequent Treatment - All	96%	96%	100.0%	98.3%	99.7%	100.0%	100.0%	100.0%
Breast Symptomatic	93%	93%	95.8%	98.3%	97.9%	93.7%	95.0%	93.9%
A&E - Total time in A&E 4 Hours or Less	95%	95%	95.9%	94.4%	81.1%	77.7%	75.0%	76.7%
C-Diff rates - Inpatients	31	10	10	11	7	7	2	9

[6] For further information, detail and indicator definitions see http://www.productivity.nhs.uk/

Figure 15 - HHCT performance against national standards July 2016

	Full Year Target	YTD target	Q2 Prev yr	Q3 Prev yr	Q4 Prev yr	Q1 Curr yr	Jul 2016	YTD
RTT - % Incomplete Pathways within 18 weeks	92%	92%	97.7%	94.4%	93.9%	93.5%	93.3%	93.3%
All Cancers - 2 Week Wait	93%	93%	97.3%	96.1%	91.5%	94.1%	98.9%	96%
All Cancers - 31 day wait from referral to treatment	96%	96%	100.0%	100.0%	100.0%	98.3%	100.0%	100%
All Cancers - 62 day wait from referral to treatment	85%	85%	88.6%	82.9%	86.2%	90.2%	88.0%	84.5%
All Cancers - 62 day screening	90%	90%	91.7%	100.0%	100.0%	66.7%	75.0%	92.2%
All Cancers - Subsequent Treatment - Drugs	98%	98%	97.1%	94.9%	95.9%	96.8%	100.0%	100.0%
All Cancers - Subsequent Treatment - Surgery	94%	94%	94.9%	94.4%	97.0%	98.2%	100.0%	99.0%
All Cancers - Subsequent Treatment - Radiotherapy	94%	94%						
All Cancers - Subsequent Treatment - All	96%	96%						
Breast Symptomatic	93%	93%	94.4%	97.2%	94.5%	95.1%	95.1%	95.4%
A&E - Total time in A&E 4 Hours or Less	95%	95%	97.4%	94.1%	87.1%	80.2%	86.5	80.6%
C-Diff rates - Inpatients	11	11	3	1	1	4	0	4

3.8.4 Patient demographics

The ONS 2016 population estimate of the Cambridgeshire and Peterborough CCG is over 850,000 (Figure 16). Of these, just under 200,000 live in Peterborough, 124,000 in Cambridge with the remaining half a million in the smaller market towns of St Neots (40,000), Wisbech (31,000), Huntingdon (24,000), March (23,000), Stamford (21,000), Ely (20,000) and St Ives (16,000) and places in between.

Peterborough is one of the fastest-growing cities in the UK according to the Centre for Cities (2015)[7] study, with an annual growth rate of 1.6% between 2003 and 2013, more than double the national average of 0.7%. Growth of 11% is forecast in Peterborough between 2016 and 2021, compared with 10% for the CPCCG and 4% for SLCCG.

The population profile of Huntingdonshire is expected to become older faster than the average for the rest of Cambridgeshire and Peterborough. While the CPCCG population over the age of 65 is forecast to grow by 14% between 2016 and 2021, Huntingdonshire is forecast to grow by 17% so that by 2021, one in five of the population will be over 65 placing immense pressure on health services.

[7] Centre for Cities (2015) *Cities Outlook 2015*, Centre for Cities (January 2015) Available at http://www.centreforcities.org/reader/cities-outlook-2015/3-city-monitor-the-latest-data/#figure-1-population-growth

Figure 16 - CCG population forecasts

District council/UA/ CCG	Total Population				Over 65s					
			Change 2016-21				Change 2016-21		% over 65	
	2016	2021	No	%	2016	2021	No.	%	2016	2021
Fenland	98,300	104,000	5,700	6%	22,200	24,800	2,600	12%	23%	24%
Huntingdonshire	177,800	193,400	15,600	9%	33,800	39,400	5,600	17%	19%	20%
Peterborough	198,300	220,700	22,400	11%	28,400	32,200	3,800	13%	14%	15%
CPCCG other	377,300	416,600	39,300	10%	62,900	71,900	9,000	14%	17%	17%
CPCCG total	851,700	934,700	83,000	10%	147,300	168,300	21,000	14%	17%	18%
SLCCG total	145,839	152,224	6,385	4%	34,290	37,929	3,639	11%	24%	25%

Increasing population will drive demand for healthcare, but an ageing population will create significantly more demand than is attributable to the population rise alone. Data from the CPCCG shows that almost two out of every three hospital bed days they commissioned were occupied by patients over the age of 65 in 2013/14. The highest occupancy by this age group was in Hinchingbrooke where they occupied more than three out of every four bed days (Figure 17). This figure is forecast to rise to as high as nine in every ten bed days by 2031.

Figure 17 - Bed days occupied by patients over 65

Bed days occupied by patients aged over 65 as % of all bed days	Actual	Forecast		
	2013/14	2016/17	2020/21	2031/32
Addenbrooke's	67%	69%	72%	80%
Hinchingbrooke	76%	79%	82%	89%
PSHFT	66%	68%	71%	79%
Others	44%	46%	49%	59%
TOTAL	62%	64%	67%	76%

Collaboration should meet the needs of an ageing population in Huntingdonshire locally whilst managing the significant population growth in the urban population of Peterborough.

3.8.5 Health of the people within the catchment

The Joint Strategic Needs Assessments and Public Health profiles for the catchment areas provide a summary of the health needs in the catchment of the combined trust. A summary of key local health indices is shown in Figure 18.

In response to the Peterborough Joint Strategic Needs Assessment (2016)[8] and the move of Papworth Hospital to the Cambridge Biomedical Campus, PSHFT has developed a business

[8] Peterborough UA (2016) Joint strategic Needs Assessment published September 2016 Available at https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

case which protects and enhances the cardiology services at Peterborough. The case aims to meet this specific need of the Peterborough, Fenland and South Lincolnshire populations, whilst also meeting the health requirements of an ageing population in Huntingdonshire district.

Figure 18 - Summary of health indices in enlarged catchment area

Area	Priorities
Peterborough	Reducing premature mortality, reducing inequalities in coronary heart disease and promoting healthy lifestyles.
Huntingdonshire	Addressing inequalities in health, planning in partnership to meet the needs of an ageing population and long term prevention of ill health across all age ranges.
South Lincolnshire	Reducing levels of obesity, alcohol related disease and levels of smoking.
Fenland	Preventing coronary heart disease, meeting the needs of an ageing population, ill health associated with alcohol misuse, engaging the local population and improving communication on health issues.

In response to the Cambridgeshire Joint Strategic Needs Assessment and the ageing population in Huntingdonshire, HHCT has proposed a health campus to meet the complex needs of older people. The campus is described in more detail in the clinical vision.

3.9 Summary

The case for change is built on the need to address the needs for healthcare, for a growing and ageing population across the catchment in a financially constrained environment. This needs to be provided locally where it is safe to do so, with the critical mass to support the size of teams.

4. Option appraisal

4.1 Introduction

'Do nothing' is unacceptable as it fails to address the clinical and financial unsustainability challenges and does not support the direction described by our commissioners in the strategic options case.

The remaining three options that were considered in detail describe greater integration ranging from service level agreements, through to a single management team operating across two boards and full merger.

The fundamental difference between merger and the other two options is the deliverability of the required joint working by the two clinical teams. These were identified in the option appraisal as different ways that people work in the two organisations, with organisational structures which can result in difficult interfaces, different decision-making processes and delegated authority, disputes over responsibility for financial investment, incompatible IT systems and inability to standardise, as well as competing priorities and cultures in the respective organisations.

While none of the options completely eradicates all barriers, particularly those linked to culture, the appraisal conclusively showed that there was less risk in the merger option due to the greater direct control over the change process.

4.2 Changes since the OBC option appraisal

The OBC option appraisal was conducted in March 2016. Since that date, the most important change has been the Care Quality Commission inspection of HHCT due to their overall 'Requires Improvement' rating and the 'special measures' which were imposed after a previous inspection in 2015. As a result of the most recent inspection, 'special measures' have now been removed and they have been rated as 'Good' overall.

Changes have been made to the finances which are described in the finance chapter which include alignment of assumptions for sustainability and transformation funding, cost improvement and CCG demand management schemes.

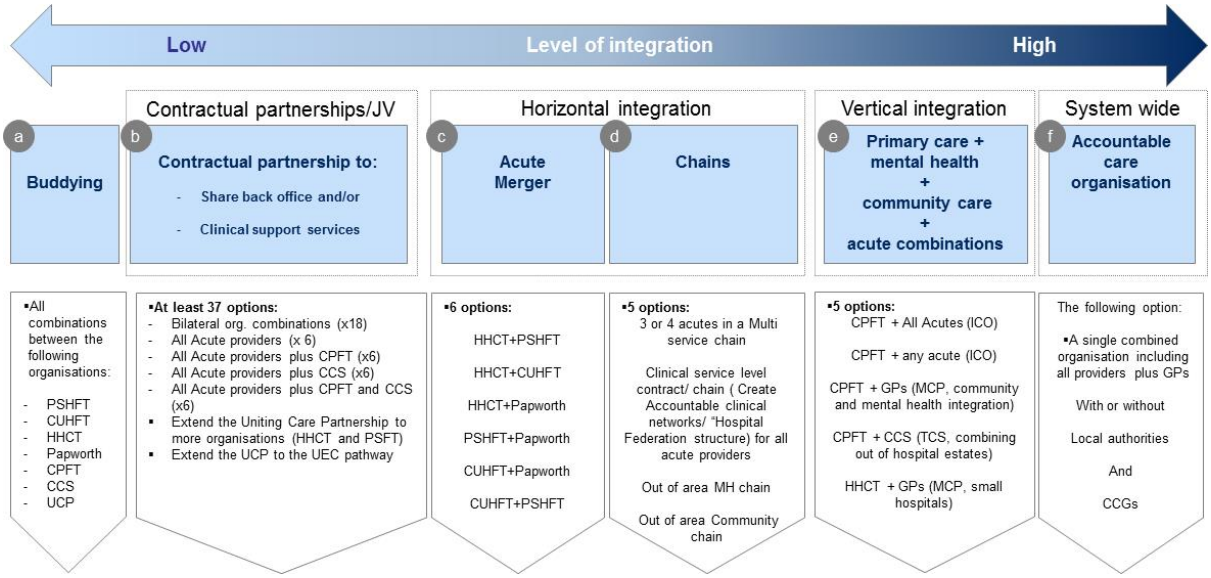
There have been service closures at HHCT since the completion of the OBC. The nuclear medicine service has recently stopped in August 2016 because of issues with specialist staff and equipment. Dermatology outpatient service which was provided on the HHCT site by Addenbrooke's is now no longer provided following a 12 month notice period.

4.3 Options to address the key drivers

4.3.1 Long list options

The long list of options identified by the local health economy for collaboration ranged from low to high levels of integration as shown in Figure 19. They range from 'loose' buddying arrangements through the whole spectrum of contractual partnerships, horizontal and vertical integration, through to the creation of a single organisation providing health needs for a given population.

Figure 19 - Long list of organisational form options across the local health economy



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

The Local Health Economy partners agreed an incremental approach to changing both function and form across Cambridgeshire and Peterborough, via the development of a short to medium term (0 to 5 years) programme of work involving the Cambridgeshire and Peterborough system focusing on deliverable benefits of integration and alignment.

Other options such as horizontal integration with another trust, or vertical integration with community providers or social care were discounted at this stage. Learning from the lessons of other mergers, collaboration is more likely to be successful where they:

- work in the same sector
- are geographically close
- the acquiring trust is larger than the trust being acquired

Working in the same sector

Collaboration between organisations working in the same sector is more successful. As was shown in chapter 3, there are many similarities in the range of services provided by the two trusts. Both trusts provide district general hospital care to catchment populations which border each other.

While there are future plans in the LHE for vertical integration with primary, community and social care, the level of synergies is lower than there are between the two hospitals, and for this vertical integration was discounted at this stage.

Geographically close

Mergers between organisations which are geographically close are more successful than those with more distance between them. Indeed there are few, if any, planned or actual mergers where the NHS trusts were not neighbours.

Collaboration of the two trusts makes sense geographically when compared with Addenbrooke's, Bedford, Kettering or Lincoln hospitals.

The best road links exist between the HHCT and PSHFT trusts compared with other acute hospitals. The A1(M) makes joint working of clinical teams achievable, particularly when compared with the travel distance and more importantly travel time incurred if the trusts were to attempt working with other hospitals.

The main transport links in Cambridgeshire and Peterborough are the A1 north-south road which connects Huntingdon and Peterborough, and the A14 east-west road which connect Huntingdon with Cambridge. The regional rail link connects Peterborough and Huntingdon on the East coast mainline. Huntingdon is connected to Cambridge by the guided busway.

The A14 between Huntingdon and Cambridge is often congested as the east-west traffic on the A14 merges with the A1 to M11 north-south traffic on a two lane dual carriageway. The A1(M) four lane motorway link between Huntingdon and Peterborough is far less congested. Typical road journey times calculated using Google maps (Figure 20) shows the Google average travel time by car at 7.30am on 5 September (peak time), and 2pm (off peak).

Figure 20 - Travel times to Cambs & Peterboro hospitals from HHCT catchment

Travel to hospitals/ mins (miles)	Hinchingbrooke		Peterborough City		Addenbrooke's	
	Peak:	Off Peak:	Peak:	Off Peak:	Peak:	Off Peak:
Alconbury	14-35 (5.6)	16 (5.6)	24-30 (19.4)	22-28 (19.4)	40-90 (26.5)	35-45 (26.5)
Biggleswade	28-45 (20.1)	30 (20.1)	45-55 (39.7)	45-90 (39.7)	40-50 (22.3)	45 (22.3)
Chatteris	28-35 (16.0)	26-30 (16.0)	35-45 (22.5)	40 (22.5)	30-75 (26.8)	45-55 (26.8)
God'chster	7-10 (2.1)	6-8 (2.1)	26-35 (24.7)	26-35 (24.7)	35-75 (20.8)	26-35 (20.8)
Huntingdon	7-9 (2.0)	6-9 (2.0)	35-45 (25.9)	30-40 (25.9)	35-65 (22.0)	30-40 (22.0)
Kimbolton	20 (11.2)	20 (11.2)	35-50 (29.1)	35-45 (29.1)	55-100 (33.0)	45–60 (33.0)
March	40-50 (23.0)	45 (23.0)	35-45 (20.7)	40 (20.7)	65-85 (34.3)	60-70 (34.3)
Ramsey	24-30 (12.6)	24-26 (12.6)	26-35 (17.2)	30 (17.2)	50-70 (30.6)	50-55 (30.6)
Sandy	24-35 (17.2)	24-28 (17.2)	40-55 (36.8)	40-50 (36.8)	40-50 (23.0)	45 (23.0)
Sawtry	18-40 (11.2)	18-22 (11.2)	18-24 (14.8)	18-22 (14.8)	45-100 (31.1)	40-50 (31.1)
St Ives	14-18 (6.3)	16 (6.3)	35-45 (25.9)	35-45 (25.9)	35-55 (20.7)	30-40 (20.7)
St Neots	16-20 (9.1)	18 (9.1)	35-45 (28.7)	35-45 (28.7)	40-65 (22.4)	35-45 (22.4)
Stilton	22-40 (16.0)	22-28 (16.0)	14-20 (10.0)	14-18 (10.0)	45-100 (35.9)	40-55 (35.9)
Swavsey	20-26 (12.4)	22-26 (12.4)	35-50 (33.2)	35-45 (33.2)	28-40 (15.0)	26-35 (15.0)
Warboys	18-24 (8.9)	18-20 (8.9)	35-45 (21.7)	40 (21.7)	40-65 (26.1)	40-50 (26.1)
Yaxley	20-26 (16.8)	20-24 (16.8)	14-20 (7.3)	14-18 (7.3)	45-100 (36.7)	40-55 (36.7)

Times between Huntingdon and Addenbrooke's (maximum 65 mins) are 50% longer at peak time than they are from Huntingdon to PCH (maximum 45 mins) even though Addenbrooke's is four miles closer.

Even St Neots which is six miles closer to Addenbrooke's incurs an additional 20 minutes travel time (45% longer) compared to driving north on the A1(M) at peak time.

Keeping services safer and local as a result of the merger will only require patients to travel to tertiary centres when the clinical benefits outweigh the additional cost and the difficulty of doing so.

Although HHCT is a similar distance from Kettering, congestion on the A14 around Kettering and the different commissioners make this merger less attractive.

For the reasons given, horizontal integration with other acute providers at Kings Lynn, Bedford, Lincoln, Kettering and Addenbrooke's were discounted. Other barriers to integration with the first four providers were discounted due to the limited clinical pathways already in place with these trusts, the different commissioners and separate sustainability and transformation planning processes.

Acquiring trust is larger than the trust being acquired

As was shown in Chapter 3, PSHFT has over twice the income of HHCT, more than double the number of beds, and over twice the catchment population. Other neighbouring trusts include Kings Lynn and Kettering, but Kettering is of a similar size to PSHFT (£219m income), and Kings Lynn is geographically less accessible than HHCT with travel distances of around an hour as well as being in a different LHE with different commissioners.

4.3.2 Short list options

This evaluation of the short list of options resulted in four options which would be further explored (Figure 21):

Figure 21 - Short list of options for collaboration between PSHFT and HHCT

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

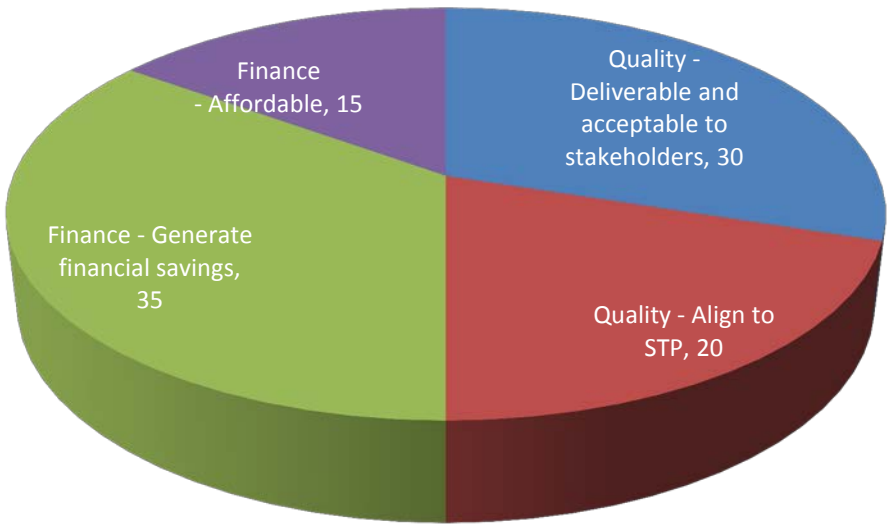
The four short listed options were assessed using the criteria shown in Figure 22, using a process agreed by both boards.

Figure 22 - Option appraisal criteria

Must be deliverable and acceptable to patients and other stakeholders including staff	• Maintain safe staffing levels • Maintain commissioner requested services • Minimise the extent to which patient choice is reduced • Ability to alignculture and other values in a short period of time
Aligns to STP plans that aim to secure sustainable and safe services for patients	• Enabler to address the capacity mismatch across the patch • Compatability with the clinical work streams currently underway • Ability to build on local clinical collaborations and work already done [with UCP] in the community • Aligns with the principles of the Five Year Forward View
Must generate financial savings to ensure safe and sustainable services for patients	• Continue high quality services within the financial envelope • Ensure long term financial viability of any new provider forms • Significant financial savings through synergies and better use of physical capacity
Must be affordable, making the best use of public funds	• The cost of investment must not be excessive relative to the financial benefits • The payback period should be reasonable • Must consider what/whether central funding will be available within the LHE

Options were appraised by an equal number of executives and included both Medical and Nursing Directors from both trusts in a session which was independently facilitated and monitored by an external assurer. The boards agreed weightings for the assessment criteria (Figure 23) with quality and finance equally weighted.

Figure 23 - Option appraisal criteria weightings



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

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

4.4 Appraisal of options

Figure 24 – Summary of option appraisal

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

The option appraisal process resulted in a strong and clear recommendation that option 4 (merger) was the best form to deliver the stated aims of the collaboration.

The four options were assessed and scored with a higher number indicating that the option is more likely to meet the appraisal criteria (Figure 25).

A detailed description of the option appraisal is included in Appendix 2.

4.4.1 Meeting the clinical sustainability challenge

The key clinical benefits of merger identified by the Executive teams were tested with clinicians during development of the FBC. A summary of the benefits is summarised in Figure 25.

For similar reasons to those identified in Figure 25, merger is the best option to address the key issues of scale and the consequent ability to recruit and retain the clinical skills required for the populations we serve.

Meeting the recruitment challenge is key to our clinical benefits case. Since approval of the OBC, teams have been working together to recruit to some of the posts in the clinically unsustainable services, with HHCT candidates being offered the opportunity to work in joint team with PSHFT consultants in the knowledge that both trusts are considering merger.

Figure 25 - Benefits of merger

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

Example 1 - Clinical haematology is one example where HHCT have been unable to recruit. Once the post was advertised as working with the PSHFT team, there were applications from strong suitably qualified candidates, meaning that patients in the HHCT catchment will benefit from locally provided expertise.

Example 2 - The orthopaedics teams from both trusts have met and discovered that PSHFT had more good quality middle grade doctor candidates than posts, whereas HHCT had insufficient candidates to fill all their posts. Through discussion between the teams and with the potential candidates at interview, they were able to offer a joint approach which filled all the vacancies at HHCT.

These early examples demonstrate the recruitment benefits which we anticipate will be achieved through the merger of other services. However, they are dependent on a commitment to the two trusts merging.

4.4.2 Meeting the financial challenges

The OBC demonstrated at a high level that from FY20 onwards, the deficit of the combined trust was forecast to be £6.7m yearly, a significant improvement over the current forecast yearly deficit of £31.7m for both trusts in FY17.

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

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

This is described in more detail in the following chapters where the savings associated with merger are analysed in greater detail. This includes how the clinical and financial benefits identified in the OBC will be delivered, together with an updated analysis of the associated savings. This is compared to the FY17 budgets of both organisations.

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

A high level review of both organisations' assets and liabilities is provided so that both boards understand the risks and opportunities of the merged organisation.

A summary of the NPV calculations of the three options for collaboration over 10 years, discounted at the Treasury recommended value of 3.5% is presented in Figure 26. This shows that option 4 provides the highest return over a period of 10 years.

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

- NPV over 10 years (standard assumption for strategic cases)
- Redundancy is not included in the calculation of costs as per the Green Book; and
- Full benefits are realised from year 2 under options 2 and 3.

Figure 26 - Option appraisal scores and NPV

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

4.4.3 Maintaining patient choice in Huntingdonshire

Both trusts stated they are passionate about providing services which are better, safer and local. They are committed to providing high quality care that is easily accessible to the local population.

There may be future changes, particularly as a result of the STP, but there will continue to be an ED consultant and acute physician-led urgent care service, and obstetric led maternity service at Hinchingbrooke.

There are already some complex cases (such as strokes, heart attacks and major trauma) that are not treated at Hinchingbrooke and this will remain the case, with Hinchingbrooke continuing to provide a 24 hour service for adults and paediatrics with all other conditions, from minor injuries and illnesses through to major conditions.

4.5 Areas the merged trust will serve

4.5.1 Catchment areas

The combined catchment area for both trusts will result in a larger population which will sustain larger clinical teams and allow sub-specialism which will improve recruitment and retention of staff. The merged trust catchment is shown in Figure 27. The core catchment is based on 40% of the population in each electoral ward being treated at either HHCT or PSHFT.

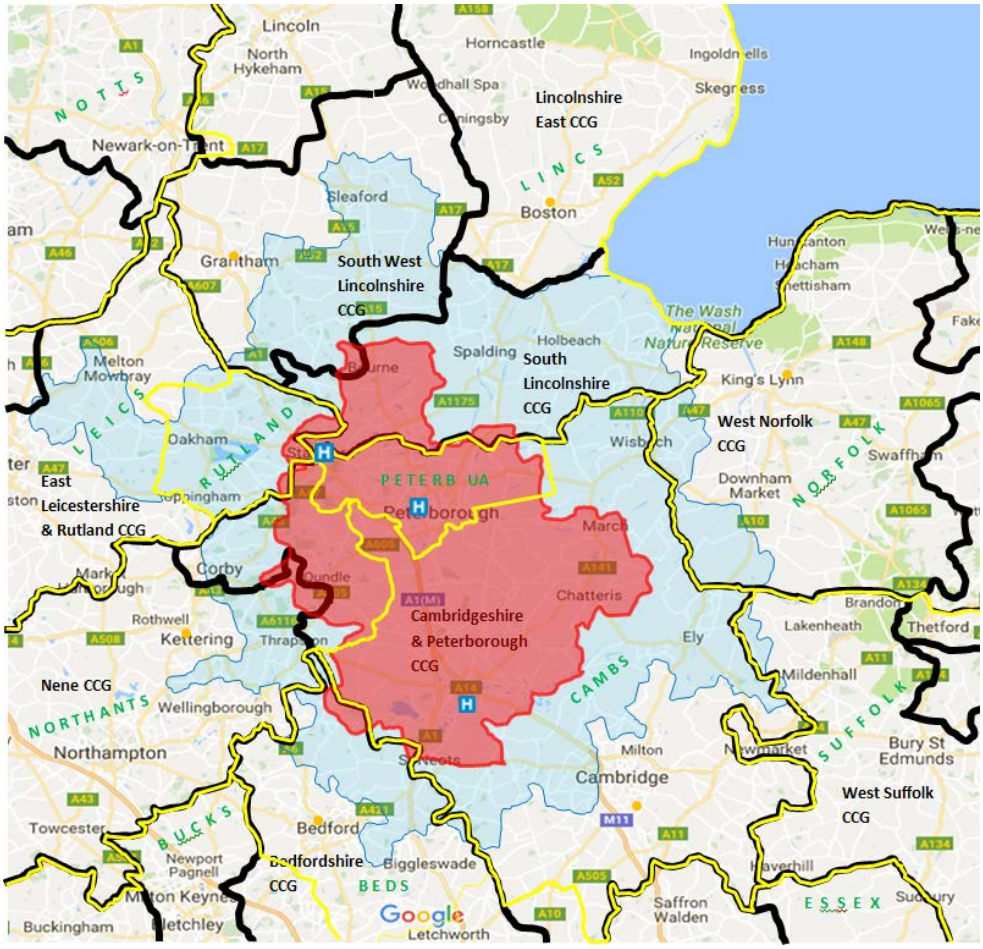
The combined trust catchment includes Peterborough, Huntingdon, South Lincolnshire, central and northwest Cambridgeshire, Stamford and St Neots. The A1 is a key route which passes through the centre of the catchment.

The core areas include the urban area of Peterborough, and the market towns of St Neots, Huntingdon, Stamford, St Ives, Bourne, March and Chatteris.

The wider catchment extends to the city of Ely and the market towns of Wisbech, Oakham, Spalding, Sleaford, Thrapston and Holbeach.

Six CCGs are included in the core catchment area including Cambridgeshire and Peterborough CCG, South Lincolnshire CCG, East Leicestershire and Rutland CCG, Nene CCG, South West Lincolnshire CCG and Bedfordshire CCG. Other CCGs in the wider catchment include West Norfolk CCG and West Suffolk CCG.

Figure 27 - HHCT and PSHFT catchment areas



Key:

- Hospitals
- Wider catchment area
- Core catchment area
- PSHFT / HHCT Hospitals
- CCG areas
- County Boundary intersecting CCG
- County Boundary

4.5.2 HHCT and PSHFT clinical synergies

As well as being geographically close, there are clinical synergies between PSHT and HHCT. Both DGHs provide similar levels of care at similar levels of acuity the main difference is the volume. They fit together naturally as service providers for the catchment area.

4.5.3 Confirmation of the preferred option by CEOs

During development of the OBC, an Executive-led appraisal of the options for collaboration was completed. We considered four options for collaboration: do nothing; service level agreements between the two trusts to provide services; a single management team working across both trusts but reporting to two separate boards; and, full merger.

Following an independently-observed and board-approved appraisal process; full merger was identified as the preferred option as it provides the best opportunity to sustainably meet the financial and clinical challenges.

On review of the information contained in the full business case, both CEOs have confirmed that the evidence supports even more strongly than before that merger is the preferred option.

Merger of HHCT and PSHFT will:

1. Maintain or improve the sustainability of clinical services at HHCT
2. Improve the sustainability of clinical services at PSHFT
3. Enable financial benefits of more than £9m to be achieved through the integration of back office functions
4. Improve patient experience through recruitment and retention of the best specialists with more realistic rotas, increased training and educational opportunities
5. Improved infrastructure for example through the single procurement and running of IT; greater flexibility of major equipment and more robust business continuity
6. Actively engage with the local community through the development of a membership strategy and body in Huntingdonshire. PSHFT has over 9,000 members with public and staff representation on the Council of Governors and the ability to appoint the Non-Executive Directors and hold the Board to account. This would be expanded to Huntingdonshire as a part of a merger.

The CEOs of both organisations have reviewed the basis of the option appraisal conducted in March 2016 and confirm that merger remains the preferred option.

4.6 Regulator OBC view

Following Board approval, the OBC was reviewed by NHS Improvement who supported the findings and the decision to progress towards Full Business Case.

4.7 Competition and Markets Authority (CMA) view

NHS Improvement (NHSI) provided an analysis of GP referral patterns and additional information from the trusts to the Competition and Markets Authority (CMA). After reviewing the analysis, in June 2016, the CMA told NHSI that it did not propose to seek further information about the merger. This does not preclude the CMA from reviewing the merger if, for example, it were to receive a complaint. However, on this basis, and having discussed this with NHSI, we propose not to notify this merger to the CMA.

4.8 Commissioner support

The Cambridgeshire and Peterborough CCG Governing Body considered the proposed merger at their meeting in public on 13 September 2016. On the recommendation of their Clinical and Management Executive Team, the Governing Body agreed to support the proposed merger (formally acquisition) of PSHFT and HHCT.

The Governing Body acknowledged that whilst the final decision rests with each individual Trust Board following review of the Full Business Case, they believe that the principles of the merger support the clinical, workforce and financial sustainability of both Trusts.

A copy of the supporting letter is included at Appendix 3.

4.9 Summary

The option appraisal shows merger as the best collaboration option to address the challenges of clinical and financial sustainability faced by one or both organisations. The option has been confirmed by the further work undertaken on the finances and clinical services during development of the FBC.

5. Clinical vision for our merged Trust

Merger will help to improve clinical and financial sustainability and will provide exceptional opportunities to deliver a step change in the strength and depth of many of the patient services currently provided. These opportunities will arise as a combination of the increased catchment population and critical mass of clinical specialists.

The merged Trust will be significantly more attractive to prospective job applicants and clinical leaders which, in partnership with primary care, community and specialist partners will improve services for the catchment population.

For those services which will continue to provide 24/7 emergency cover and those where there are significant national recruitment challenges, there are limited opportunities to make significant changes to services from day one, although recruitment should improve. There are opportunities to make improvement to outpatient and elective care more quickly.

The first 18 months of the merger, while challenging, will be an exciting time in which to establish the level of ambition for the combined trust. During that time, we will further develop the clinical vision described in this chapter. The right culture will be fostered to provide clinical and managerial leaders and teams with sufficient autonomy and freedom to take advantage of the available opportunities.

5.1 Vision for the combined trust

A clinical vision for the combined trust has been developed by the clinical advisory group and the Boards of both trusts. It sets out an overarching five year vision to:

"Deliver excellent health care in the most efficient way from our hospitals which are great for patients and great for staff."

We will safeguard high quality services within our hospitals through developing durable and meaningful relationships with community partners to reduce pressure on the healthcare system.

We will deliver this vision through:

- Consistently delivering high quality services regardless of location or time
- Ensuring equality and ease of access for all of our services with minimal duplication and delay
- Being an organisation that is always learning and teaching
- Having a diverse workforce that is confident, competent, happy and able to meet the needs of our patients
- Delivering care in the right setting for patients and changing the way we provide care through innovations such as the Health Campus in Huntingdon thereby better integrating all elements of health and social care
- Increasing our research and innovation footprint to enable us constantly to improve our services
- Continuing to compare and benchmark our quality and safety against others to learn how we can improve our services

- Building a shared culture and value base that is founded on doing and being the best we can be for our patients, staff and communities

We have been clear in our communication with the public and staff throughout our engagement period that there are no plans to reduce any services at any hospital site as a result of this merger. This is not an assurance that things will never change. It is possible that at some point in the future our commissioners may decide they want to see services delivered differently. However, any significant changes to the provision of clinical services would require commissioners to undertake a full consultation with the public.

The Sustainability and Transformation Plan (STP) update published by Cambridgeshire and Peterborough CCG in July 2016 gave assurances that 24/7 A&E, obstetric-led maternity and paediatric services will remain at Hinchingbrooke.

Both trusts are passionate about providing services which are better, safer and local. They are committed to providing high quality care that is easily accessible to the local population. There may be future changes, particularly as a result of the STP, and other national recommendations to improve pathways of care.

We are also committed to the ongoing continuation of our partnerships and networks with specialist and tertiary services to ensure that our patients have access to world-class services such as those available at Addenbrooke's and Papworth. We see these relationships as crucial in ensuring delivery of best practice, promoting innovation and continuing to improve patient outcomes. They will also assist in the recruitment and retention of high calibre staff.

5.2 Clinical vision

Our clinical vision is described in Figure 28.

Figure 28 - Clinical vision

Our clinical vision describes our aim and priorities to develop a successful combined trust arising from the merger of HHCT and PSHFT, that will deliver the best patient care as close to home as possible. In developing our strategy we are aware of our responsibilities to secure financial sustainability and to play a lead role in the local health economy.

The 'Five Year Forward View' sets out a clear and compelling direction for the NHS. It explains that the NHS needs better ways of delivering services, including those that are not confined to hospital care. Our combined organisation provides us with many opportunities to implement these ideas to strengthen existing essential services and to develop specialised services closer to home.

In doing this we recognise that:

- Care should be personal, whilst based on population health needs.
- All aspects of care should be patient centred and rigorously evaluated by measurement of quality outcomes captured through effective IT infrastructure and systems.
- Care should be delivered in the right place, by the right person, first time every time
- There should be renewed focus on coordinated care systems and networks
- A greater emphasis should be given to out-of-hospital care
- Consolidation of services should be supported where it demonstrably delivers improvements in quality and safety

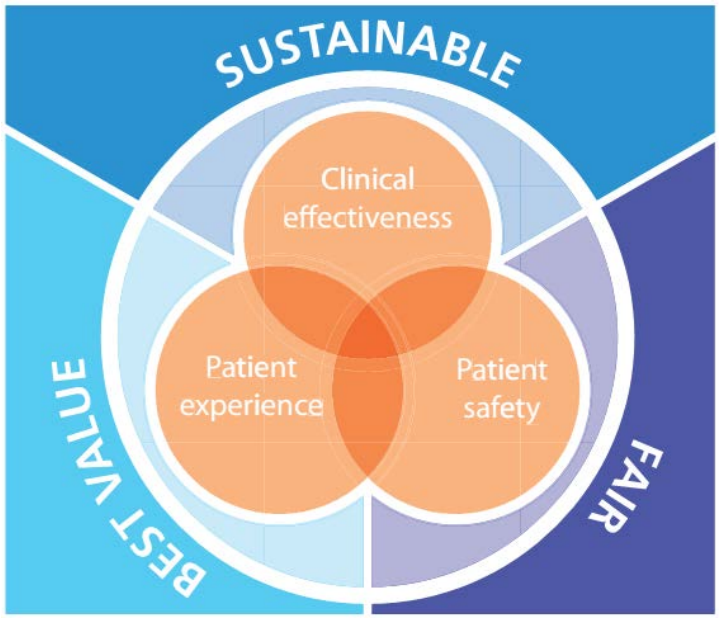
- Equity of care is central to our beliefs and therefore greater standardisation of processes, use of technology and shared information are essential

We recognise that our staff and our patients are crucial to our success. This is their strategy and reflects their commitment to high quality and safe services forming the foundation for excellence in our new organisations.

5.3 Clinical sustainability

Sustainable services are those which are located and sized appropriately according to need, and staffed by people with suitable experience and qualifications to provide high quality services that are effective, efficient and represent value for the tax payer (Figure 29).

Figure 29 - Definition of clinically sustainable services



The CAG defined services as being 'clinically unsustainable' if one or more of the following conditions are met:

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

Working with these criteria, medical and nursing directors for both trusts identified four services that are currently unsustainable.

5.3.1 Clinical sustainability challenges facing the combined trust

For both trusts 'doing nothing,' and remaining as they are, is not an option. We have identified that clinical sustainability challenges face both trusts, with HHCT, as the smaller of the two, generally facing the greatest challenge.

The OBC described 12 services which are unsustainable now or will become unsustainable in the medium term if there is no change to the immediate situation or approach (Figure 30). Respiratory was added because it is a high volume medical specialty with a shortage of

consultants at Hinchingbrooke and a reliance on diagnostics undertaken at Papworth which will be more difficult to sustain when Papworth moves to the Addenbrooke's site.

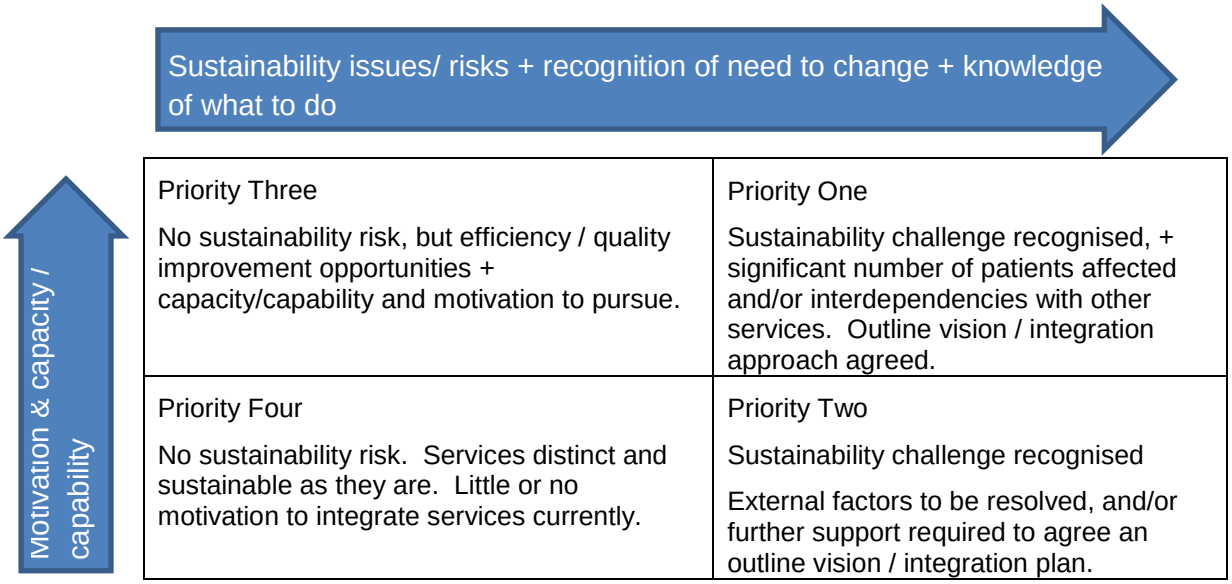
Figure 30 – Unsustainable services identified in the OBC

	Unsustainable	
	Now	Medium term
Accident & Emergency	✓	
Acute Medicine		✓
Cardiology		✓
Clinical haematology	✓	
Diagnostic imaging / Interventional radiology		✓
Gastroenterology (PSHFT issue)		✓
Nephrology		✓
Neurology		✓
Ortho-Geriatrics (part of orthopaedics)		✓
Palliative care		✓
Respiratory *added post OBC*		✓
Spinal surgery (part of orthopaedics)	✓	
Stroke	✓	

5.3.2 Sustainability plans

The experience from other mergers shows that integration must be realistically paced and carefully managed or the intended benefits are unlikely to be achieved. The Clinical Advisory Group prioritised those services which face the greatest sustainability risks for integration first, identifying them with a change readiness evaluation tool (Figure 31).

Figure 31: Clinical Service Integration - Prioritisation according to need



The six priority services for focus in the FBC are:

- Stroke
- Emergency Department
- Diagnostic imaging
- Cardiology
- Respiratory medicine
- Clinical haematology (blood disorders)

Respiratory was added because it is a high volume medical specialty with a shortage of consultants at Hinchingbrooke and a reliance on diagnostics undertaken at Papworth Hospital which will be more difficult to sustain when Papworth moves to the Addenbrooke's site.

5.3.3 Clinical engagement

The process of developing the future vision for all clinical services has been clinically led. The project team has met with 27 services. The three remaining services, paediatrics (including neonatal intensive care), nephrology and pathology, have not been engaged at this time because they are provided at Hinchingbrooke by other NHS providers. The possibility of integrating these services may need to be revisited at some point in the future however they are outside the scope of this business case.

For all of the clinical services the same methodology has been adopted, but more time has been spent with the services identified in the Outline Business Case as having the highest priority due to sustainability risks, and also because of significant inter-dependencies with other services.

The clinical engagement has taken place over the summer period, with many meetings held with both HHCT and PSHFT teams together. Where this was not possible, separate trust services shared notes and plans to develop a shared view.

There has been excellent engagement by clinical staff in the process. For each service, teams adopted a common approach which identified:

1. Their current state of change readiness
2. Their strengths and weaknesses as current services
3. Opportunities and threats of moving towards a merged service
4. Current levels of integration, and future milestones for an increasing integration; including what will be achieved by 'day 1', 100-days post transaction, remainder of year one, year two etc.
5. An outline plan (more specific for the 6 services) of actions for the period leading up to, and after, the merger (transaction) date.

Integration plans have been summarised in a single page. The full range of one page single summary integration plans are contained in Appendix 5 some of which are in draft while others have been agreed with the clinical teams.

A clinical integration model shown in Appendix 6 has been developed based on a clinical networking approach used for the STP. In developing this approach we recognised the value of creating a shared culture for our new organisation and the services delivered within it. The establishment of common ground, a common vision and the cultural integration of different teams are a cornerstone of the work already undertaken. Continually building on this and

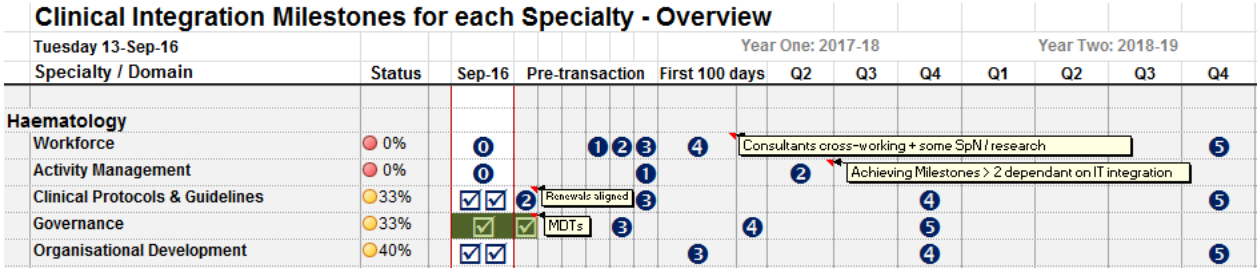
strengthening it as we go forward will enable us to create truly integrated services and staff with shared value bases and approaches.

Gateways have been developed across five domains, workforce, activity management, clinical protocols and guidelines, governance, and organisational development. Integration will be appropriately phased, with support, infrastructure and leadership in place to reinforce and sustain the changes made. Each domain has five gateways ranging from zero (not integrated at all) to five (fully integrated). A copy of the service integration milestone definitions is provided as Appendix 6.

The specific actions required to move through each gateway will vary from service to service, depending on the level of integration to be achieved, although there will be many common themes. There are also interdependencies which will dictate the pace of change such as the requirement for IM&T infrastructure.

A summary overview of where we expect each service to be, before and after transaction, is being developed, a service at a time. It will inform a future more detailed clinical service strategy work once we are operating as a single Trust. A sample of the integration timeline is shown in Figure 32 and the timeline for all six priority specialties is in Appendix 7.

Figure 32 - Sample clinical integration timeline



The numbers refer to defined gateways being achieved by a particular point in time. Level 5 represents full integration of the two teams. This is explained further in Chapter 10 - Moving forward.

5.4 Vision and plan for six priority clinical services

The PSHFT and HHCT clinical teams for the six priority clinical services have had a series of clinical integration meetings to examine what makes these services unsustainable either now, or in the medium term, and explore how this could be addressed through integration. They have also identified the opportunities to improve the quality of their services. This process is iterative and will be developed further during the period up to and after the merger.

Of the six clinical services identified in the OBC there are some immediate opportunities to improve. The work undertaken to date has also identified that sustainability for a number of the services will take longer due to the necessity to recruit to key posts at one or more sites.

Clinical haematology have identified and commenced implementation of service developments to improve the current range and level of services delivered across all trust sites. This will address the identified issues and diversify the services available locally to patients.

ED and **diagnostic imaging** services at **both Trusts** have a number of vacancies which limits the possibility of sharing staff across all sites without potentially destabilising the other service. The merger will not immediately resolve the clinical sustainability of these services. We have identified future opportunities that will improve the standardisation of service delivery and the opportunity for attracting suitable staff through recruiting to a larger and more diverse service.

Stroke services clinicians from both trusts reaffirmed the OBC conclusion that the current service is potentially sustainable at PSHFT although there are staff recruitment challenges on both sites at present. The stroke service is currently unsustainable at HHCT because there are no specialist stroke consultants or specialist registrars in post with cover provided by general medical locum doctors, and the general medical rota out of hours. PSHFT have had challenges meeting the clinical standards for access to dedicated stroke beds.

PSHFT has budget for four consultants, with two substantive consultants currently in post plus two locums.

Community stroke provision is weak across the local health system, and there is no early supported discharge pathway supporting either site.

Cardiology and **respiratory** services at HHCT have historically been delivered in conjunction with Papworth Hospital. Our work has identified the opportunity to strengthen the services for both specialties within a merged organisation, and recognises the ongoing value and need to be part of a wider network with Papworth, enabling services to be developed and delivered with a world class partner. In continuing to work more closely with Papworth clinical sustainability issues can be addressed at pace whilst the services between PSHFT and HHCT stabilise as additional staff are recruited, and new services are developed.

The summaries below describe: the key challenges now; how the combined trust will improve the way these services are delivered for patients, and a vision for the future shape of their service.

5.4.1 Stroke

Care for patients with stroke (damage to the brain tissue caused by either a bleed or blockage of blood supply to the brain) is generally defined in four phases:

- Hyper-acute – the first 24 hours
- Acute – Days 1-3
- Sub-acute – 3-7 days
- Rehabilitation – Generally around 30 days in a hospital with ongoing care in the community

Clinicians from both trusts reaffirmed the OBC conclusion that there is a desire to continue the hyperacute stroke services at PSHFT. There are staff recruitment challenges on both sites at present. The stroke service is unsustainable at HHCT as there are no specialist stroke consultants; cover is provided by general medical locum doctors, and the general medical rota out of hours.

PSHFT has budget for four consultants, with two substantive consultants currently in post plus two locums. Length of stay and mortality rates are good and benchmark well with other

providers although SSNAP[9] (stroke performance indicators) are not being achieved sustainably at PSHFT.

Community provision is weak across the local health system, with no early supported discharge pathway supporting either site. This means that patients who have suffered a stroke are unable to access rehabilitation within their home as early as best practice recommends.

HHCT provides a stroke rehabilitation service but without specialist stroke consultant oversight. In addition vascular support from Addenbrooke's at HHCT has reduced, and there is no psychology input for stroke rehabilitation patients. HHCT have recently increased the level of speech and language therapy support. Feedback from clinical teams is that the consequence is that patients therefore spend significantly longer in hospital.

In a 'Do nothing' scenario, if there was no consultant cover at HHCT, there would be less opportunity to improve rehabilitation for these patients.

The length of stay (LOS) for stroke patients at PCH is low and in the upper quartile nationally; average LOS 11.9 days vs. 18.9 days nationally. Mortality rates are also below average; however performance against key targets is susceptible to stroke bed availability. The two key indicators are which are not being consistently met are:

- 80% of stroke patients are treated on a stroke unit > 90% time
- 60% of Stroke patients directly admitted to an acute stroke unit within 4 hours

It is anticipated that some of the capacity constraints will be alleviated through the improved patient pathways which will be implemented as part of the planned merger.

A merged service will provide consultant oversight for all stroke rehabilitation patients delivered through a fully integrated stroke service. Our merged service reflects the ambition that rehabilitation services should be delivered locally. In addition to this, future service developments will prioritise delivery of rehabilitation at home to enable our patients to return to the community and their homes as quickly as possible.

The integration will include stroke, rehabilitation and neurology support, for which the merging of these other specialist areas will also be a benefit.

It is acknowledged that stroke services at both sites will also be developed going forward as part of the wider system STP work which is reviewing and identifying further opportunities to improve stroke services and outcomes through working in a more integrated and networked way including the development of community services to support discharge pathways and reduce the length of time patients need to spend in hospital.

The planned merger of the Trust with HHCT will address a number of challenges in the current service and improve the quality of patient care and outcomes through:

[9] The Sentinel Stroke National Audit Programme (SSNAP)

- The design of a more efficient and effective patient pathway with the HASU service at PCH, and HHCT continuing to provide stroke rehabilitation. This will ensure patients receive the right care, in the right place, at the right time
- Reduction in length of stay and associated improved clinical outcomes
- Recruitment to vacant consultant posts
- Alignment of the approach with the rehabilitation allied health professionals teams; physiotherapy, occupational therapy, speech and language therapists.

It is anticipated that as key consultant posts are recruited to and the subsequent pathway improvements for both sites are in place, benefits to patients will improve recovery from stroke. Anticipated benefits include:

Quality

- Fully integrated stroke service with strengthened rehabilitation and community links
- 7 day consultant cover across both sites
- Improve patient care and experience
- Reduce length of stay
- Provide a TIA service across both sites with consultant rotation
- Provide specialist stroke rehabilitation to improve patient outcomes
- Increase in research and development opportunities
- Meet clinical standards for stroke care and time to treatment

Sustainability

- Provision of 24/7 thrombolysis cover in-house
- Reduce reliance on the current tele-medicine service
- Additional PSHFT/HHCT consultant resource for tele-medicine service
- Reduce bed days/length of stay
- Fully integrated stroke service with enhanced consultant and therapy cover 7 days per week

Workforce

- Recruitment and retention
- PSHFT 4 full time neurologists support the service

Figure 33 - CCG SSNAP Stroke dashboard Jan to Mar 2016

Stroke national standard	National average	C&P CCG
% of applicable patients who go directly to a stroke unit within 4 hours	54.8%	46.7%
% of patients treated by a stroke skilled ESD team	34.6%	1.9%

Merger of the stroke teams will bring definite benefits for patients, but to optimise them requires commissioner support to improve community services. The lack of an Early Supported Discharge (ESD) service in Cambridgeshire and Peterborough is a key contributory factor to the reported SSNAP performance. The latest CCG SSNAP Stroke Dashboard (Figure 33) shows that Cambridgeshire and Peterborough CCG ranks poorly

when compared with the national average. In Cambridgeshire and Peterborough only 1.9% of patients were treated by a stroke skilled ESD team compared to 34.6% nationally.

Figure 34 shows how sustainability threats will be addressed by the proposed merger.

Figure 34 - Stroke sustainability threats

Sustainability threats	Merger benefits
Rehabilitation service at HHCT not supported by specialist stroke physicians	Combine skills and expertise
Locum / premium / agency costs	Combined approach to improve value for money
Variable quality from locum / non-specialist teams	Improved governance and quality improves with permanent staff
Difficult to recruit/retain medical staff	Improved ability to recruit Improved training and development opportunities
Payment mechanisms do not cover costs of rehabilitation	

The next steps to develop stroke service integration are described in Figure 35.

Figure 35 - Stroke sustainability next steps

Next steps	Date
Pre-transaction:	
Staff visits to each site and combined stroke team meeting following FBC approval	Dec-16
HHCT lead (locum) to participate in eastern region stroke video conference/ MDT	Oct-16
Map SSNAP data return completion processes at each site	Jan-17
Develop SLA for therapy support at HHCT and scope ESD potential with commissioners	Jan-17

Stroke Services - What patients and their carers can expect

Current patient experience

Care for patients who have suffered a stroke (damage to the brain tissue cause by either a bleed or blockage of blood supply to the brain) is generally defined in four phases:

1. Hyper-acute – the first 24 hours

2. Acute – days 1-3

3. Sub-acute – 3-7 days

4. Rehabilitation – around 30 days in a hospital, with ongoing care in the community

Peterborough City Hospital has a specialist hyper-acute stroke unit. There are four full time neurologists who support the service. There is currently no specialist stroke provision at Hinchingbrooke Hospital and there is reduced provision for vascular treatment.

There are currently staff recruitment challenges at both sites. At Hinchingbrooke Hospital there are no specialist stroke consultants. This means patient rehabilitation is not overseen by a specialist. There is also no psychology support for stroke patients.

Community provision is also weak. There is no discharge support pathway at either site and patients are unable to access rehabilitation at home as early as best practice recommends. Therefore patients are staying longer in hospital.

Patient experience under a merged trust

A merged trust would provide all patients with a fully integrated stroke service with strengthened rehabilitation and community links. This reflects the ambition that rehabilitation services for stroke patients should be delivered locally.

This integrated service will benefit Hinchingbrooke stroke patients in particular, as they will see the greatest improvement in patient care and outcomes, and reduced length of time spent in hospital.

As defined in the four phases of care for stroke patients above, all stroke patients will continue to receive treatment for acute stroke at the specialist stroke units at either Peterborough City Hospital or Addenbrooke's Hospital to ensure they receive timely treatment delivered by specialist stroke staff.

Once discharged, they will undergo a period of rehabilitation at whichever hospital is local to where they live. Hinchingbrooke patients undergoing rehabilitation will benefit from specialists who will oversee their recovery, and help improve their outcome.

Another major benefit to Hinchingbrooke patients is that specialist stroke consultants will support both sites. This also means that patients from the Huntingdon area who have suffered a TIA (also referred to as a 'mini-stroke'), will receive treatment at Hinchingbrooke Hospital. Stroke services will develop further as part of the wider local health system plan. Future developments are expected to prioritise rehabilitation at home, so patients can leave hospital as quickly as possible.

These improvements will not all happen overnight, as they will be partly dependent on filling existing vacancies, which should be easier to fill within a merged trust

Additional benefits:

As a merged trust there will be increased research and development opportunities. The trust will be in a position to meet clinical standards for stroke care and time to treatment. We can reduce reliance on the current 'tele-medicine' service and provide additional consultant resource for 'tele-medicine' service. We will be in a better position to attract, recruit and retention specialist stroke staff.

5.4.2 Emergency Department

The Emergency Department (ED) at HHCT is not sustainable under current arrangements. The department is seeing 11% more patients in the first quarter of this year than in 2014/15 which reflects the national trend. Despite this increase, the most recent published NHS figures show that the HHCT ED is the third smallest 'Type 1' department in England[10] seeing an average of 132 patients per day, of whom 29 require admission.

Due to its size, HHCT does not provide some specialist emergency services (i.e. trauma, heart problems, stroke), and has long standing network arrangements and ambulance protocols in place to ensure these patients are seen and treated at either Papworth, PCH or Addenbrooke's where the specialist trauma, cardiac and hyper acute stroke services are located.

HHCT have had some success in recruiting ED consultants over the last few years with the recruitment of two consultants however retention has been difficult resulting in the current staff in post at HHCT of two full-time, and one part time substantive consultant out of an establishment of six. They are supported by locum doctors which presents a problem for the department in terms of clinical continuity.

Recruitment difficulties are attributed to the challenges of running a small service. These issues are further compounded by a national shortage of ED consultants and ED nursing staff.

HHCT as a trust received a 'good' rating in its CQC report in August 2016. The Emergency Department remains challenged however, and was rated as "*'requires improvement'.*[11]

PSHFT has made good progress on consultant recruitment, with 11 out of 12 posts filled substantively. It has more challenges in middle grade recruitment, where there are still several vacancies covered by locums, and an over-reliance on agency nursing.

The merger integration plan is for an emergency service that maintains the current level of access for patients.

Medical staffing will initially require the continuation of separate rotas, but there is the potential for the consultants and some other key staff to spend time working on each site, which will allow greater flexibility and help staff to maintain a wider range of skills and competencies, thereby improving the likelihood of being able to recruit to current vacancies compared to the status quo.

Further quality benefits will be achieved from increased standardisation of services, training and development, increasing the attractiveness of the service to prospective staff. The merger presents the opportunity to develop standardised and enhanced services associated

[10] A&E Attendances & Emergency Admissions monthly statistics, NHS and independent sector organisations in England, Quarter 1 2016-17, Unify2 data collection, 11th August 2016.

[11] HHCT CQC Report 2016 – p.6

with minor injuries and ambulatory care pathways across both sites. This also provides the opportunity for the development of a number of support posts such as emergency nurse practitioners and acute geriatricians to support the long term clinical sustainability of urgent care services at HHCT through a more diverse workforce.

Figure 36 shows how sustainability threats will be addressed by the proposed merger.

Figure 36 - Emergency Department sustainability threats and merger benefits

Sustainability threats	Merger benefits
Standalone small service at HHCT	Combine skills and expertise
Difficult to recruit/retain consultants	Improved ability to recruit
Difficult to fill junior posts - both sites	Improved training and development opportunities
Staff capacity to meet demand	New and different roles developed jointly, e.g. extended practice
Locum / premium / agency costs	Combined approach to improve value for money
Variable quality from locum teams	Improved governance and quality improves with permanent staff

The next steps are shown in Figure 37 which is included in the implementation plan and will be updated as further clarity emerges from the STP.

Figure 37 - ED next steps

Next steps	Date
Pre-transaction:	
Joint meeting(s) of department leads to share challenges and plans	Oct-16
Agree joint approach to training, policies, guidelines and quality standards to meet internal and CQC requirements	Dec-16
Joint engagement on STP work	Ongoing
Agree opportunities for a shared recruitment and retention strategy for hard to fill posts	Dec-16

The vision for future services will be influenced by the models of care to be considered through the System Transformation Planning process.

The reality of national as well as local challenges for senior medical and nurse staffing in emergency care may affect the pace at which integration can take place, but the new organisation will offer different opportunities. The STP has determined that for both HHCT and PSHFT 24/7 urgent care services will continue. In the planning for future service delivery it is assumed that the profile of current emergency presentations will not change.

In addition to the Emergency Department itself, there are key interdependencies with other services; most notably the 24/7 two tier rotas of consultants and middle-grade doctors who take responsibility for patients admitted from the emergency department. The services required to support an urgent care service across both sites are acute and general medicine, elderly medicine, respiratory medicine, medical gastroenterology, gynaecology, general surgery, trauma, orthopaedics, critical care, general anaesthetics and cardiology.

The dependencies on other services required to support urgent care delivery are shown in more detail in Appendix 8 which is an extract from work undertaken by the South East Coast Clinical Senate.

Emergency Departments - What patients and their carers can expect

Current patient experience

Hinchingbrooke Hospital

The Emergency Department at Hinchingbrooke is the third smallest in England. It sees an average of 132 patients per day, of which 29 patients require admission. During the first quarter of 2016, the department saw 11% more patients than last year. The increase in A&E attendances is now a national trend.

Due to its size, some specialist services are not provided (such as trauma, heart problems and stroke). Patients presenting with these types of illnesses are treated at Papworth, Peterborough City Hospital or Addenbrooke's.

Hinchingbrooke is struggling to retain emergency consultants due to its size, as well as the national shortage of emergency consultants and nurses. It currently has two full-time consultants and one part-time consultant out of the six it requires. These consultants are supported by locum doctors which impacts the continuity of care received by patients. These challenges are expected to continue if the trusts do not merge.

Following the Care Quality Commission inspection in August 2016, which recommended the hospital come out of special measures, the Emergency Department was rated 'requires improvement'.

As a result of the above, the Emergency Department is not considered sustainable in its current form.

At Peterborough City Hospital

Peterborough City Hospital has made good progress in recruiting consultants, with 11 out 12 permanent posts in place. However several vacancies are still covered by locums, and there is an over-reliance on agency nursing.

Patient experience under a merged trust

Both Hinchingbrooke and Peterborough City hospitals will continue to provide urgent care services to their local populations 24 hours a day. The minor injuries unit at Stamford Hospital will continue to operate five days a week between 9.00am and 5.00pm. Patients who require treatment for severe trauma or complex illnesses will be referred to specialist centres, such as Addenbrooke's Hospital.

Hinchingbrooke patients will experience the greatest benefit from a merged emergency department. They will see an enhanced quality of service as they are treated by a larger number of experienced consultants, nurse practitioners and junior doctors. This will provide a safer service and ensure staffing levels meet patient demand.

One exciting development for Hinchingbrooke patients will be the ongoing growth of support for frail and elderly patients and emergency and advanced nurse practitioner roles. These nurse practitioners have already proved to be very popular with patients and free up senior medical staff so they can spend more time with patients who have the most serious conditions.

Additional benefits: The merger provides greater opportunity to improve the recruitment, development and retention of skilled doctors, nurses and other health care professionals. This will mean patients at Hinchingbrooke Hospital will have better access to permanent staff, which brings with it greater continuity and quality of care from a settled team.

Consultants will fulfil training and teaching sessions to ensure staff can develop their skills across all sites. There will be attractive prospects for all grades of emergency staff.

5.4.3 Diagnostic imaging

Clinicians have confirmed that diagnostic imaging will become unsustainable in the medium term due to the lack of staffing to continue the full range of existing services at HHCT and the meet the demands of 7-day working. If we do not merge, there will be an increasing reliance on locum cover and delays to reporting of results, which has an impact on clinical decision making, and also increases costs due to locum staff and outsourced reporting.

The teams recognise that there are significant quality and efficiency benefits of coming together as a larger integrated service, but significant investment is required for these to be realised.

Specific imaging services that are at risk at each site are shown in Figure 38.

Figure 38 - Diagnostic imaging service specific risks

Imaging service	Unsustainable at PSHFT	Unsustainable at HHCT	
Vascular		✓	
CT colonography		✓	
Paediatrics	✓	✓	
Nuclear medicine	✓	✓	HHCT service decommissioned Aug 2016
Interventional	✓	✓	
Thoracic (chest)			Supported at PSHFT by HHCT consultant
MDT cover		✓	
Neuro opinion		✓	
MSK & ultrasound		✓	

- **IT infrastructure and clinical IM&T systems**

The integration and alignment of clinical IM&T systems and the IT infrastructure to support them is essential; not just to support the integration of imaging teams, but also to enable

other clinical specialties to work effectively across sites with seamless access to information from any location.

- **Imaging Equipment**

Some key items of imaging equipment are due for replacement. HHCT have two CT scanners, one of which is new, the other is beyond its serviceable life.

In summary, merger will address the sustainability issues as described in Figure 39.

Figure 39 - Diagnostic imaging sustainability threats

Sustainability threats	Merger benefits
Specific areas of service at risk & nuclear medicine decommissioned (Aug-16)	Stabilisation and increased opportunity for cross-cover, + opportunity to look at re-establishing nuclear medicine service at HHCT.
Stand-alone small service at HHCT	Combine clinical skills, experience and expertise – including peer support.
Difficult to recruit/retain consultants	Improved ability to recruit
Difficult to fill junior posts - both sites	Improved training, development and sub-specialisation opportunities
Staff capacity to meet demand	New and different roles developed jointly, e.g. extended scope radiographers
Locum / premium / agency & reporting outsourcing costs	Combined approach to improve value for money, and improve flexibility of reporting locations
Variable quality	Improved governance and quality improves with permanent staff

The next steps for the teams once the FBC decision is finalised, is to undertake a gap analysis to more fully assess the scope of work required to develop an integrated service. A summary of the next steps is provided in Figure 40.

Figure 40 - Diagnostic imaging next steps

Next steps	Date
Workforce: Clinical leads – spend time to understand services to develop a future service model outline (particularly w.r.t. recruitment risk areas)	Oct-16
Workforce: PACS/RIS manager HHCT – Priority appointment	TBC
IT infrastructure: 1GB (expandable) fibre link – for image sharing IT systems development and testing	Dec-16
High level mapping of referral reporting policies. To commence post FBC ratification	Dec-16
Governance: Joint governance meetings established (to be run as for an MDT)	Dec-16
Hon contracts for all consultants on both sites	Dec-16

Diagnostic Imaging - What patients and their carers can expect

Current patient experience

There is a concern that Diagnostic Imaging (e.g. X-rays and MRI scans) will become unsustainable at both sites. There is a lack of staff at Hinchingbrooke Hospital, increasing reliance on costly locum cover and outsourced reporting. There are delays in reporting results which impacts on clinical decision making and for patients this means waiting longer to find out results of scans and X-rays. There is currently an inability to meet the demands of seven-day working.

Patient experience under a merged trust

Under a merged trust, patients at all sites will benefit by being seen by members of one combined radiology team. The team will support all three hospital sites and will use a single reporting system. This will improve treatment times and patient outcomes as the department strengthens its staffing and technology.

Patients will be given the choice to attend for scans and X-rays at Hinchingbrooke, Peterborough City or Stamford hospitals.

Patients will also receive their results faster because consultants will be able to view images at either hospital site, seven days a week. Inpatients will have their scans reported in a more timely fashion, as there will be seven-day reporting of urgent scans.

There will also be the opportunity for trainees to work across all sites, this presents an attractive career opportunities for new radiology doctors and radiographers and will be important for ensuring sustainable radiology services are provided for the future.

5.4.4 Cardiology

The cardiology service at HHCT is unsustainable due to the small size of the clinical team. There is one consultant in post out of an establishment of two, who is supported by a locum consultant, and two visiting consultants who provide outpatient clinics.

It has not been possible to recruit to the two vacant consultant roles, and as a consequence the team cannot provide adequate support to middle-grade doctors. As a result, the Trust is working with the Deanery to ensure that the consultant coverage available will support the maintenance of training grade posts at the HHCT site. At this current time the training grade posts have been withdrawn pending the resolution of the consultant staffing gaps however plans are in place to redress this by December 2016 in conjunction with Papworth.

The service at PSHFT, although larger, will require additional consultants as demand grows. Recruitment for both HHCT and PSHFT is difficult, at HHCT due to the service size and at PSHFT because some services normally in a DGH are provided by Papworth. To ensure the best service for our patients we recognise the ongoing value of a wider network with Papworth to enable our services to continue to be developed and delivered with a world class partner.

Discussions are taking place on the potential transfer of Percutaneous Coronary Intervention (PCI) and the more complex cardiac pacing procedures to PSHFT before Papworth moves to the Addenbrooke's site in 2018. This would bring significant benefits for patients by bringing care much closer to home, reducing bed days lost due to patients waiting to be transferred to Papworth and make cardiology posts at PSHFT much more attractive to potential consultant recruits. Merger of the services increases the combined catchment population which also supports the transfer of these procedures and results in more patients being able receive their treatment closer to home.

The vision for the cardiology service is to deliver a greater range of outpatient services at HHCT where only general cardiology clinics are provided currently e.g. rapid access chest pain, heart failure, and pacing follow-up clinics.

The model for inpatient cover will be refined as the System Transformation Plan for cardiology is developed and agreed. Support will also be gauged from the wider group of clinicians and the Deanery which coordinates the training of junior doctors.

It is recognised that delivering comprehensive cardiology services in the combined trust is reliant on continued specialist links with Papworth. This is particularly important for the HHCT site where a number of the local patients may choose to continue their affiliation with Papworth post-merger.

It is recognised there are national challenges with recruitment to cardiology posts and so PSHFT and HHCT will continue to work closely with world renowned Papworth, to ensure we are in the best position to develop a service to meet the needs of our patients and attract the best clinicians to deliver the service as close to home as possible.

Merger will help the cardiology service develop out of hour's advice and seven day inpatient review.

The key benefits of this merger are that it will:

- Support the reinstatement of trainee doctors at HHCT providing better care for patients.
- Increase the size of the clinical team and enable a greater range of outpatient services at the HHCT site.

This will mean a larger team to support the wider catchment population and enable the expansion of the type of services which could be provided locally. Possibilities include CT guided cardiology procedures at HHCT, and elective PCI and complex pacing at PCH. This will be influenced by the recommendations in the STP.

A summary of the benefits of merger is provided in Figure 41.

Figure 41 - Cardiology merger benefits

Sustainability threat	Merger benefits
Cardiology Trainees (Jnr Drs) at HHCT withdrawn by the Deanery	Improved training and development & opportunity to have training grade posts at HHCT reinstated.
Small service at HHCT & reliance on shared posts with Papworth for OP clinics	Combine skills and expertise. Increase in the size of the clinical team enables a greater (new) range of outpatient services to be offered at HHCT, and repatriation of diagnostics
Difficult to recruit to consultant vacancies	Greater catchment area supports development of more specialist services (e.g. elective PCI) & opportunities for sub-specialisation = **Improved ability to recruit**
Variable quality from locum teams	Improved governance and quality improves with permanent staff
Out of hours advice and guidance	Improves support and decision making for GPs and other clinical teams
7-day inpatient reviews	Supports timely clinical decision making, shorter length of stay and better clinical outcomes

The plan in Figure 42 will deliver improved inpatient cover and outpatient services at HHCT by summer 2017 with key milestones. The key risk is recruitment, which will be mitigated as more certainty emerges regarding the future range of services to be commissioned, most notably if PCI and complex pacing services are to be developed at Peterborough.

Figure 42 - Cardiology next steps

Next steps	Date
Pre-transaction:	
Share and commence alignment of clinical policies	Dec-16
Share activity and demand information to inform future service model	Nov-16
Agree inpatient staffing model and establish expectations for cross-site working	Mar 17
Commence recruitment	Mar 17
Post transaction:	
Commence development of service models starting with outpatient clinics	Jun 17

Cardiology - What patients and their carers can expect

Current patient experience

The cardiology service at Hinchingbrooke Hospital is unsustainable due to the size of its clinical team. At the moment patients are seen by one permanent consultant, two locum consultants and two visiting consultants who provide outpatient clinics. The department requires three permanent consultants.

Recruiting cardiology consultants is difficult for both trusts. For Hinchingbrooke, this is due to its size, and for Peterborough, this is because some services are provided by Papworth, the specialist heart hospital. Trainee posts have been withdrawn while recruitment of consultants continues. There is also a need for closer working with Papworth Hospital to develop new cardiology services.

Patient experience under a merged trust

Patients will benefit from a combined and strengthened cardiology service across the area, supported by Papworth in preparation for its move their new hospital in Cambridge in 2018.

For patients who have Hinchingbrooke as their local hospital, the increased team will be able to provide an extended range of cardiology outpatient services and diagnostic tests locally.

There will be sufficient depth of consultant cover for patients across the combined area, which means we will be able to offer a wider range of procedures at Peterborough City Hospital, such as cardiac pacing. We will also be able to provide inpatients with greater access to specialist consultant opinions throughout the week.

Patients requiring the most complex procedures and care will still be referred to the world class services of Papworth Hospital.

Additional benefits: We will be able to reinstate trainee doctors at Hinchingbrooke, and there will be more support for innovations in heart surgery.

5.4.5 Respiratory

There are two respiratory consultants at HHCT and both posts are shared with Papworth giving a total of 1.3 wte at Hinchingbrooke. A capacity and demand mismatch and the part-time nature of the consultant posts mean that cross-cover and continuity of oversight for respiratory inpatients at HHCT is a challenge and the range of outpatient services is restricted. This is likely to mean more clinical staff being required.

PSHFT have five substantive consultants, one of whom is currently taking a career break.

A number of diagnostics for respiratory patients are undertaken at Papworth which will become would become difficult when Papworth moves to Cambridge. The Papworth move will also reduce consultant input due to increased cross-site working and travel time. The specialty team and the CAG agreed that respiratory medicine should therefore be classified as unsustainable in the medium term, and treated as a priority for integration.

Again, as for Cardiology, the opportunities for acute medical inpatient cover arrangements are similar:

Elective care: Merging the respiratory team will enable the development of services and repatriation of patients that currently need these procedures undertaken elsewhere:

- Endobronchial ultrasound (EBUS) & thoracoscopies (both sites)
- Bronchoscopy at HHCT

Outpatients: A larger team and greater opportunities for sub-specialisation will enable an increased range of services to be offered at HHCT. Examples are:

- Specialist clinics to be introduced for HHCT patients: Interstitial lung disease (ILD), tuberculosis (TB), chronic obstructive pulmonary disease (COPD), lung cancer, pleural, asthma and oxygen therapy services.
- Walk-in clinics to be developed at (both sites) to reduce urgent care demand

Diagnostics: There is a good respiratory physiology service at HHCT. Potential developments are:

- Specialist imaging & interventional support
- Sleep studies at HHCT

Key benefits of merging the respiratory teams are:

- Increase in the size of the clinical team enables a greater range of elective, diagnostic and outpatient services at both sites, especially HHCT.
- Improved consultant recruitment. Appointment to vacancies.
- Greater catchment area supports the development of specialist services to be provided locally (rather than travel to Leicester or Addenbrooke's)
- Community pathway redesign across a larger catchment
- Development of an improved out of hours cover and 7 day services

A summary of the benefits of merger are provided in Figure 43

Figure 43 - Respiratory merger benefits

Sustainability threats	Merger benefits
Small service at HHCT & reliance on shared posts with Papworth for OP clinics	Combine skills and expertise. Increase in the size of the clinical team enables a greater (new) range of outpatient services to be offered at HHCT, and repatriation of diagnostics.
Difficult to recruit to recruit to consultant vacancies	Greater catchment area supports opportunities for sub-specialisation = **Improved ability to recruit**
Variable quality from locum teams	Improved governance and quality improves with permanent staff

The next steps in integrating the services are shown in Figure 44.

Figure 44 - Respiratory implementation plan

Integration plan	Date
Pre-transaction:	
Activity management: Share activity and demand information & use to inform future service model	Nov-16
Clinical protocols & guidelines: share audits and action plans, align clinical policy renewals and start combined meetings	Dec-16
Workforce: Agree staffing model (IP), establish expectations re cross-site working, business case + commence recruitment	Mar-17
Post transaction:	
Develop service models (starting with outpatient clinics) as new consultants come into post	Jun-17

Respiratory services - What patients and their carers can expect

Current Patient Experience

Respiratory medicine at both sites cannot be sustained as they are. There are two respiratory consultants at Hinchingbrooke and both of these posts are shared with Papworth. Continuity of care for respiratory inpatients is a challenge and the range of outpatient services is restricted.

Peterborough has five permanent consultants. The expectation is that diagnostics undertaken at Papworth will become less workable when it moves to Cambridge.

The Papworth move will also reduce consultant input due to increased cross-site working and travel time.

Patient experience under a merged trust

Merging the respiratory teams will enable the development of services locally so that patients who currently need treatment to be carried out elsewhere, can receive their treatment closer to home. This means fewer longer journeys for patients.

A merged trust will see respiratory patients benefitting from the expertise of a larger team. This will benefit Hinchingbrooke patients as it will enable a greater range of planned, diagnostic and outpatient services to be provided than currently offered. This will also strengthen support for inpatients.

Specialist clinics will be introduced for Hinchingbrooke patients providing treatment for tuberculosis, chronic obstructive pulmonary disease, lung cancer, asthma and oxygen therapy services.

Walk-in clinics will be established alongside both emergency departments at Hinchingbrooke and Peterborough to reduce urgent care demand. The respiratory physiology service

currently based at Hinchingbrooke will be able to develop specialist imaging, interventional support and sleep studies.

Patients requiring the most complex procedures and care will still be referred to the world class services of Papworth Hospital.

Additional benefits: The greater population area will be supported by the development of specialist services provided locally, so that patients will not need to travel to Leicester or CUH. Clinical haematology

The clinicians of both trusts agreed that the clinical haematology service at HHCT is unsustainable due to the size of the service and the difficulty in recruiting and retaining staff. There are currently no substantive consultants in place for this service at HHCT, whereas there are five consultants at PSHFT. Recruitment difficulties are attributed to the challenges of running a small service, resulting in:

- Greater reliance on agency/locum staff
- Quality impact
- Cost impact

These impacts are further compounded where there is a national shortage of staff. There are currently[12] 35 Consultant Haematologist vacancies nationally, five of which are within a 50 mile radius.

Consequently, patients at HHCT do not have the same access to sub specialty services as patients at PSHFT. There is a strong haematology nursing team at HHCT providing continuity to patients, but continuity of consultant care is reduced because of the current reliance on locum doctors, particularly for patients who require longer term treatment as they are less likely to see the same doctor throughout their care.

The vision is to provide the catchment population with full access to all haematology services of the combined organisation. This will include the usual adult haematology services, a Teenager and Young Adult service, CLIC Sargent (childhood blood cancer and leukaemia services), and other haematology sub-specialties.

This will be delivered by a fully integrated consultant-led haematology service in place by the time of merger, with excellent site-based nursing, pharmacy and support services.

By 1 April 2017, we will have an on-site Monday to Friday middle grade doctor presence on both sites, and a substantive consultant will be appointed to be based predominantly at Hinchingbrooke. The wider merged haematology team will provide cross-cover, and also provide a wider range of services.

[12] www.jobs.nhs.uk search for “Consultant Haematologist” & “England” results = 35 vacancies nationally 15 August 2016

In this combined model the overall number of budgeted consultant posts will reduce by one with this post being converted to a middle-grade doctor, based wholly at HHCT. This combined model will provide more, and better targeted medical care and advice than is currently provided by the two locum consultants at HHCT. It will also provide greater flexibility and support for outpatients, with specialist clinics being provided at HHCT which have not previously been available locally.

Clinical teams will work towards a single approach to all guidelines and protocols with a single clinical leadership. Not only will this improve the quality of care for patients in the Hinchingbrooke catchment, it will also be a cost-effective service with significantly less reliance on locum doctors. The quality of, and access to, care will significantly improve due to a fully staffed single team of consultants, middle grades and specialist nurses. There will be greater opportunity for services closer to home, with a wider range of subspecialty services. Inpatient support on both sites will be stronger with a larger team and a common approach across all sites.

Patient benefits

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

Staff benefits

- Sustainable, high-quality staffing depends upon services being attractive to future applicants and current staff. Making services attractive involves ensuring:
- front-line staff are exposed to the learning opportunities they want and need for professional development;
- Appropriate work-life balance, for example, enough staff on rosters to allow for a sustainable rotation of on-call duties;
- Working together will make our organisations more attractive to staff, improve morale and recruitment and reduce reliance upon locum and agency staff.

Financial benefits

- Conversion of two locum consultant roles to substantive consultant and a staff grade doctor
- Opportunity for research income and access to clinical trials

Additional Quality benefits

- Training and education opportunities.

- Haematologist input into the following at HHCT:
  - Thrombosis committee
  - Transfusion committee
  - Cancer management
  - Lab management
- Opportunity for participation in Research and Clinical Trials which used to be a key feature of the service at HHCT, but unable to sustain with locum cover.

An integration plan (Figure 45) developed by the clinical teams will deliver improvements by the time of the merger.

Figure 45 - Clinical haematology next steps

Integration plan	Date
Joint consultant appointment panel	Sep-16
Agree and advertise Staff Grade role at Hinchingbrooke	Sep-16
Revise consultant job plans to reflect 11 session on site presence at Hinchingbrooke and on-call	Oct-16
Review locum consultant appointments depending on permanent appointments	Dec-16
Agree revised approach to inpatient ward rounds and review on both sites	Mar-17

The next steps for clinical haematology are shown in Figure 46.

Figure 46 - Clinical haematology sustainability threats

Sustainability threat	Merger benefits
Stand-alone small service at HHCT	6 consultant integrated service
Difficult to recruit/retain consultants	Fully staffed clinical team
Locum / premium costs	Value for Money
Variable quality	Integrated clinical governance
Limited service development	Integrated service strategy and access to wider range of services
	Opportunities for research

Clinical Haematology - What patients and their carers can expect

Current patient experience

Currently the Clinical Haematology service at Hinchingbrooke Hospital is run by two locum consultants who run outpatient clinics alongside permanent nursing staff. The service is configured to deliver less intensive chemotherapy. Patients who require more complex therapy

are referred to other hospitals. The specialist Haematology/Oncology Unit at Peterborough City Hospital has five permanent consultants.

Adult patients from the Huntingdon area diagnosed with acute Leukaemia (a severe, sudden and life threatening condition), have to travel to Peterborough City Hospital to receive not only their inpatient chemotherapy, but also their ongoing outpatient treatment, which is delivered by the specialist Haematology/Oncology Unit. This means that patients have to travel regularly to Peterborough, sometimes daily, for a period of up to five months for transfusions and doctor appointments.

Patients living in Peterborough have an easier experience because the distance they need to travel is less. In addition, Huntingdon patients aged 19-20 are not permitted to receive any cancer treatments at Hinchingbrooke Hospital. Instead they must travel to Addenbrooke's or Peterborough hospitals. Peterborough patients of a similar age have their treatment at Peterborough because the unit is one of three designated hospitals in East Anglia for teenagers and young adults with cancer, supported by the charity CLIC Sargent, which can make this very difficult time in a young person's life a little easier.

Patients at Peterborough benefit from seeing the same member of the five-strong permanent consultant team, this offers them greater continuity of care, which is beneficial to their mental and physical health.

Patient experience under a merged trust

Under a merged trust, the clinical haematology services at both trusts would combine. Adult patients at Hinchingbrooke will see the greatest benefit because they will have access to a wide range of haematology services at their local hospital, delivered by an expanded, permanent team. They will rarely need to travel to Peterborough, unless they require specialist care as an inpatient.

The expanded haematology team will run haematology clinics at all hospital sites, where they will deliver specialist medical and nursing expertise. This will give Hinchingbrooke patients access to a larger team of experts across the whole range of blood diseases at their local hospital. This also means that patients who have to make regular hospital visits will receive high quality care from specialists on long term contracts. This means they will be able to build ongoing relationships with their consultant.

Hinchingbrooke's Haematology patients in the 19-24 age range will be able to access the CLIC Sargent services from the Hinchingbrooke site.

For Hinchingbrooke cancer patients, treatment will be provided in excellent modern facilities at the superb new Macmillan Woodlands Centre at Hinchingbrooke Hospital. Cancer patients from Peterborough and South Lincolnshire will continue to receive excellent treatment at Peterborough City Hospital.

By using the same clinical systems, patient information will be shared by clinicians across all sites, which will give patients a more responsive service.

Additional benefits: A larger team that offers a wider variety of patients and different working environments will be a more attractive prospect for new doctors in this field, eliminating the recruitment issues that have been faced by Hinchingbrooke. The newly refurbished Macmillan Woodlands Centre is a great venue with a good reputation. This will also help attract new staff.

5.5 Planning for other clinical services

All clinical services provided by both trusts have met with the project team to explore the impact of merger and have identified numerous benefits. The clinical and management teams have already identified numerous benefits from merger. The common factor is the opportunity which a larger, expanded catchment population, and greater critical mass of clinical specialists, can provide.

Areas of benefit which have been identified include:

- Making the most benefit from exceptional modern estate and facilities across the two organisations.

  This includes the PFI building at PCH, the Treatment Centre at HHCT, and the Woodlands Cancer Centre at HHCT.

- Strengthening of areas with single handed sub-specialties and support services, including access to peer support and audit.

  This covers staff from several different clinical professions. A swift benefit will come from enhanced patient access to specialist advice during leave periods and this should also give opportunities to improve cancer access.

- Working to improve access to emergency and 7 day services for the enlarged single catchment population.

  Some services have more extended access for patients due to the numbers of specialist nurses in their site-based teams.

- Formalising and expanding training clinical rotations to improve the attraction of the Trust

  Middle grade doctors and specific therapy rotations.

- Learning from best practice on both sites

  Improve services such as one stop and virtual clinics and length of stay including neurology, urology and plastic surgery.

- Strengthening and/or repatriating services due to the larger catchment population

  This will be initially focused on some of the smaller clinical support areas so that patients will not have to travel as much for some services, but further examples also include urology, radiotherapy and neurology

- Enhanced staff access to some core training and development including clinical practice development

  This will be attractive for all clinical professions.

- Improving clinical research and expanding clinical trials across the combined catchment

  Building on existing strengths we will use research nurse specialists across both catchments.

- Standardising the services commissioned across the area

  Several areas have been identified where there are clear differences in the services commissioned, or there are gaps in one or other area

- Standardised approach to working with GPs and community provider partners

  Specialties point to the challenge in understanding exactly what services are available and from whom. A merged trust will have a consistent approach to working with several community providers as well as independent and primary care services

- Making best use of clinical equipment

  High value endoscopy and theatre equipment will be better utilised

- Working together on joint recruitment to attract high quality staff

  Where there is critical mass to support a whole appointment rather than part-time posts

- Opportunity to benefit from clinical leadership of colleagues in specific areas

  There are some exceptional staff across the two organisations and their skills and leadership can be deployed to the wider benefit of the combined organisation

5.6 Clinical due diligence

The trusts are seeking an external clinical opinion on the proposed way forward for the integration of clinical services. This will not be completed before the FBC is presented to the boards in September, and is due in late October. The findings will be incorporated into the implementation plan and will be considered by both boards in November. The scope of this review is included in Appendix 1.

5.7 Wider strategic opportunities

There will be other opportunities to benefit the wider health and social care providers in the local health economy. The merged organisation will deliver services across three sites located at Peterborough, Huntingdon and Stamford. In coming together as one organisation we have many opportunities to develop our services together which will enable us to meet the health needs of our population in a different and innovative way but also preserve the uniqueness associated with local opportunities. The health campus development at the Hinchingbrooke site supports delivering care differently in an integrated way which is entirely compatible with the merger.

5.7.1 Case study: Stamford Hospital redevelopment

The redevelopment of the Stamford Hospital site was approved by trust board in 2014 following significant engagement and consultation to develop and agree a clinical service strategy for the site. The redevelopment will focus on a larger range of clinical services on the east side of the site, releasing land on the west for alternative uses. The preferred option is for this land is to work with partner(s) to provide a range of health and social care services on the site for the benefit of the local population.

The agreed Trust clinical strategy for the site includes:

- A new bariatric MRI for the site to be the third for PSHFT as a whole
- Growth in outpatient capacity to expand the range of outpatient services delivered locally e.g. paediatrics, ophthalmology etc.
- Second ultrasound machine to meet growth in antenatal clinics as well as other patients requiring diagnostics
- A new phlebotomy facility to accommodate the large growth in local demand and improve patient experience through new waiting and treatment facilities
- Increasing chemotherapy and lymphedema treatments on site to allow more patients to access this service locally
- Continuing day case activity on site
- Creating a new Pain department to improve patient and staff experience
- New electrical infrastructure including a new generator to improve the resilience of the site

Tenders have been awarded for all aspects, designs have been completed and agreed with operational areas and work has already begun on the electrical infrastructure and generator to support the safe delivery of care. The MRI is due to be on site and operational for winter 17/18 and the remainder of the programme is due to start to be delivered in 17/18.

5.7.2 Case Study: Hinchingbrooke Health Campus

Smaller district general hospitals such as Hinchingbrooke play a key role in their local community, but struggle to maintain services within their current budgets. Hinchingbrooke has a vital role to play in the future of healthcare services in Cambridgeshire, but knows it must evolve to meet the challenges it faces.

In order to support the needs of the local population it is progressing an ambitious plan to build a new intergenerational health campus on its site. This would integrate primary (including GP), secondary, community and social care services, together, with around 400 new residential dwellings and older people's care facilities. Developers would also build a stepdown medihotel for patients who do not need the resource-heavy benefits of an acute hospital bed.

In addition, there are plans for:

- a new private patient facility
- 300 staff residences for junior doctors, nurses and support staff
- accommodation for 70 medical students
- a pool, gym and therapy centre

The colocation of the health campus and acute hospital enables the Huntingdon site to redesign care pathways to reduce hospital stay and work more closely with community health and social care partners to deliver services in an integrated way. The colocation of services enables the site to establish alternative workforce arrangements which supports staff working both in the hospital and community and offers a more seamless health care experience for the people of Huntingdon. The health campus will offer a diverse range of services and support the overarching vision for health services that are delivered as locally as possible. This also helps to meet local authority pressures and will provide an annual revenue stream to support future sustainability.

5.7.3 Research and development

Combining the Research and Development teams across the two sites brings benefits to all patients. The collective complementary skills will make the enlarged organisation attractive to commercial trials. Historically Peterborough has had a relatively small team of staff that tended to focus on specific and quite specialist trials for small groups of patients. With a relatively larger sized team, Hinchingbrooke has focussed on a broader range of trials involving more patients. By combining these two approaches both populations of patients will benefit as they will all have access to both broad and specialist trials. The staff will also benefit as they will get a broader range of experience over more trials and a combined large team will offer an attractive option to potential new recruits

5.8 Summary

In approving the Outline Business Case, the two trust boards recognised that the merger of clinical services within one organisation should help to address issues of present or future unsustainability.

The further work which has taken place with all of the clinical services provided by both trusts confirms that this will materially improve issues of clinical sustainability.

For services, such as haematology, the progress will be rapid and should be in place by the time of formal merger and will already be able to demonstrate benefits

For some services such as Stroke, Cardiology and Respiratory, merger provides the clear opportunity to move to substantial service improvements and enhancements by the end of the first full year of merger, with clear benefits from working as a single service across more than one site, in particular better local access to high quality services.

For services such as Diagnostic Imaging and the Emergency Departments progress is likely to be slower because it will be heavily influenced by the particular national challenges of recruitment to consultant and middle grade posts as well as some shortages in qualified ED nurses. For imaging, there is a dependence on developing joined up IT systems.

However, even at an early stage it is clear that there are opportunities to work together on the aspects which will make the new organisation a more attractive place for prospective candidates, such as training and development and opportunities for subspecialisation. We will also be able to make progress on joint approaches to accreditation, emergency planning, equipment and IT connectivity.

In line with the Five Year Forward View national blueprint for the NHS, the work with all the specialties clearly shows that progress can be made towards a range of qualitative, operational and financial benefits. The combined organisation will be able to offer a more resilient and complete secondary care service for patients, with strengthened links to our primary, community and specialist centre partners, in line with the STP aims to offer more integrated services to patients.

6. Vision for corporate and support services

6.1 Corporate team integration

The OBC concluded that the merger of clinical services will require single, merged corporate and back office functions to ensure seamless, integrated delivery. Merger of corporate teams will provide:

- Harmonised corporate policy and processes which clinical services are required to follow
- Integrated information and technology allowing clinicians to access to records and information across all sites
- Clarity of contracts with commissioners
- Prevent duplication of reporting by clinical teams
- Clear accountability and ownership
- Make best use of resources to support clinical teams

6.2 FBC development work

Building on the work in the OBC, further joint engagement by corporate teams has developed a proposed vision for how the merged corporate and back office teams will be configured. These teams will come together to support the delivery of merged clinical teams while delivering a minimum £9m in cost reduction through reducing duplicate management posts, volume discounts on service contracts, consumables and licence fees, and in the long term better use of existing estate and single replacement of IT systems.

Complimentary executive leads for the departments have designed proposed workforce structures that would be sufficient to support the clinical and non-clinical operations of a medium DGH over three sites. These structures have accounted for effective management of any identified current risk at any site, and in the executive's opinion are best placed to deliver excellent support and performance outcomes for the enlarged organisation. The executives have also made suggestions as to whether their new teams would need to be co-located with other roles and departments, or spread out across the sites in order to deliver this support most effectively.

It is proposed that following FBC approval and appointment of the executive team, all corporate teams will be engaged with and consulted on their proposed departmental structure and location according to the section set out in section 7.1. It is hoped that this will benefit the individuals in providing clarity and transparency as to the proposed direction of travel and give them sufficient time to consider and discuss the roles they may wish to be engaged with in the short and long term. It will also allow the organisation sufficient time for all views to be sought on the proposed structure and functions and a final position to be confirmed that best supports the enlarged organisation to achieve its aims.

For each of the eight corporate services, we have described the key changes which will be made, both before and after merger. A detailed integration plan will be developed as part of the Post Transaction Integration Implementation Plan in November 2016.

6.3 Operational divisions (Ops)

The operational divisions will work in a fully integrated capacity with specialist colleagues in finance, HR and corporate nursing to deliver high performance in quality of care, patient experience and outcomes and against national performance metrics. They will provide a supportive environment through which staff can reach their full potential and can have adequate opportunities to develop their skills and retain career progression within the organisation.

It is proposed that operationally, the organisation will be split into operating divisions governed by a medical lead a nursing lead and a senior manager,. Where appropriate a suitably experienced and skilled allied health professional could take the medical or nursing lead position.

The Clinical Lead and senior management posts as a minimum will be in post by day 1 so that all staff will have clear knowledge of who their senior leadership team are from transaction date.

Some specific posts will have separate professional accountability lines directly to Trust board to provide assurance that quality, safety and performance is being delivered e.g. Chief Pharmacist and Head of Midwifery.

Where appropriate clinical support services such as therapies will be integrated throughout the divisions so care can be delivered and co-ordinated according to where treatment plans are agreed and delivered. The divisions will also have clinical and quality support within them to maintain and continuously improve quality of care with guidance and support from the corporate nursing teams.

Likewise it is envisaged that the divisions will have integrated finance and business partners to support them in achieving performance against workforce and financial indicators and outcomes.

The strength and depth of clinical leadership will be maintained to support the integration of services and ensure that a safe balance is delivered between maintain clinical standards of daily care across all sites whilst also working with teams to deliver full integration. This will be reviewed at end of year 1 for future possible financial reductions if safe to do so.

A separate combined team will focus on PMO and CIP delivery and work across divisions to ensure the agreed CIP and transformation plans are delivered according to plan. This team will be constructed according to best practice and in line with any requirement from external regulators.

6.3.1 Integration

Maintaining performance and quality for all patients at every site requires support for staff on each site. The leadership team will work on dedicated days at each of the two acute sites. This will mitigate risks to slower decision making and lack of access to senior management that have been highlighted as lessons learnt from other mergers.

Throughout year 1 the leadership team will appoint to their junior and middle management posts.

As the leadership is appointed they will adopt best practice from both sites, which will further increase quality and efficiency. An example might be the ability to outsource clinical support functions whilst delivering a financial benefit.

6.3.2 Benefits

One of the key benefits of merging the two organisations is that operational best practice from both sites can be adopted in order to facilitate more efficient and effective working for the benefits of patients and staff.

Chief Operating Officers at both sites agree that having a larger number of beds with which to flex capacity to meet peaks and troughs in demand will improve patient care by reducing elective and emergency waiting times, as well as increase the organisations ability to meet national performance standards.

Further patient and clinical benefits are possible in an enlarged organisation as delivery of national initiatives such as e-prescribing become more feasible due to enlarged buying power.

With regard to administrative and management functions there are considerable benefits that are possible from an enlarged organisation. It is noted that as the smaller acute site, HHCT would provide an ideal site for the training and learning of junior managers, giving them a breadth of experience not usually possible in larger district general hospitals. This could offer candidates from the national graduate management training scheme more opportunities to acquire a breadth of management skills that they can then take forward onto the larger acute site of PSHFT, giving the organisation an ability to cultivate and retain individuals with a high level of management and leadership capability.

6.3.3 Risks

The two key risks highlighted by the two current Chief Operating Officers is a key issue in lessons learnt from other mergers;

1. **The performance of the enlarged organisation deteriorates as focus on day to day issues is weakened through distraction on issues of integration and merger**

This case assumes service continuity will be delivered through no initial reduction in medical leadership posts and this decision has purposely been taken in order to mitigate the risk of reducing leadership posts to a level where the day to day roles cannot be adequately performed alongside integration of teams and subsequent transformation. Once the latter changes are deemed sufficiently complete, then structures can be re-reviewed for the possibility of further savings. This reduces the requirement for additional integration posts to be funded.

2. **Staff at any site become isolated from management**

As well as a commitment to all site working with dedicated site allocated days at the two acute sites within the senior directorate leadership teams, there is within the proposed structure a proposed deputy COO role which will manage the site managers and patient flows on all the of the hospital sites. In this way it is planned that staff and teams on all sites will have the ability to access their senior leadership team on a regular weekly basis.

6.4 Finance

There will be a single finance team working across the enlarged trust with four core teams. The senior leads of these teams will be co-located with the Finance Director to ensure efficient communication and information flows direct the financial decision making of the leadership team.

Aside from exceptions listed below, the staff within the four areas could have a permanent site base at any location. Although it will be important to ensure the bulk of the department remain permanently together, to have 10 hot desks at the other main acute hospital site will also be important to ensure that financial good governance is embedded in every corporate and operational area regardless of location.

6.4.1 Principle teams

Financial Management

This function will ensure that the day to day financial management and reporting within the organisation, is undertaken in an accurate and timely manner. Through finance business partners they will work within operational directorates to help promote sound financial decision making based on accurate financial reports and information. This team will also work closely with HR business partners and operational senior leadership teams to identify and deliver savings and efficiency opportunities in line with agreed forecasts.

Financial Services

This team has a responsibility for managing the financial services for the enlarged trust itself. This includes transactional administration, cash offices and charitable funds.

Charitable funds will continue to be allocated to site or service dependencies rather than merged, in that way the trust can honour the spirit of why donations were made and ensure any spending is allocated to those areas specifically.

Cash offices are likely to be required at both main acute hospital sites.

Contracting and Performance

This team will focus on the agreement and monitoring of all external contracts with commissioners and other providers. This includes private patients and prior approval treatment financial processing, to ensure the trust receives all income due. As relates to performance against external contracts with the trust, this team will also build effective performance management processes across the enlarged organisation to ensure delivery and to escalate risks to performance delivery in a timely manner to trust executives.

Procurement

This team can be located at any site, but true efficiencies in purchasing power will be more likely to materialise if the team is all based together. The team will continue to work closely with the East of England procurement hub and as part of the STP to ensure delivery of Lord Carter recommendations. As a larger organisation however there will be more immediately realised benefits when purchasing new items due to economies of scale and greater leverage within the market to negotiate price reductions.

The stores team whose role it is to receive and move goods through the hospitals will need to be site based at each of the three sites.

6.4.2 Integration

Following the standard consultation period, all heads of department will be appointed as soon as feasible but other posts will be appointed in a staged process which is reliant particularly on the ability to merge the two ledgers by day 1.

Both Finance Directors have considered both Trusts' Financial Services systems, and are identifying the preferred accounting system for the enlarged organisation. The intention is to migrate to a single financial management system by 1st April 2017 and therefore remove the need to consolidate two sets of accounts for a prolonged period. Although this time scale is extremely tight the benefits, including the financial benefits, are extensive. This decision also informs many others, for example the choice of payroll provider which will share data with the financial management system. Typically moving from one system to another takes a minimum of 6 months given the type and scale of task so this process should start no later than October 2016.

For the immediate period post merger there will need to be two teams to close down the annual accounts of both trusts and ensure all due process has been followed, particularly at the HHCT site.

6.4.3 Benefits

An enlarged team with a greater depth of post grading throughout the department, allows for individuals to have more opportunity for growing their skills and experience and career within the organisation rather than needing to look at other organisations for this. In itself this will be likely to lead to improved recruitment and retention and will give the rest of the organisation a more skilled and expert resource on which to rely.

As a smaller organisation, HHCT in particular has a reduced number of roles and therefore capacity with which to build strong internal performance management systems to manage service level performance against activity and performance related targets. An enlarged team will help both acute sites to more robustly build and maintain systems to support operational teams in delivery against national and local targets.

There is an inherent accounting set of principles and procedures that are specific to FTs. As such the finance staff currently at HHCT may have an increased opportunity for this kind of exposure and to build up their experience and knowledge as a result.

6.4.4 Risks

There is a risk that staff who are not permanently appointed into the new structure, or who are concerned about their future prior to the appointment process, will vacate their posts early.

1. **Corporate knowledge of ledger**

There is a particular risk in losing the corporate knowledge around both ledger systems as whichever system is not chosen for the enlarged organisation, there will be a continued requirement for corporate historical knowledge and legacy financial reports. Staff with the working knowledge of both systems have already been engaged in a project team so that they continue to form part of any agreed solution, and so the agreed solution includes their corporate system knowledge.

2. **Delivery of single ledger by day 1**

A specific finance department risk is around the delivery of one ledger to the timescales indicated above. Should this not be concluded by day 1 then many staff will need to be retained for the whole of 2017/18 in order to run a second ledger system. This is also a risk to the remaining organisation as there will continue to be two sets of financial reports which is likely to impede the effectiveness with which departments can manage their financial forecasting and achieve agreed savings and efficiency targets effectively.

To mitigate this risk a project team has already been established with leads from each organisation, and they are working together to deliver a cost benefit analysis of both systems promptly, and will then work together on the merging of the ledgers. System providers have already been contacted and informed and are working with the two trusts on plans to integrate information. In this way should a decision by boards be taken to merge then much of the planning and initial actions would already have been taken.

6.4.5 Next steps

With an integrated single ledger from day 1, all staff within the trust will begin to work to a merged budget profile. In itself this will be a significant change and learning process for many staff and they will need adequate support to ensure this happens smoothly.

Once embedded there is likely to be a continuing set of efficiency savings and budget line realignments throughout the first year in particular, as well as the work with new teams to agree 18/19 budgets and CIP delivery plans.

These two elements will require significant support to be in place.

6.5 Human Resources

The Human Resources (HR) and Organisational Development (OD) Directorate will develop workforce strategy, policies and procedures for the enlarged trust. These will align with and support overall organisational development and the successful delivery of the overall Trust strategic aims and objectives.

The key objective for the workforce function will be to support the creation of a high performing workforce that achieves excellent clinical, operational and financial outcomes. To deliver this trust wide objective, the HR and OD team will be well-motivated, highly performing and highly skilled individuals working together to support the rest of the staff of the trust in their achievement of the same objective.

The HR and OD function will continue to actively participate within the East of England and Peterborough and Cambridge networks on local projects such as system based workforce planning and recruitment, and contribute to and deliver national changes and initiatives (for example the implementation of the new junior doctor contract).

6.5.1 Principal teams

Learning and Development

The Learning and Development team will facilitate all management and leadership development activity alongside all staff mandatory and discretionary training events predominantly on both main acute sites within current education centres, but also off site and at Stamford where appropriate. It will link closely with both the Medical Education team and the corporate nursing department to ensure clinical training is effective, standardised and to a

high standard for all our teams. The team will also lead our work on apprenticeships and NVQ's and manage the libraries in both main acute sites.

Organisational Development

The Organisational Development team will have the critical leading role for the significant work around combining cultures and driving forward the organisational development programme as detailed in Chapter 7. Although the team members will work across all three sites to (for example) lead and facilitate staff engagement and development events, they will have an office base at the same site as the main HR department.

Resourcing

The resourcing team will predominantly be located together at one site, but may work via hot-desks at alternative sites as required. They will deliver a comprehensive end to end resourcing service, including dealing with all medical staffing matters.

Flexible Staffing Services

This team will continue to provide a high quality temporary staffing service, both through our internal bank and through partner agencies. Again it is likely this team will be located together on one site but may work via hot desk at alternative sites as required.

Occupational Health

Occupational Health will provide a health and well being advice and treatment service to all employees of the Trust. Occupational Health clinics will continue to be run across the two main acute sites and thus the team are likely to be split over those two main acute locations. The team will also provide an advice service to managers on how to support staff to return to work safely following periods of ill health.

Health and Safety

The Health and Safety team will work closely with the combined estates team of the enlarged trust to identify and manage risks to minimise any and all health and safety issues for employees, patients and visitors onto any of our three sites. This includes the mandatory training of all staff in health and safety related issues. Whilst the team may be collocated in one location, they will work regularly across all three sites.

Payroll and pensions

The payroll and pensions team will primarily manage an outsourced payroll contract and be the link to the NHS Pensions agency. They are likely to be located together at one site.

Workforce information

The workforce information team will continue to provide the vital management information on the workforce to the Trust. It is expected that they will be located together on one site.

HR Business Partners

Whilst transactional and specialist HR/OD services will be centralised, HR Business Partners and their direct support will, whilst very firmly a part of the corporate HR / OD function, provide that vital bridge between the Trust's operational Directorates and the transactional and specialist advice and support they need from the rest of the HR/OD function. It is expected that whilst they may be based in one location, they will be working across all sites via hot desking facilities.

6.5.2 Integration

Following FBC approval and appointment of the executive team, there will be a period of engagement and consultation on the new HR/OD departmental structure. This will be undertaken as early as possible to provide clarity on the proposed direction of travel and give sufficient time to consider and discuss the proposed structure and functions to meet the needs of the enlarged organisation.

Alongside the corporate nursing team, the Trust's flexible staffing service (FSS)will begin work as soon as the FBC is approved on merging the current teams of bank staff within the two separate organisations so that bank staff have a full range of shifts available to them on all three sites. This will provide this important group of staff with a greater range of shifts to meet their personal circumstances. It also benefits the organisation as more staff will be available to fill vacant shifts. This will only be done where the skills and clinical processes are safe to do so.

It is proposed that the implementation and integration of the department will be led by the appointed Director of Workforce and OD to ensure progress is timely and the directorate lead by example for the rest of the organisation. The Director of Workforce and their team will also oversee the support and delivery of organisational change throughout the remainder of the trust.

6.5.3 Benefits

Benefits of merging the two HR and OD functions impact on the organisation as a whole and are discussed more fully in Chapter 7.

6.5.4 Risks

The most significant risk to this department is that the volume and demand from the rest of the organisation, for support in managing their organisational change programmes overwhelms the ability of the department to effectively manage day to day functions. Performance against key workforce KPIs around mandatory training and annual appraisals for example could begin to deteriorate. Management and mitigation against this will be in agreeing clear and aligned organisational change programmes of work across the organisation post merger ratification and ensuring resource mapping of support from HR is effective.

6.6 Corporate Nursing and Medical Department

This department's main function will be to support clinical staff in all areas of the Trust to deliver high standards of care to all patients. For this to happen effectively the staff in the department are mainly clinical staff who have trained in specific roles that can be used generically across the Trust to develop, sustain and monitor best practice thus enhancing quality. The clinical executive leads for this department are accountable for ensuring that appropriate actions are taken to comply with mandatory and statutory requirements as well as ensuring adequate support is in all areas of the Trust to deliver high standards of care to all patients. The executive leads, through feedback from their teams, provide assurance to trust board, regulatory and other external bodies in respect of the effective and safe delivery of care standards.

6.6.1 Principal teams

Although the Chief Nurse and Chief Medical Officer's main base will be with the rest of the executive team, the Deputy Chief Nurse as a minimum will be mainly based on the alternate acute site with the other senior leadership layer shared across sites to provide daily senior clinical leadership for escalation of issues and as a point of contact for all staff and patients.

Regular hot desking facility would be required at each site.

Clinical Audit and Effectiveness

This department will be focussing on running the clinical audit programme across the clinical specialties They will provide assurance that clinical risk management is effective and robust across all areas. The department will oversee the implementation of NICE Guidance across the Trust and the team will ensure effective Board assurance regarding compliance to key metrics.

The research and development (R&D) function of the new organisation will be centrally managed in order to provide single leadership, thereby further embedding R&D and driving the development of new patient trials within the organisation thus benefitting patients, and to providing specialist professional support to those nurses and doctors who conduct the trials.

Infection Control

Working across all hospital sites this team will provide oversight and scrutiny as well as specialist advice for staff managing patients with complex infection control needs, and will also take a leadership role in minimising and managing any larger scale outbreaks that could and would impact on safety, productivity and efficiency of the new organisation. This team will provide assurance to the Director of Infection Prevention and Control and Trust Board regarding compliance with key regulatory and statutory metrics.

Patient Engagement

This department will include many specific front facing teams that will focus on the delivery of exceptional patient experience. These are proposed to include PALS team, Complaints, Interpreters, Chaplains, Volunteers, Safeguarding and Learning Disability, as well as Equality and Diversity advisors. All of these teams will be working across sites to ensure the enlarged organisation can provide equitable and continuously improving high care for the diverse range of patient needs that the new catchment area will cover.

Patient Safety

This team will provide training and practice development support to all relevant clinical staff in the new organisation ensuring equity of care provision across all of the wards and departments. Specialist staff in tissue viability, falls and continence will be part of this team and they will be responsible for training staff in these specialist areas and managing clinical risks associated with these harms.

Legal Services

The Legal Services Department will work with staff and departments across the enlarged Trust on all issues related to:

- Clinical Negligence and Personal Injury Claims received by the Trust.
- Inquest correspondence and preparing staff for attendance at Inquests.
- Loss/Damage Claims from patients/visitors/staff.

- Provides a general advisory service to staff on legal issues.

6.6.2 Integration

It is proposed that following FBC approval and appointment of the executive team, the whole of this department will be engaged and consulted with, on the new departmental structure. It is envisaged that this will benefit the individuals in providing clarity and transparency as to the proposed direction of travel and give them sufficient time to consider and discuss their new or proposed roles. This will allow views to be sought on the proposed structure and functions and a final position to be confirmed that enables the enlarged organisation to achieve it's aims.

All senior posts will be recruited as soon as feasible but other posts will be appointed in a staged process alongside the merger of clinical systems etc. An example is the production of the Quality Account for both organisations which will need to be completed by end Q1 and will require both current teams to remain and oversee its production.

By day 1 the enlarged Trust's quality and performance strategy will be endorsed by the new Trust board and be aligned to the Trust wide strategy. This will be the predominant driver in relation to clinical vision and strategy for the Trust. The executives with support from their heads of each department will drive the implementation of this thereby delivering the full integration so as to provide a single clear approach to all clinical staff within the organisation during a period of change.

6.6.3 Benefits

There are several benefits to the Trusts merging.

We know from the dual role already created in respect of Emergency Planning Resilience and Responsiveness (EPRR) the benefit of enabling a consistent approach has allowed for more effective time management as well as providing a more robust response in the event of an incident. For example we can ensure that each site plan can utilise resources most effectively in a flexible manner across the trust in order to protect normal services and enable swift recovery to the benefit of all patients whether they were directly involved or not.

Strong and reliable systems for ensuring medical revalidation exist at both sites. PSHFT has developed, using an already established electronic recording database, a robust process for ensuring and monitoring nursing revalidation, which has been held up nationally as innovative and good practice. By rolling this out across both sites we will reduce duplication and become more consistent and efficient.

There is currently an in-house team of trained staff at PSHFT providing legal services whereas due to its size and related volume of claims, HHCT predominantly pick this up through non-specialist legal staff with external advice as needed and in conjunction with the NHS Litigation Authority. By merging, the PSHFT team will absorb the additional HHCT workload for minimal additional cost. The benefit of this is not just financial but from a legal quality assurance perspective the service will be more consistent and supportive to the clinical staff involved.

An integrated approach to learning from a quality and clinical risk perspective and taking current best practice from both sites will enhance practice and again ensure consistency across the organisation. An improved robustness of the Practice Development team through

becoming larger, will provide standardised training across all the trusts sites ensuring consistency of care delivery and reduce variation across the new organisation. The multi-site organisation would provide learners with greater opportunity thus making it more attractive to students and support an increase in student cohorts.

There will be a single Caldicott Guardian and one Speak Up Guardian that will work across the merged organisation again providing consistent approach and ensure learning.

6.6.4 Risks

The internal due diligence work across Quality and Performance functions will identify issues and risks organisations during transition; this will be supplemented and confirmed through the external due diligence work and the well-led review report.

There are currently a number of emerging risks associated with the merger from a clinical perspective:

- Different systems and processes for monitoring and recording patients physiological observations i.e. NEWS and e-observations at PSHFT, with MEWS and paper at HHCT.
- Different patient records/documentation included within nursing records e.g. nutrition risk assessment, care plans etc
- Electronic incident recording system i.e. both now use Datix but limited archive prior to introduction at HHCT in October 2015
- Different IT systems e.g. PACS, K2 (maternity system)
- Different systems and processes for claims management
- Different software for managing Trust documentation e.g. policies and procedures
- Different uniform approaches– potential to delay a sense of uniting the organisation particularly for staff and patients moving between sites
- Different approaches to moving away from paper based patient records (scanning and storage issues)
- Different infection prevention and control strategies (e.g. deep cleaning methods)

The Quality and Performance work stream board members are considering the level of risk each of these presents to staff being able to work cross-site and clinical teams being fully merged. An integration plan is being formed including any mitigating actions to minimise the risks. All priority risk areas will be aligned by day 1

6.7 Facilities

There are a number of factors to be considered in successfully merging the two Trust Estates & Facilities departments, whilst maintaining momentum on current strategic initiatives and projects. This is due in part to the variations in current key issues that both departments face and the organisational forms of the respective teams.

Estates and Facilities national strategy and management is in the middle of significant change to meet the financial and quality challenges within the wider NHS (Carter metrics/ surplus land for residential targets/ lack of capital funding, etc.), and the merged organisation will be addressing these and be in accordance with national best practice.

6.7.1 The estate

HHCT covers land of 40 acres and is predominantly made up of the 1980's "Best Buy" format from that era. Ownership tenure is mainly fully retained, with nearly all soft FM services, including catering and domestic services, managed by the Trust via direct NHS employees. There is a small PFI on site in the form of a Treatment Centre built in 2005 that is well managed and is in first class condition.

PSHFT by contrast, is predominantly a large PFI at the Peterborough site with well-publicised complexities and issues that require specialist experience and knowledge of PFI contracts. There is a small amount of retained estate in Peterborough, but the bulk of the PSHFT retained estate is at Stamford which is a smaller community style hospital offering a range outpatient and day case services close to patients homes.

6.7.2 Capital Projects

HHCT has begun a large strategic estates redevelopment plan to create a health campus on the site, bringing together a variety of health, education and social care needs onto a single site for the benefit of the Huntingdonshire population. This is being progressed through the establishment of a Strategic Estates Partnership (SEP) and is it at the final stage of its sign off process.

As well as the ongoing complexities and implementation of remedial works related to the fire issues in the PSHFT PFI, there are other strategic estates projects in progress, including the building of additional bed capacity at PSHFT and the proposed redevelopment of the Stamford Hospital site.

Both HHCT and PSHFT have identified and established their respective prioritised capital programmes (in conjunction with clinical team engagement), which include space upgrades and refurbishments, plus medical equipment replacements such as MRIs, at all three locations.

6.7.3 External Environment

Both organisations have recently received Estates & Facilities reports from the Lord Carter central team that gives current performance measures and targets to "model hospital" standards. This has been useful in focussing key actions on how each Trust can improve the use of its Estate (e.g. clinical to non-clinical space ratios) to reduce costs and deliver a more cost effective service.

HHCT has particular space ratio and condition challenges with its metrics and the Health Campus SEP model is the strategic response to these.

In driving down costs and improving quality – linked to delivery of care, the direction of travel for many NHS Estates & Facilities departments has been to look at outsourcing certain functions where there is sufficient scale to do, and where the quality and effectiveness of the service provided by a commercial partner is an improvement to in-house provision.

Due mainly to PSHFT having a significant PFI representation, many areas are already outsourced. As HHCT still run many functions in-house, the aggregation of scale creates a real opportunity for a combined Estates & Facilities team, linked to functional outsourcing.

Finally, as part of the Cambridgeshire & Peterborough STP activity, Estates is a defined work stream linked into the back office efficiency programme. The STP Estates Working Group is reviewing how and if it would be feasible in the future to work collaboratively towards delivering a single Estates and Facilities function for all NHS bodies within the region. Some Trust teams have insufficient scale and skills to continue as standalone teams, so this is gaining momentum and support.

6.7.4 Principal teams

Soft-FM (Facilities Management)

Overseeing and/or delivering services within all the retained Estate such as catering, linen and laundry, car parking, transport, post room, etc. Services which are vital to ensure run effectively for the benefit of patients and the efficient running of the operational areas. These areas can be aggregated and reviewed as part of a proposed outsourcing programme.

Hard-FM

This team oversees and delivers engineering, building maintenance, grounds and gardens, medical equipment maintenance, etc. These areas can be aggregated and reviewed as part of a proposed outsourcing programme.

PFI

Directly managing the PFI contract arrangements for the enlarged Trust and ensuring commercial partners deliver to the agreed contracted performance. This includes completing the current remedial work at PSHFT PFI relating to fire back to legislative standards.

Fire Safety

A statutory post, this member of staff will ensure that all sites are safe for staff, patients and visitors to occupy from a fire perspective, liaising with Cambridgeshire Fire & Rescue as necessary. They will also deliver the mandatory fire training to all staff required on each site.

Sustainable Development

The enlarged Trust has a moral, ethical and legal obligation to ensure it functions within the minimum possible carbon footprint and that wherever possible it works with staff, patients and visitors to minimise any negative impact on our environment and the communities they serve.

Capital

It is envisaged that project management of capital schemes for the enlarged Trust will be provided via the SEP corporate structure, with the Trust direct teams acting as informed clients. This better aligns the required resources to larger SEP project outputs and can be scaled to suit the projects to be delivered in a given financial year.

6.7.5 Integration

If the Estates & Facilities functions of both Trusts are merged, they will work as a single Department across all three sites, sharing expert knowledge and skills flexibly to where in the Trust they are most needed. Although there would be site based roles, a number of management and supervisory roles will function across the portfolio and operate on a hot desk basis.

The vision of the merged Department is to begin immediately on all significant supply chain contracts between the Trusts (where timings of contracts allow) in order to begin delivering reductions to combined contract values based on volume discounts.

Throughout the following two years, there will be a series of consecutive exercises to test the market for quality, effectiveness, reliability and cost of outsourcing for the combined and enlarged functions. Any proposals that arise would need to be formally agreed by the Trust Board prior to implementation.

6.7.6 Benefits

The current variability has resulted in two teams with a large range of experience and skills, undertaking often quite different daily duties. Bringing them together into one team spreads this expertise across all three hospital sites, which will enable all parts of the Trust to benefit.

Certain key Estates & Facilities posts are well known for being difficult to recruit into and many Trusts experience high agency costs within their departments in order to cover the functions safely. An enlarged department will reduce the reliance of either trust on more costly agency resources now and in the future, as skills can be shared across sites and create better resilience. The enlarged trust will also provide a more attractive option for substantive candidates to join from a variety of role and personal development perspective.

Non-pay benefits will also result from a merger, as volume based price reductions can be substantial given that commercial contracts can be large in value in this functional area. Another key benefit will be the re-alignment of the compliance work that both Trusts are doing. This will provide assurance to the new Trust board that we are managing our resources effectively and efficiently.

6.7.7 Risks

The predominant estates and facilities risk associated with the merger is that momentum and focus is lost from the key strategic projects that are currently underway and which already form part of the Trust Board strategic objectives.

Migration plans for merged teams will also require careful planning to maintain standards and ensure teams are fully motivated throughout. With the potential for some Trust teams to be reviewed for outsourcing, this may create some levels of uncertainty for a period of time.

Strong experienced leadership, underpinned by a clear strategy and timeline will be essential to mitigate against this resource uncertainty.

6.8 Information Management and Information services (IM&T)

The IM&T services within the enlarged organisation are fundamental to the successful integration of all clinical and back office areas. Both HHCT and PSHFT have a large number of clinical and non-clinical systems that will all need aligning in a phased programme of work over a number of years. Whilst this takes place the technical knowledge of how these systems work and interlink will be vital to maintain on each site, as will site knowledge of IT infrastructure and how data and information is transferred across and externally to the site.

Due to this it is proposed that the IM&T department of both organisations remain intact albeit under one leadership and management team. This team will oversee a planned integration programme of work working closely with clinical and back office colleagues. It is expected

that additional staff will be required for an intermediate period to provide project management and specific technical advice to run and support the integration, these are factored into the integration costs for the merger.

As the integration programme progresses according the integration plan set out to boards in November, then there will be a planned phasing of pay and non-pay reductions in line with benchmarked best practice for modern IM&T departments in the NHS. A commitment by the enlarged trust board to continue its focus and recognition of IT as an enabler for clinical service change will continue to drive down costs in the long term and improve clinical efficiency and patient safety.

6.9 Corporate Governance

The company secretary department will be at the heart of governance operations within the enlarged organisation. It will advise and support the new Board in directing them how to achieve the organisations new strategic aims and vision, in compliance with corporate law and ethical and regulatory requirements.

6.9.1 Principal teams

Executive Support

There will need to be a team of administrative personnel supporting the executive and non-executive members of staff in managing the workload and requirements of their positions. This team will also service board and subcommittee meetings, and ensure information accurately flows in both directions between Board, subcommittees and senior management. Individuals will be appointed into this team following the confirmation of the new Board members, which will also consider how the executive support function relates to the operational teams of the individual directors.

Information Governance

This team is responsible for ensuring necessary safeguards are in place and embedded throughout the organisation, for the appropriate use of patient and personal information. This includes provision of training, reviewing any alleged breaches of relevant national guidance and law, providing advice and guidance to operational areas of the Trust, taking responsibility for the national assessment of information governance standards through the national IG Toolkit, and liaison with the statutory regulator for this area – the Information Commissioners Office.

Compliance and Risk

The compliance team provides support to the Company Secretary in ensuring the Trust has effective procedures in place to ensure compliance with all relevant corporate governance regulatory and legal requirements. This includes reviewing the Trust's compliance with its licence, monitoring corporate policies, reviewing national policies and documents and their dissemination and managing the corporate risk register via a board assurance framework that should inform the board of risks against the strategic objectives, and either give assurance or easily highlight issues with the management of mitigations against those corporate risks. This will be particularly important immediately before and for some time after transaction as the various risks described in chapter 10.5 will need careful management.

6.9.2 Integration

It is proposed that following FBC approval and appointment of the executive team (including the Company Secretary role), the whole of this department will be engaged and consulted with on the new departmental structure as one and without further delay. This will benefit the individuals in providing clarity on the proposed direction of travel and give sufficient time to consider and discuss the roles they may wish to be engaged with in the short and long term. It will also allow the organisation sufficient time for all views to be sought on the proposed structure and functions and a final position to be confirmed that best supports the enlarged organisation to achieve its aims.

The department will be co-located with the executive team to provide timely advice and support. There will be a permanent presence on each main acute site for information governance support for staff, and a hot desk function to facilitate cross site working.

Both trusts will undertake end of year reporting by the end of month 2. Individuals with the knowledge and experience of the two organisations will be retained to complete this function.

Both organisations currently have level 2 compliance against the information governance toolkit and this level will be maintained as a minimum in the enlarged organisation.

6.9.3 Benefits

An enlarged team with a greater depth of post grading, will allow for individuals to have more opportunity for growing their skills and experience and career within the organisation rather than needing to look at other organisations for this. In itself this will be likely to lead to improved recruitment and retention and will give the rest of the organisation a more skilled and expert resource on which to rely.

With particular regard to information governance, a merger and subsequent larger team offers the rest of the organisation more resilience in providing daily contact and advice on issues relating to data protection. This is an advantage to staff and patients over the current position where immediate advice is reliant on single individuals being present and not being on leave. A safer and more resilience to ways of working for staff indirectly benefits patients through their safe data storage.

A larger team will also allow for individuals to undertake professional qualifications in becoming a company secretary, which is something the current smaller teams of both organisations are unable to support.

6.9.4 Risks

There is a risk that staff who are not permanently appointed into the new structure, or who are concerned about their futures prior to the appointment process, will vacate their posts early. This could result in the loss of corporate knowledge necessary for accurate closing down of the previous year's reporting.

From day 1 the enlarged Trust will be responsible for the safe collection, processing and storage of confidential data on all three sites. As such there needs to be absolute clarity to all staff as to the policy and guidelines they need to be followed to avoid a breach of data protection law due to staff working to different policies on different sites.

6.10 Summary

All corporate directors have agreed the form and function of their service under the new organisation. The merged organisation will deliver recurrent savings of over £9m through the integration of its corporate and back office teams, thereby fulfilling the commitment to improve the overall financial sustainability both of the new organisation and the LHE.

7. Workforce and organisational development

This chapter describes the process for supporting the workforce through the proposed merger, and shows the benefits to the workforce of working in a larger trust. Workforce changes will be supported by expert HR advice and will follow legally compliant best practice, and will be part of a wider organisational development programme which is also described.

7.1 Workforce

The key workforce objective for the merger will be to support the creation of a high performing workforce that achieves excellent clinical, operational and financial outcomes. We will create an environment which supports our workforce with personal and professional development opportunities and promote the combined organisation as an employer of choice locally and nationally.

This will be delivered partly through workforce change and through organisational development. This will result in new ways of working for clinical teams to support the enhanced level of service we aim to deliver. The restructured corporate and back office services will support the clinical services more efficiently.

7.1.1 Workforce benefits of a combined organisation

The combined organisation will undertake a workforce review and plan across the three hospital sites. The aim will be to ensure that we deliver outstanding patient care through having:

- the right people,
- in the right place
- to carry out the right tasks
- at the right time

Patients will benefit from improved outcomes and experience associated with a more flexible workforce working across the larger clinical specialities.

A key benefit will be the increased ability to recruit to key skill shortage areas. PSHFT has not had the same recruitment challenges as HHCT and a significant proportion of consultant vacancies have been filled. However, both trusts have found it difficult to attract applicants to some areas such as stroke, where there is a national shortage of applicants and have relied in some cases on long term locum appointments.

HHCT has struggled to recruit to key clinical posts in a number of specialities, including acute medicine and emergency medicine. This is due mainly to the size of the Trust and the inability to offer work in bigger teams, or to sub specialise, opportunities which are often sought by prospective consultant appointees.

The need to deliver clinical services whilst working around high vacancy levels can be very challenging for clinical leaders and this can lead to a lack of continuity of patient care. The combined organisation will be much better placed to offer potential candidates the opportunity to work in bigger teams, to sub specialise where appropriate, to work on a multi-site basis and to benefit from less onerous on call commitments. These are all reasons why candidates

have already been attracted to some posts at PSHFT and we are confident that this will continue and grow with the combined organisation

The combined organisation will have an enhanced recruitment and retention strategy which covers the catchment and networks for all three hospitals, providing wider access to pools of staff for all professions and roles.

It will also be easier to attract students from colleges, university placements and secure associated, external funding aligned to both recruitment and education. When these potential candidates are identified and employed, the combined organisation will be better placed and resourced to retain them based on being able to provide much more focused and accessible career development opportunities.

We will be able to offer broader and more challenging work placements, interesting and more rewarding work, with more effective and timely talent and succession planning.

In the future, the NHS plans that hospitals will grow their own future clinicians and staff. A bigger trust will be able to offer alternative training programmes and support for nurse trainees, and grow the competencies of our bands 1-4 staff (support roles such as health care assistants and physiotherapy assistants. It will support the introduction of new roles such as Physicians Associates as support networks will be easier to access. A combined organisation has a much stronger opportunity to access training and education funding than two organisations operating and bidding separately.

PSHFT has an established and resourced Organisational Development function along with well-established programmes of leadership and management development and both of these would be of wider benefit to the combined organisation.

Other benefits include better opportunities for training and development. With an enlarged service there will be a wider variety of training opportunities than many staff have been able to access in smaller organisations.

7.1.2 Delivering organisational change

We are absolutely committed to ensure that all organisational changes are made through adherence to best professional practice, and in line with the relevant employment legislation. The consultation requirements for TUPE and potential redundancies will be in line with legislative requirements and the policies of both current organisations which set out the agreed process for consulting upon organisational change and the protections available to those affected by change. Every effort will be made to minimise any staff redundancies. Many of the posts that are identified to be reduced are currently filled with temporary or agency staff, or indeed are already vacant. Where posts are filled with substantive staff then the organisation will work with individuals to find suitable alternative positions including where feasible providing on the job training.

Throughout this process, there will be active and consistent partnership with our recognised Trades Unions and, where appropriate, other staff representative bodies.

Transfer of Undertakings (Protection of Employment) (TUPE)

Although in practice, the two trusts are merging, with regard to the transfer of staff from HHCT to PSHFT, legal advice is that as this is an acquisition of HHCT by PSHFT, the

requirement will be for HHCT employees to TUPE into PSHFT under the same terms and conditions of service (or whatever name the combined organisation will adopt). There is no requirement for PSHFT staff to TUPE into the combined organisation. As required under TUPE, HHCT staff will transfer with their existing HHCT terms and conditions of employment.

Subject to the approval of this full business case by both Boards an indicative timetable for the consideration of the expected workforce changes might be as follows

Organisational change

The plan to deliver the workforce changes described in Chapters 5 and 6 will be to the following timetable:

- During December 2016, formal consultation will commence with recognised Trades Unions on TUPE and any potential redundancy situations.
- During December 2016, Executive Directors will develop and agree consultation documents in readiness to consult with staff in those areas expected to be affected by change
- During January 2017 consultations led by the relevant Executive Director, with support from Director of Workforce and OD will commence. These will be undertaken in line with the organisations' organisational change policies regarding proposed changes to structures in the "back office", including operational and clinical support functions.
- By mid-February 2017, following the completion of consultation, final decisions to be made with regard to any proposed changes in structures and these notified to the Trades Unions and affected staff.
- During late February and early March, where required, selection processes to be undertaken to start to identify those who may be at risk of redundancy. Those staff so identified can be informed of that decision but, to comply with TUPE legislation, no notice can be issued until after the date of the transfer (i.e. until after 1 April 2017.)

Any period between the notification to individuals that they are now formally at risk and the formal issuing of notice, will be added to the normal contractual notice period and used proactively in terms of actively seeking suitable redeployment and alternative employment opportunities for those affected.

7.2 Best practice opportunities

The Post Transaction Implementation Plan will set out in detail how improvements in practice will be delivered. However, combining the two organisations will offer an excellent opportunity for all back office services to review their practices and make the new teams better than the existing two services.

A refreshed Workforce and OD strategy and supporting plan of work, developed in partnership with all stakeholders, will clearly describe the future workforce management in the combined Trust.

Founded on professional and industry best practice, our plan will also drive efficiency and continuous improvement through improved and integrated HR systems and a close alignment to the East of England workforce streamlining project.

Our Workforce and OD function will continue to actively participate within the East of England and Peterborough and Cambridge networks on local projects such as system based workforce planning and recruitment, and from a national perspective we will work together on implementation of the new junior doctor contract, building better opportunities for rotation and experience for these key staff within a merged organisation.

Whilst a key and prominent area of focus for the workforce team will be supporting the delivery of the vital Organisational Development Strategy and its associated plans for the combined organisation, a focus on other key areas of delivery will be maintained and enhanced. This will ensure that where there are already in place good standards of achievement in one or other of the two current Trusts, that these are, as a minimum, maintained and delivered across the whole of the combined organisation. Examples of these, showing the latest performance figures for both Trusts are shown in Figure 47.

Figure 47 - Workforce KPI current performance

Topic	PSHFT performance	HHCT performance
Mandatory training compliance	91%	89%
Performance appraisal completion	89%	62%
Sickness rate	3.57%	3.88%
Turnover	10.62%	16.01%
National FFT (recommend as a place to work)	71%	55%
National FTT (recommend as a place to receive care)	86%	73%

7.2.1 Workforce risks associated with the merger

The HR leads for both trusts have identified the key workforce risks associated with the merger, and the associated mitigations (Figure 48). The most significant risks include lack of clarity of timescales and poor communication of the reasons for the change. These will be addressed through active early and clear communication with the workforce and their representatives.

Figure 48 - Workforce risks and mitigations

Risk	Description	Mitigation
Delay to consultation process will impact retention and staff morale	Significant delays after the FBC decision will cause uncertainty for in staff in the affected areas, resulting in poor morale and staff choosing to leave the organisations	Both trusts will communicate with staff in as transparent way as possible and wherever possible engage staff within decision making process. The key is to be honest as possible, keep staff informed so they know what is happening, when it will happen, who is at risk and above all else WHY change is happening
Risk to overall employee satisfaction	The effect that large-scale change can have on the morale and engagement of staff is of concern and a potential risk for the combined organisation	At the heart of mitigating this risk is to get this communication process right and in doing so establish a strong communication system, to proactively give clear communication to our staff in

Risk	Description	Mitigation
		a timely way and to avoid damaging rumors
Risk to current initiatives and programmes lose momentum	Staff could get the impression that the significant work and effort they have put into the two existing OD programmes: Good to Outstanding "G2O" (PSHFT), and Good and Beyond (HHCT) will no longer be valid, which is not the case	The organisations will retain and build upon the valuable outputs from these programmes going forward to enable the best of both to emerge for the combined organisation
Incompatible cultures.	It is well documented that integration between organisations with conflicting corporate cultures can be the biggest obstacle to a successful merger	A distinct stream of work aligned to the culture and organisational development for the combined organisation will lessen the risk of separate cultures surviving and, by building upon the best cultural aspects from both, will enable the creation of a new and robust culture for the future
Loss of key talent	During any period of change, the resulting uncertainty can prompt key talent to consider opportunities in other organisations. This can result in loss of organisational memory and even loss of whole services in single handed specialties.	We will encourage all our staff to engage with the merger plans, by providing ideas and feedback on the changes which will be invaluable to the combined organisation and all our staff. This will help our staff feel more connected to the organisations they work for, knowing they are adding their value, knowledge and experience to the plans. Our leaders will look towards the new teams and explore how they will best work together to plan good retention strategies
Inability to implement the proposed change	Delivering significant change requires the commitment of the workforce and effective leadership resource to be successful	We will successfully implement a new vision and strategic direction for the combined trust to gain the commitment of everyone within that organisation. The vision will highlight the who, what, why, when, and how of the change process. Our leadership teams will reiterate clearly aligned descriptions of what the change and the future looks like. By doing this the vision will be more compelling to employees

7.2.2 Equality and diversity

The NHS Workforce Race Equality Standard (WRES) aims to increase NHS leadership drawn from diverse communities and ensure frontline staff are free from discrimination. The combined trust will continue the existing strong commitment from HHCT and PSHFT to WRES and the associated actions.

Workforce diversity data will be collected to provide a baseline for any restructuring that may take place. Workforce and recruitment plans will include details on how we can ensure that the workforce is reflective of the communities served by the combined trust.

The combined trust will develop and implement a plan to address the under representation of staff groups based on gender, age, race, disability sexual orientation and other 'protected characteristics', including, but not limited to, middle and senior management posts and opportunities.

7.2.3 Conclusion

There are clear workforce benefits from the merger of the two organisations.

There will be clear benefits in the combined Trust's ability to recruit, develop and retain staff when compared to the two trusts standing alone.

The opportunities for financial savings from the merger of two back office support functions into one are very clearly evidenced, the merger also offers the clear opportunity to streamline services and ensure they bring together the best of both going forward. As described in the Outline Business Case, such provision will not be possible if the two organisations remain as separate entities.

Whilst processes connected with the required organisational changes will follow the relevant legislation, organisational policies and best practice, they will only be successful if they are undertaken in clear and close partnership working with the recognised trades unions, Staff Governors and Staff Councils.

Similarly, the successful engagement and development plans described in the Organisational Development section below will be essential to the success of the merger.

7.3 Organisational development

7.3.1 The OD approach

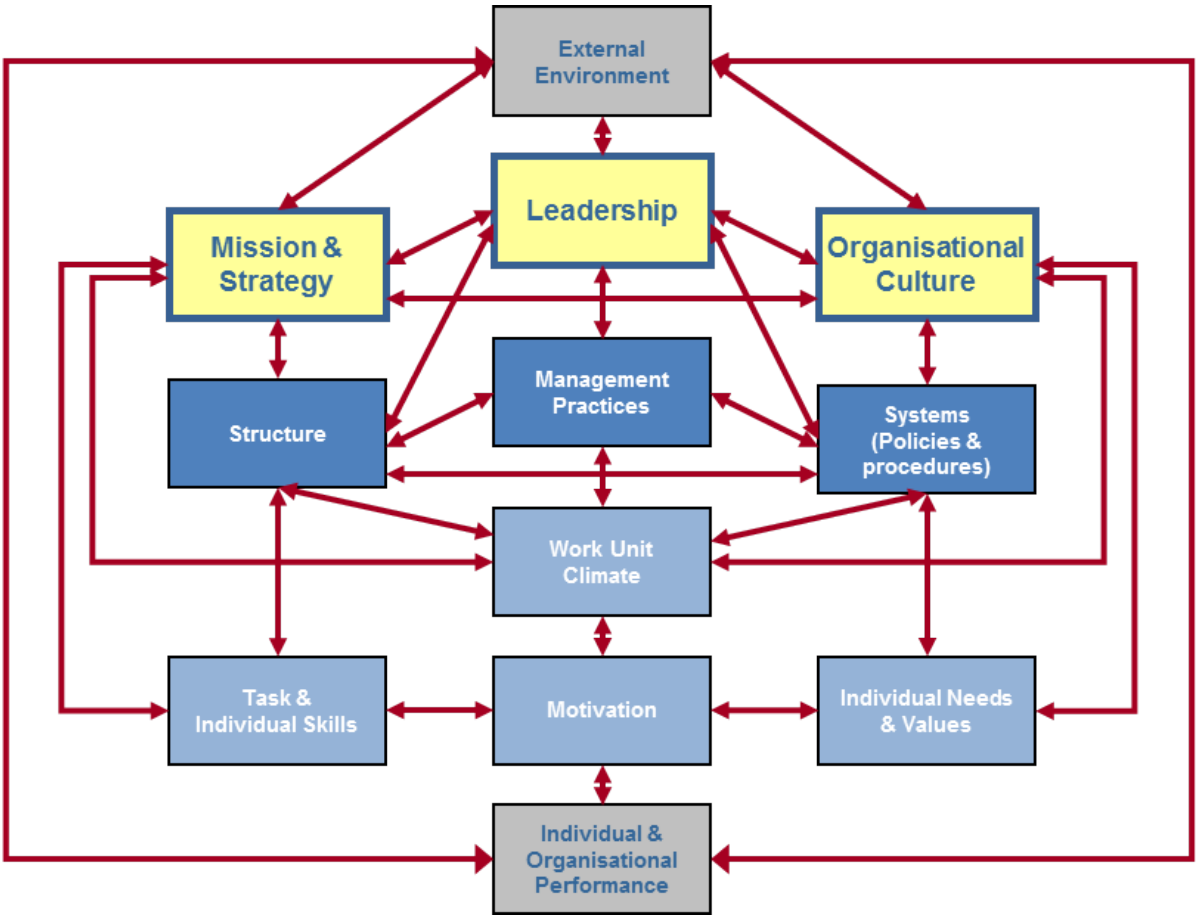
It is our intention that in planning for and forming the combined organisation a planned and systematic approach will be taken to organisational development. This will ensure that all interventions are properly analysed, researched and best practice followed before starting plans, programmes and interventions.

It is well evidenced that this systematic and carefully managed process of organisational development will ensure that the proposed benefits are delivered.

We will adopt the Burke Litwin model of Organisational Development (Figure 49) which provides a framework for organisational diagnosis and change. It recognises that there are many elements within organisations which need to be aligned to deliver real benefit.

The model drives identifies three critical areas of transformational exploration and intervention namely; **Mission and Strategy, Leadership and Organisational Culture**. Each of these is expanded upon below. Additionally, the model focuses specific attention on more transactional areas such as structures, management practices, and systems e.g. policies and procedures.

Figure 49 Burke-Litwin model of OD



7.3.2 The OD vision

Mission and strategy

The organisation will have an agreed and clearly articulated organisational vision and strategy, with explicit strategic objectives demonstrating the route by which the vision will be realised.

This overall vision and strategy will be strongly underpinned and influenced by a distinct clinical vison. All employees will have absolute clarity as to the aims of the organisation and the part they play in the achievement of those aims.

The overall vision, strategy and objectives will drive and coordinate the activities of all the constituent parts of the combined organisation.

The combined organisation will have developed a strong “brand” one that is recognised and understood by patients, partners, staff and other stakeholders alike.

Culture

A distinct, unique and unifying culture will emerge for the combined organisation which, whilst evidently needing to reflect the vision, direction and attributes of the organisation, but will also reflect the importance of the identity of our three separate hospital sites and reflect and respect their heritage.

An agreed set of values and supporting behavioural frameworks, based on both trusts current value and behaviour framework will be in place and these will directly guide the way we work both within the trust but also and importantly with our customers, partners and stakeholders.

All employees, from Board to ward will be expected to undertake whatever their role is in the organisation in line with the agreed values and personally demonstrate the behaviours as set out in the personal responsibility frameworks.

Leadership

All leaders in the organisation, from Board to Ward, will feel equipped and developed to lead the organisation to deliver outstanding services to the communities we serve. A comprehensive programme of development will be in place which will help them to adapt to and excel in the challenging, turbulent and changing environment of the NHS in the next 3 -5 years.

The foundations of this will be centred on an agreed personal responsibility framework for leaders and will be further underpinned by improved talent management, succession planning, coaching and mentoring. Of particular focus will be the provision of excellent leadership development for our most senior clinical leaders who will drive the improvement of their services alongside the delivery of the Trust's overall aims and objectives.

7.3.3 Work to date

Aligning the cultures of the merging organisations is a key priority for both Boards. This section describes the approach and key actions both before and after transaction. While some parts of the programme will be delivered prior to transaction, the alignment of culture is an important process which will continue over the ensuing five to ten years.

Significant work has already been undertaken on the creation of a clinical purpose for the combined organisation, engaging senior clinical leaders from both Trusts. This work can be seen in chapter 4 of this document.

The Board of the combined trust will lead the development of an overall vison and strategy and determine the key objectives for the combined organisation going forward from 1 April 2017. They will establish and model the required leadership behaviours going forward. At both current organisations work is already underway to explore, through engagement sessions with employees, both the required behaviours for leaders throughout the organisation and the required range of leadership and management development offerings that will be required to equip leaders and managers in the combined organisation for the next 5 years.

These separate but important strands of work will need further exploration and bringing together to establish a clearly agreed set of values based leadership behaviours and associated development needs and solutions.

7.3.4 Developing the culture

There has been recognition in both trusts and at TPB, that the need to address cultural differences between the trusts is paramount to delivery of the synergies and benefits. Significant activity has already been undertaken through listening events at both Trusts, through the "Good and Beyond" at HHCT, and the "Good to Outstanding (G2O)" at PSHFT,

programmes, to explore with staff the current culture at each Trust and this has produced a wealth of vital information and material which, at PSHFT has led the development of the Trust's overarching OD programme "G2O". Further additional intelligence as to the current views of staff on culture and related matters can be found from both the outcomes of the national staff survey and, importantly, from the local staff cultural barometer surveys undertaken at both trusts.

The cultures of both the trusts have been assessed using the Organisational Cultural Assessment Instrument (OCAI) tool see Appendix 9. Views on the current and desired culture for the combined organisation have been explored in detail with the Boards of both Trusts.

Whilst, from the OCAI assessment there are some significant differences as to how each Board views the **current** culture of their organisation, it is important to note that the view of both Boards as to the future **preferred** culture for the combined organisation are almost entirely aligned.

This then presents a unified baseline against which to revisit with staff of both organisations their views on the desired culture for the combined organisation. This work, will also include exploration of staff views on leadership, values, personal responsibility frameworks, engagement and communications and much more.

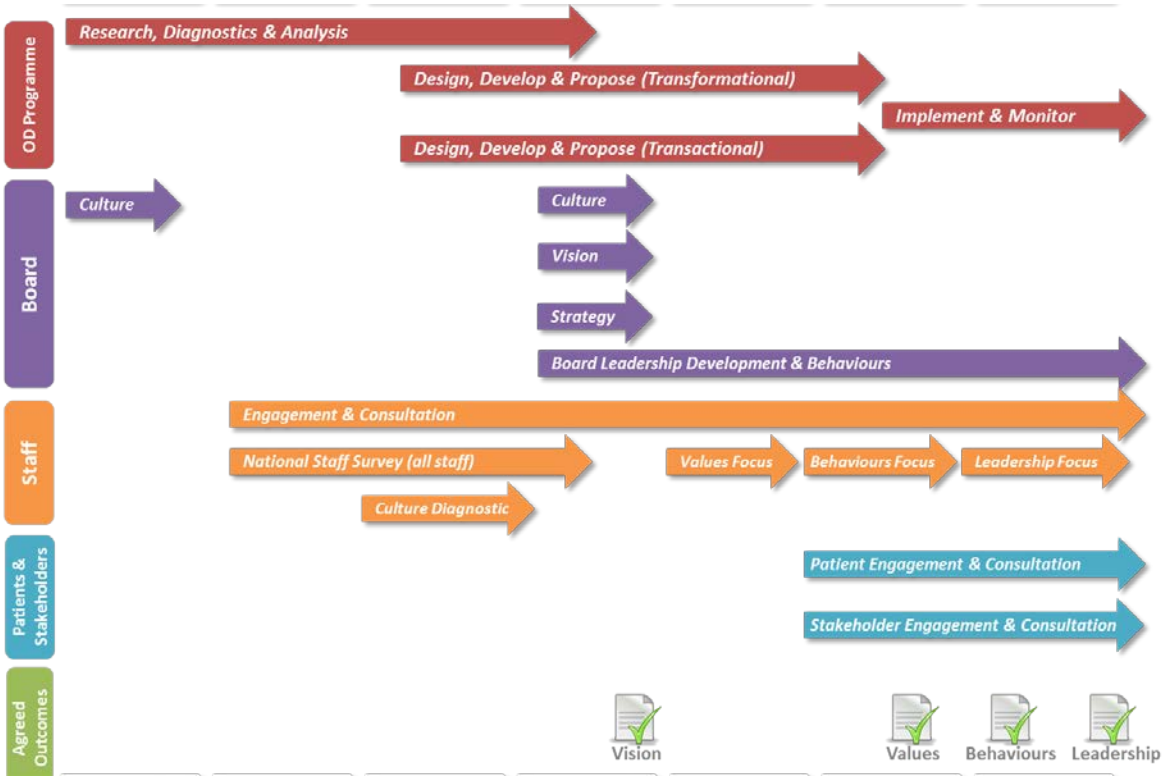
7.3.5 Summary and next steps

In terms of OD activity, neither of the two organisations are starting from a standing position. Much work has been carried out in both organisations and the new OD programme will build upon these solid foundations and in doing so recognise and respect its heritage and value.

HHCT have recently had their CQC rating improved to "Good" which matches that at PSHFT. The new OD programme will explore how both these "Good" organisations can become 'Outstanding' as a combined organisation. This overall ambition to move from "Good to Outstanding Together" will be central to a connected, inclusive and aspirational OD programme.

Whilst the granular detail of the actions and activity is set out in the detailed work programmes for each element of the Burke Litwin model of Organisational Development, Figure 50 sets out the key timelines and main deliverables to transaction date. This plan is underpinned by more detailed activity plans which will fully embed the required changes beyond 1 April 2017.

Figure 50 - OD timeline



8. The financial case

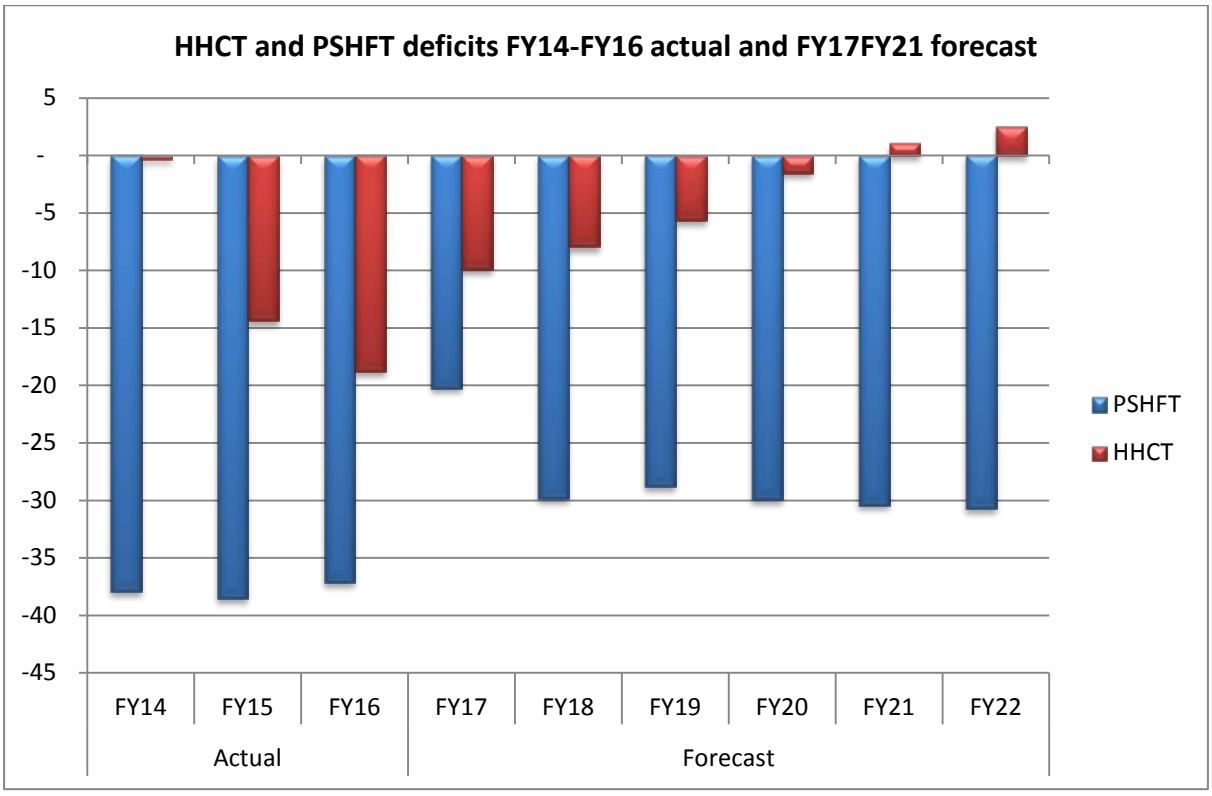
8.1 Financial challenges facing both trusts

The financial experience of both trusts demonstrates that reliance on traditional cost improvement plans is insufficient to reduce underlying deficits. At best it only delays future deterioration in finances and potentially impacts on the level of service. The financial case builds on this in more detail and shows the positions for each trust and the combined position.

8.1.1 Income and expenditure

Both trusts have been operating at a combined financial deficit (Figure 51) for at least two years. The combined deficit for FY16 is £55.9m, compared with £52.9m in FY15 and £38.2m in FY14. PSHFT has been at a stable but high level of deficit whereas HHCT's position has significantly deteriorated from a break even position over the past three years.

Figure 51 - PSHFT and HHCT financial performance FY14 to FY21



8.1.2 Cost improvement plans (CIP)

Both trusts plan to deliver significant efficiency in the next five years (Figure 52). The financial value of the combined Trust's CIP is in excess of the NHS Improvement target of 2% per annum.

The cost improvement programme is made up of three distinct areas:

- Increased income, predominantly being repatriation of activity currently carried out by external/private providers.
- Efficiencies, including those which result in agency cost savings.

- Strategic investments, including the Strategic Estates Partnership (SEP) at Hinchingbrooke.

Figure 52 - Future cost improvement target as percentage of operational expenditure

% of Operational Expenditure less PFI	FY17	FY18	FY19	FY20	FY21	FY22
PSHFT	4.8%	4.2%	2.4%	2.4%	2.4%	2.5%
HHCT	5.6%	4.9%	5.0%	5.0%	4.8%	4.7%
Merged Trust	5.1%	4.4%	3.2%	3.2%	3.1%	3.2%

In addition to the 2% national target, PSHFT plans to deliver an extra £7.6m saving in FY17 and £5.8m in FY18, equivalent to a total CIP target of 4.8% and 4.2% respectively. The 'stretch' is in response to a 2015 external review and the 2016 Carter report which identified efficiency gains to be achieved by reducing reliance on agency, procurement efficiency and increasing utilisation of outpatients (income). Thereafter, PSHFT reverts to the national target for CIP.

HHCT also plans to deliver CIP levels which are above the 2% national target, resulting in an additional £4.3m saving for FY17 and £3.5m in FY18, equivalent to a total CIP target of 5.6% and 4.9% respectively. They plan to deliver this through procurement efficiency, reduction in staff cost, and income growth. The Strategic Estates Partnership makes a significant contribution to delivering the HHCT cost improvement plan. For the following four years, HHCT plan to deliver above national average CIP of just under 5%.

Figure 53 shows the areas the Trusts plan to make cost improvements for the three years from FY18 to FY20.

Both trusts are assuming demographic growth in line with commissioner plans, and efficiency gains to deliver outsourced work already being funded by commissioners, including the repatriation of work from the private sector.

As much of the cost improvements achieved in previous years have been delivered through transactional type cost base reductions, it becomes increasingly difficult to identify further opportunities in the outer years. Merger savings present an opportunity for the trusts to deliver a significant contribution to making the required savings.

Figure 53 - Cost improvement plans

£m		HHCT			PSHFT		
Work stream	**Scheme title**	**FY18**	**FY19**	**FY20**	**Fy18**	**FY19**	**FY20**
Income Growth:							
Commissioning	Coding & counting	1.7	-	-	-	-	-
Commissioning	PHDU	-	-	-	0.6	0.1	-
Service changes	Stroke Rehab	0.3	0.3	-	-	-	-
Service changes	Bowel Scope screening	0.1	0.1	0.5	-	-	-
Service changes	Other Service changes	-	0.5	0.5	-	0.5	0.5
Theatres	Repatriation of elective activity - part of STP	0.9	-	-	benefit in reduced outsourcing (below)		
Private patients	Private patient business	-	0.3	0.3	-	0.1	0.1
Commissioning	Incremental increase per five year plan (assume Radiotherapy is in addition to this)	-	-	-	0.9	1.0	1.0
Commissioning	Repatriation of elective activity per LHE work	-	-	-	-	-	0.9
Commissioning	MRI	-	-	-	0.2	-	-
Activity gain		0.7	1.5	0.5	-	-	-
Efficiencies							
Procurement	Procurement savings	0.8	0.8	0.8	1.2	1.2	1.2
Outpatients	OP productivity improvements	0.1	0.1	0.1			
Outpatients	OP productivity improvements	-	-	-	2.0	-	-
SMSK - bring back in-house currently outsourced work		-	-	-	0.9	0.9	-
Medicines management	Medicine management / OP prescribing	0.3	0.3	0.2	0.6	-	-
Ward staffing	Nursing/HCA efficiencies	0.5	0.5	0.5	1.1	1.1	-
Medical staffing		-	-	-	0.5	-	-
Corporate staffing	Corporate cost reduction	0.4	0.5	-	-	-	-
Strategic:							
SEP developments	Long term land leasehold income	-	0.2	0.7	-	-	-
SEP developments	Hinchingbrooke Living development	-	0.2	0.5	-	-	-
SEP developments	Operational revenue from clinical support	-	-	0.2	-	-	-
SEP developments	Estates Management Services	-	-	0.4	-	-	-
SEP developments	SLA income from back office support	-	-	0.2	-	-	-
SEP developments	Utilities supply and administration	-	-	0.1	-	-	-
SEP developments	Income from new Education/ R&D Facility	-	-	0.1	-	-	-
SEP developments	Medi-Hotel income	-	-	0.1	-	-	-
Radiotherapy Expansion project		-	-	-	0.8	-	-
Fire stopping caseation		-	-	-	-	0.9	-
Turnaround budget to be absorbed into savings		-	-	-	1.0	-	-
Other:							
To be identified		-	0.5	0.1	1.2	0.4	2.6
TOTAL		**5.8**	**5.8**	**5.8**	**11.1**	**6.2**	**6.3**

8.1.3 Strategic Estates Partnership (SEP)

HHCT is in the process of forming a joint venture with a private sector partner to plan, fund and deliver major estates developments on the Hinchingbrooke site. The SEP Joint venture (JV) is an innovative venture that sees the private sector working closely with the Trust to deliver improvements to the estates in which NHS services are provided.

The set-up is different to a PFI model in that the Trust is a 50:50 shareholder of the JV and therefore is able to maintain more control over the developments. Following a procurement process, a preferred partner has been chosen and commercial discussions are being finalised alongside relevant regulatory approval.

In addition to delivering the clinical vision for the health campus, HHCT has assumed £5m annual net contribution which is at the lower end of the commercial partner estimates. This makes a significant contribution to the CIP target by FY20.

8.1.4 Capital investment

Both organisations have significant capital requirements over the coming five years, as they replace medical equipment and upgrade operational IT systems to maintain patient safety.

PSHFT has a limited capital budget and the HHCT capital plan relies on profits from the strategic estates partnership to generate the required funding.

PSHFT's capital plan includes work that has recently begun at Stamford including redevelopment expenditure on the buildings and a new MRI.

It should also be noted that additional IM&T costs of £2.8m were identified in the externally commissioned review of IM&T that would be required in a do-nothing scenario, principally at HHCT, in order to bring the current IT systems and infrastructure to a safe level.

Investment in IM&T is crucial to safe and effective delivery of care to patients and is vital for clinical team integration.

8.2 Financial position of both trusts without merger (baseline)

8.2.1 PSHFT

Figure 54 shows the detailed baseline financial plan including Income and Expenditure Account, Balance Sheet and Cash Flow for PSHFT.

The PSHFT deficit improved in FY17 due to the receipt of System and Transformation (S&T) funding in that year only. Otherwise the deficit is steady at around £30m, the main reasons being implementation of CIP's offsetting inflation effects.

The forecast cash position has been derived from cash flows arising from operating activities and any shortfall in cash is assumed to be loan funded.

Figure 54 - PSHFT financial baseline data

Baseline Data (PSHFT)

	units	Actual 2013-14	Actual 2014-15	Actual 2015-16	Outturn 2016-17	Forecast 2017-18	Forecast 2018-19	Forecast 2019-20	Forecast 2020-21	Forecast 2021-22
Summary Income and Expenditure Account										
Operating Income (inc in EBITDA)										
Clinical income	£m	215.5	219.5	230.7	241.6	247.5	253.4	259.6	268.0	276.6
Non-clinical income	£m	18.8	30.6	30.1	42.8	29.7	30.0	30.2	30.6	30.9
Total operating income, inc in EBITDA	£m	**234.4**	**250.1**	**260.8**	**284.4**	**277.2**	**283.4**	**289.9**	**298.5**	**307.5**
Operating expenses (inc in EBITDA)										
Employee expense	£m	(155.9)	(167.0)	(171.0)	(174.6)	(171.3)	(172.7)	(174.1)	(177.7)	(181.3)
Non-Pay expense	£m	(70.3)	(76.4)	(80.0)	(80.9)	(84.5)	(87.5)	(91.6)	(95.7)	(99.9)
PFI/LIFT expense	£m	(18.9)	(19.6)	(19.4)	(20.7)	(21.1)	(21.5)	(21.9)	(22.4)	(22.9)
Total operating expense, inc. in EBITDA	**£m**	**(245.1)**	**(263.0)**	**(270.5)**	**(276.2)**	**(276.9)**	**(281.7)**	**(287.6)**	**(295.9)**	**(304.2)**
EBITDA	**£m**	**(10.7)**	**(12.9)**	**(9.7)**	**8.2**	**0.3**	**1.7**	**2.3**	**2.7**	**3.3**
EBITDA margin %	%	(4.6%)	(5.2%)	(3.7%)	2.9%	0.1%	0.6%	0.8%	0.9%	1.1%
Non-operating income	£m	(0.2)	0.8	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0
Non-Operating expenses	£m	(27.0)	(26.4)	(27.4)	(28.4)	(30.2)	(30.5)	(32.2)	(33.1)	(34.0)
Surplus/(Deficit) before Tax	£m	**(37.9)**	**(38.5)**	**(37.1)**	**(20.2)**	**(29.8)**	**(28.8)**	**(29.9)**	**(30.4)**	**(30.7)**
Tax expense/(income)	£m	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	£m	**(37.9)**	**(38.5)**	**(37.1)**	**(20.2)**	**(29.8)**	**(28.8)**	**(29.9)**	**(30.4)**	**(30.7)**
Summary Statement of Financial Position										
Non-current assets	£m	379.0	371.8	424.0	431.0	429.1	425.0	430.5	426.4	422.6
Current assets (excl Cash)	£m	19.3	23.0	29.6	32.0	32.0	32.0	31.9	32.3	32.7
Cash and cash equivalents	£m	1.5	1.6	1.0	11.8	2.3	2.1	2.5	2.1	2.3
Current liabilities	£m	(39.1)	(47.2)	(54.2)	(56.7)	(70.9)	(58.9)	(57.2)	(58.5)	(49.9)
Non-current liabilities	£m	(369.3)	(359.8)	(367.8)	(386.8)	(390.9)	(427.4)	(464.9)	(490.0)	(526.1)
Reserves	£m	(8.6)	(10.5)	32.6	31.4	1.5	(27.3)	(57.2)	(87.6)	(118.3)
Financial Sustainability Risk Rating										
Financial Sustainability Risk Rating	Score				2	2	2	2	2	2
Capital Service Cover	Score				1	1	1	1	1	1
Liquidity rating	Score				1	1	1	1	1	1
I&E Margin rating	Score				1	1	1	1	1	1
I&E Margin Variance From Plan Rating	Score					4.0	4.0	4.0	4.0	4.0
Summary of assumptions applied in plan										
CIPs as a percentage within EBITDA less PFI expenses	%	6.0%	5.4%	5.4%	4.8%	4.2%	2.4%	2.4%	2.4%	2.5%
CIPs	£m	14.4	13.9	14.3	13.0	11.3	6.5	6.6	6.8	7.1
Cash Flow										
Operating cash flows before movements in working capital			(12.9)	(9.7)	8.2	0.3	1.7	2.3	2.7	3.3
Net cash inflow/(outflow) from operating activities			6.5	3.7	0.4	(0.0)	0.0	0.6	0.9	0.9
Net cash inflow/(outflow) from investing activities			(15.0)	(16.5)	(20.8)	(12.2)	(10.2)	(20.2)	(10.7)	(11.0)
Net cash inflow(outflow) from financing			25.2	25.3	23.1	2.3	8.3	17.8	6.8	7.0
Net cash outflow/inflow			**3.7**	**2.8**	**10.8**	**(9.5)**	**(0.2)**	**0.5**	**(0.4)**	**0.2**

8.2.2 HHCT

Figure 55 shows the detailed baseline financial plan for HHCT this includes the Income and Expenditure Account, Balance Sheet and Cash Flow.

This shows that the deficit is gradually reduced and becomes a surplus in 20/21. This is primarily due to S&T funding received in 16/17 only, the high level of CIP's which include increased income from contracting activities and also the Strategic Estates Partnership (SEP)

The forecast cash position has been derived from cash flows arising from operating activities and any shortfall in cash is assumed to be loan funded.

Figure 55 - HHCT financial baseline data

Baseline Data (HHCT)

	units	Actual 2013-14	Actual 2014-15	Actual 2015-16	Outturn 2016-17	Forecast 2017-18	Forecast 2018-19	Forecast 2019-20	Forecast 2020-21	Forecast 2021-22
Summary Income and Expenditure Account										
Operating Income (inc in EBITDA)										
Clinical income	£m	98.1	96.1	97.3	101.4	106.2	109.3	111.6	115.2	118.8
Non-clinical income	£m	13.6	14.3	15.0	16.4	12.2	12.8	15.0	17.7	18.1
Total operating income, inc in EBITDA	£m	**111.6**	**110.4**	**112.3**	**117.8**	**118.3**	**122.1**	**126.6**	**132.9**	**136.9**
Operating expenses (inc in EBITDA)										
Employee expense	£m	(65.6)	(71.8)	(77.0)	(77.0)	(77.9)	(77.9)	(78.8)	(81.3)	(82.8)
Non-Pay expense	£m	(36.4)	(41.9)	(40.0)	(40.9)	(40.5)	(40.1)	(39.9)	(40.8)	(41.5)
PFI/LIFT expense	£m	(1.4)	(1.8)	(1.9)	(1.7)	(1.7)	(1.8)	(1.8)	(1.8)	(1.9)
Total operating expense, inc. in EBITDA	**£m**	**(103.4)**	**(115.6)**	**(118.9)**	**(119.6)**	**(120.1)**	**(119.7)**	**(120.5)**	**(124.0)**	**(126.2)**
EBITDA	**£m**	**8.2**	**(5.2)**	**(6.6)**	**(1.8)**	**(1.8)**	**2.4**	**6.1**	**8.9**	**10.7**
EBITDA margin %	%	7.4%	-4.7%	-5.9%	-1.6%	-1.5%	1.9%	4.8%	6.7%	7.8%
Non-operating income	£m	0.0	0.0	0.0	0.0	2.1	0.0	0.0	0.0	0.0
Non-Operating expenses	£m	(8.6)	(9.2)	(12.2)	(8.1)	(8.2)	(8.1)	(7.6)	(7.8)	(8.1)
Surplus/(Deficit) before Tax	£m	**(0.3)**	**(14.4)**	**(18.8)**	**(9.9)**	**(8.0)**	**(5.7)**	**(1.6)**	**1.1**	**2.6**
Tax expense/(income)	£m	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	£m	**(0.3)**	**(14.4)**	**(18.8)**	**(9.9)**	**(8.0)**	**(5.7)**	**(1.6)**	**1.1**	**2.6**
Summary Statement of Financial Position										
Non-current assets	£m	88.9	100.9	101.7	100.7	98.5	97.6	98.4	97.6	96.7
Current assets (excl Cash)	£m	13.0	10.3	8.6	8.5	9.1	8.8	7.3	8.0	9.7
Cash and cash equivalents	£m	2.3	1.0	0.9	1.0	1.2	0.9	0.9	1.0	1.1
Current liabilities	£m	(11.0)	(15.0)	(16.8)	(15.3)	(15.4)	(14.7)	(14.6)	(14.2)	(13.2)
Non-current liabilities	£m	(16.8)	(22.1)	(38.9)	(50.2)	(56.8)	(61.7)	(62.6)	(61.9)	(61.3)
Reserves	£m	76.4	75.0	55.5	44.6	36.6	30.9	29.4	30.4	33.0
Financial Sustainability Risk Rating										
Financial Sustainability Risk Rating	Score				2	2	2	2	2	2
Capital Service Cover	Score				1	1	1	2	3	4
Liquidity rating	Score				1	1	1	1	1	1
I&E Margin rating	Score				1	1	1	1	3	4
I&E Margin Variance From Plan Rating	Score					4	4	4	4	4
Summary of assumptions applied in plan										
CIPs as a percentage within EBITDA less PFI expenses	%	6.65%	2.03%	5.41%	5.41%	3.97%	3.64%	4.38%	3.71%	
CIPs	£m	7.260	2.354	6.687	6.747	4.896	4.459	5.442	4.709	
Cash Flow										
Operating cash flows before movements in working capital			(4.8)	(6.9)	(2.2)	(1.8)	2.4	6.1	8.9	10.7
Net cash inflow/(outflow) from operating activities			0.5	4.2	1.9	(0.7)	0.3	1.5	(1.0)	(2.7)
Net cash inflow/(outflow) from investing activities			(7.7)	(12.3)	(3.4)	(0.4)	(4.0)	(5.3)	(4.1)	(4.2)
Net cash inflow(outflow) from financing			10.6	14.9	3.8	3.2	1.0	(2.2)	(3.7)	(3.6)
Net cash outflow/inflow			**(1.4)**	**(0.1)**	**0.1**	**0.2**	**(0.3)**	**(0.0)**	**0.0**	**0.1**

8.3 The combined Trust

8.3.1 Combined five year financial plan

Figure 56 shows the combined financial plan for the merged trusts which includes the Income and Expenditure Account, Balance Sheet and Cash Flow. The FY22 financial position improves due to combined synergy savings, reduced Public Dividend Capital dividend payments, and loan interest and inflation savings relating to these. The combined impact of these is an improvement by an additional £10.5m per annum compared to the two individual Trusts positions.

The forecast cash position has been derived from cash flows arising from operating activities and the transaction costs, any shortfall in cash is assumed to be loan funded.

Figure 56 - Combined Trust summary income and expenditure

Combined Trust

	units	Outturn 2017-18	Forecast 2018-19	Forecast 2019-20	Forecast 2020-21	Forecast 2021-22
Summary Income and Expenditure Account						
Operating Income (inc in EBITDA)						
Clinical income	£m	353.6	362.7	371.2	383.1	395.3
Non-clinical income	£m	41.9	42.8	45.2	48.2	48.8
Total operating income, inc in EBITDA	£m	**395.5**	**405.4**	**416.3**	**431.3**	**444.2**
Operating expenses (inc in EBITDA)						
Employee expense	£m	(253.1)	(247.7)	(247.9)	(252.5)	(256.7)
Non-Pay expense	£m	(129.9)	(128.3)	(129.3)	(134.2)	(139.0)
PFI/LIFT expense	£m	(22.8)	(23.2)	(23.8)	(24.3)	(24.8)
Total operating expense, inc. in EBITDA	**£m**	**(405.9)**	**(399.3)**	**(401.0)**	**(411.0)**	**(420.5)**
EBITDA	**£m**	**(10.3)**	**6.1**	**15.3**	**20.3**	**23.7**
EBITDA margin %	%	-2.6%	1.5%	3.7%	4.7%	5.3%
Non-operating income	£m	0.0	0.0	0.0	0.0	0.0
Non-Operating expenses	£m	(38.8)	(38.0)	(39.0)	(40.4)	(41.4)
Surplus/(Deficit) before Tax	£m	**(49.2)**	**(31.9)**	**(23.6)**	**(20.1)**	**(17.7)**
Summary Statement of Financial Position						
Non-current assets	£m	528.5	523.2	529.0	523.8	518.8
Current assets (excl Cash)	£m	40.5	40.5	40.5	39.6	40.2
Cash and cash equivalents	£m	1.3	3.0	2.7	1.7	2.0
Current liabilities	£m	(95.1)	(81.1)	(81.1)	(82.8)	(73.7)
Non-current liabilities	£m	(448.4)	(490.6)	(519.8)	(531.2)	(553.8)
Reserves	£m	26.8	(5.1)	(28.7)	(48.8)	(66.5)
Cash Flow						
Operating cash flows before movements in working capital		(10.3)	6.1	15.3	20.3	23.7
Net cash inflow/(outflow) from operating activities		0.0	0.0	0.0	2.7	0.9
Net cash inflow/(outflow) from investing activities		(15.6)	(13.9)	(24.9)	(14.5)	(14.9)
Net cash inflow/(outflow) from financing		14.5	9.4	9.3	(9.4)	(9.4)
Net cash (outflow) from financing		(11.4)	1.6	(0.3)	(1.0)	0.3
Financial Sustainability Risk Rating						
Financial Sustainability Risk Rating	Score		2	2	2	2
Capital Service Cover	Score	1	1	1	1	1
Liquidity rating	Score	1	1	1	1	1
I&E Margin rating	Score	1	1	1	1	1
I&E Margin Variance From Plan Rating	Score		4	4	4	4
Summary of assumptions applied in plan						
CIPs as a percentage within EBITDA less PFI expenses	%	4.5%	2.7%	2.5%	2.3%	2.7%
CIPs	£m	17.9	10.4	9.6	9.2	10.9

Key Assumptions

1. No savings have been assumed for clinical synergies
2. Pay savings are based on 16/17 budget
3. Funding of the implementation and integration costs have been assumed to loan funded
4. PDC dividend only payable in 16/17 and 17/18 due to level of relative net relevant assets
5. Activity growth in line with System Transformation Plans (STP) and include commissioner growth management activity plans (QIPP)
6. 7 day working – assumed it will be self financing.
7. S&T funding only assumed for 16/17

8.4 Transaction synergies

A total of £9.1m has been identified as the recurrent saving opportunity available through pay and non-pay reductions as part of the merger.

8.4.1 Corporate teams

Creating a single organisation will reduce overall expenditure on corporate and back office services, without impacting upon front line services. Principally this will be through reducing duplicate posts e.g. only one Board would be needed, and achieving non-pay savings through volume discounts with suppliers.

The executives of each corporate team from both trusts have together designed a proposed work force structure that would be required to manage an enlarged trust based over three sites. These proposed structures have been discussed and challenged as a combined group of executives but following any decision to merge, all staff within the departments will be engaged in a consultation process to test the proposed structures and ensure they are fit for purpose. The savings will be delivered over the first three years post-merger, in a phased process to minimise any risks associated with managing day to day activities on each site, whilst also undertaking merger integration work.

Figure 57 - Merger savings

Department	Combined FY17 pay budgets inc agency	Merged structure cost	Final Pay related savings
HR	£4,308,760	£3,279,211	-£1,029,549
Finance	£3,296,577	£2,762,110	-£534,467
Corporate	£810,280	£448,009	-£362,271
CEO	£2,713,481	£1,495,454	-£1,218,027
Corporate Clinical	£4,985,591	£4,550,678	-£434,913
Facilities	£41,088,264	£40,565,468	-£522,796
IM&T	£4,956,587	4,503,218	-£453,369
Clinical Support	£742,381	371,191	-£371,190
Ops	£15,870,370	14,065,006	-£1,805,364
Total	£78,772,290	£72,040,343	-£6,731,947

Figure 57 shows pay savings of £6.8m from merger when compared with the current budgets. It is currently proposed that there will be a reduction of circa 140 posts, some of which may incur redundancy payments (see section 8.5) but many of which will be posts that are already vacant due to the high vacancy rates and hard to recruit posts, or are currently filled by agency or temporary staff. Every effort will be made to ensure that staff are supported to remain within the enlarged organisation in the same or similar posts, and training will be provided where possible to enable this to happen.

8.4.2 Clinical savings

The £9m of projected savings from the merger does not include any that arise from integrating clinical services.

There are of course often financial benefits from clinical integration; however this is not the primary aim. All financial savings achieved from clinical integration will be used to reinvest in services, and to meet the annual improvements in efficiency and cost reduction to offset the pressure of cost inflation.

The core focus of clinical integration is to deliver services that are clinically sustainable although future financial savings should be possible. There are significant opportunities to reduce the use of locum medical staff as shown in Chapter 5. For example, £388k of haematology locum cost could be replaced with £200k cost of a substantive consultant and staff grade doctor with no reduction in the services offered. In fact, when these posts are appointed to and combined with the PSHFT team, the service as a whole will have permanent clinical staff providing better cross-cover across all sites, continuity for patients and staff, and new specialist clinics not currently available at Hinchingbrooke. The reduction in use of agency and temporary staff also improves quality of care.

In addition, for some smaller services without large numbers of inpatients, it will be possible to amalgamate on call rotas, reducing the onerous demands currently place on individuals in those teams.

8.4.3 Reinvestment of clinical savings

Chapter 5 described current underinvestment in some services, particularly at HHCT. The neurology and stroke services at HHCT are not currently sustainable requiring more medical staff to provide safe, sustainable services even as part of a bigger team. Some of the required investment will be met by reinvesting savings from other clinical synergies.

8.4.4 Non-pay savings

Non-pay related savings totalling £2.2m have been identified as an opportunity arising from a merger. This includes £1m arising from larger volume negotiating power over procurement of consumables, which is in line with Carter recommendations on procurement savings and the STP work. Further savings of £500k have been estimated by the estates and facilities team as coming from contractual saving negotiations, and a number of smaller amounts arising from for example, only needing to pay one CQC registration fee, one set of external and internal audit fees, one payroll and ledger system etc.

Although it is likely in the long term that there would be a saving in the cost required to run two sets of IT systems, the £2.2m does not include this as it assumes this would be offset in the short and medium terms by additional revenue costs required to integrate systems and train the organisations staff on the new systems.

8.5 Costs and Phasing

8.5.1 Costs

There are anticipated to be a number of costs associated with implementing the merger and learning has been taken from elsewhere in the NHS where mergers have been undertaken. These have been categorised as redundancy, internal transition costs, external costs and IT integration costs which are shown in Figure 58.

Redundancy calculations are based on the combined HHCT and PSHFT data of average staff salary and average length of service. There is an assumption agreed by both Workforce

Directors that many of the post reductions will not incur redundancy costs as staff will be redeployed or the posts are filled with temporary and agency staff. It is also recognised that some staff will be able to find alternative positions within the NHS.

Figure 58 – Phased costs and savings

	Costs						Total Costs	
	FY17	**FY18**	**FY19**	**Fy20**	**FY21**	**FY22**		
	Yr0 £'000	Yr1 £'000	Yr2 £'000	Yr3 £'000	Yr4 £'000	Yr5 £'000	Recurrent £'000	One off £'000
Costs								
Redundancy		-350	-507	-310	-159	-6		-1,332
Internal transition costs	-1,712	-3,284	-116					-5,112
External costs (legal + due diligence)	-775							-775
IT integration costs	-2,045	-2,045	-2,045					-6,134
Costs	**-4,532**	**-5,679**	**-2,667**	**-310**	**-159**	**-6**		**-13,354**
Savings								
CEO department		466	621	155			1,242	
Corporate Governance		181	181				362	
Finance		109	109				218	
HR		580	580				1,160	
Nursing		288	288				577	
Facilities		155	266	135	71	47	674	
IT/IS				113	227	113	453	
Ops		76	489	827	414		1,805	
Clinical Support		186	186				371	
Non-pay		321	931	789	179		2,219	
Savings		**2,361**	**3,651**	**2,019**	**890**	**161**	**9,081**	
Total	**-4,532**	**-3,318**	**983**	**1,709**	**730**	**154**	**9,081**	**-13,354**

Internal transition costs include a number of temporary posts that will be required to support clinical and back office area's with the merger process, ensuring there is enough capacity within the permanent teams to maintain sufficient focus on daily tasks of running an NHS trust. External transition costs include financial and legal advice related to the transaction itself.

IM&T capital integration costs have been developed following two external reviews of the systems and functionality in place currently in both trusts, and an estimation of the work required to fully integrate. The costs indicated are solely related and as a result of the merger.

There are additional IM&T costs of £2.8m identified in the externally commissioned reviews that would be required in a do-nothing scenario, principally at HHCT, in order to bring the current IT systems and infrastructure to a safe level. Revenue costs indicated as being required in the reports have been offset against any future IT savings in revenue from a reduction in licence fees etc.

8.5.2 Scenarios, Risks and Mitigations

Figure 59 - Sensitivity analysis

Category	Scenario	FY18	FY19	FY20	FY21	FY22	Risk level and mitigating actions
DOWNSIDE							
Activity Growth	No growth in activity	-1.3	-4.0	-7.3	-9.6	-13.6	The risk of lower growth is low, the growth included is prudent, particularly as QIPP schemes have assumed to deliver in full (see upside impact below)
CIP challenge	CIP's deliver at minimum 2%	-14.5	-16.4	-19.4	-21.6	-22.7	Both Trusts include ambitious CIP plans. Work has been carried out to look at more detailed schemes for the next three years. Furthermore no clinical synergies have been included in the FBC, it is expected that any monetary synergies will help to ensure CIP's are delivered
HHCT SEP	Delayed by one year and only deliver 50% saving	0.0	-0.5	-2.2	-3.8	0.0	More detailed work including sensitivities have been produced to assure the certainty of SEP. As can be seen below there is also potentially an upside as it may deliver more than is included.
Transaction costs	Assume 50% increase	-3.9	-1.1	0.0	0.0	-0.9	Transaction costs have been calculated in detail and external support has been received specifically on IT costs
Synergy Savings	Delayed by one year and 10% reduction	-5.2	-2.0	-2.9	-0.9		Synergy savings have been calculated in detail and the amount included is more conservative than has been seen in other mergers. It will be important to review this moving forward to ensure savings are being achieved and any required changes to plan effected
UPSIDE							
HHCT SEP	Assume SEP produces greater benefits	0.0	0.2	0.7	0.6	6.7	This would produce a favourable position if realised
Activity growth	CCG demand management plans not achieved (QIPP's)	1.8	4.9	3.0	4.6	14.8	This would produce a favourable position if realised
S&T funding	Additional funding received every year	14.8	14.8	14.8	14.8	15.0	This would produce a favourable position if realised
PFI support grant	Additional £15m per year received	15.0	15.0	15.0	15.0	15.0	This would produce a favourable position if realised

A number of scenarios have been modelled in Figure 59 which show the overall plan sensitivity to these factors. These have been thoroughly reviewed and the risks and mitigations considered, where the likelihood has been considered sufficiently high they have been factored in to the core financials within the FBC.

8.5.3 Net present value

Using the sensitivity analysis above, the Net Present Values for the 'Most likely', 'Best' and 'Worst' case scenarios are shown in Figure 60. The 'most likely' scenario is included within the financial analysis in this chapter. The potential best and worst case scenarios are included which demonstrate the impact of the sensitivities above. This represents significant variation which reflects the uncertainty around some of the assumptions.

Figure 60 - Net present value calculations

Scenario	NPV £m
Most Likely	52.1
Best Case	209.0
Worst Case	(92.6)

8.6 Due diligence

8.6.1 Financial due diligence

KPMG were commissioned to provide assurance of the financial models which have informed this business case. The reports are included in Appendix 10.

Key points from the reports include:

- There is significant alignment between the assumptions used in the base cases for both trusts, including treatment of commissioner activity demand management schemes and access to future sustainability and transformation funding
- HHCT has assumed the delivery of £3.2m of income in FY18 and FY19 related to planned repatriation of theatre activity and recoding activities which has not been agreed with commissioners
- There are risks related to the deliverability of the HHCT cost improvement given the current cost base, track record of delivering recurrent CIP and the unconfirmed nature of the income CIP planned for FY17/18 and FY18/19. They recommended that sensitivity analysis be considered and undertaken.
- The assumed levels of income from the Strategic Estate Partnership (SEP) and deliverability of cost improvement should be tested in a downside scenario
- Clinical synergy savings which could be realised in a merged organisation are not included explicitly in the business case as they form part of the cost improvement plan
- Negotiations with commissioners and central bodies regarding transition of central funding should continue
- Sensitivity analysis should include a downside of 10% under achievement of merger savings

Adjusting for these items results in an increase in HHCT deficit year on year, equating to an impact of -£11.7m by FY22, meaning the HHCT standalone trust will not breakeven within the five year period as shown in Figure 61. The reports highlight the risks associated with the delivery of CIP and SEP which have been included in the sensitivity analysis Figure 59.

Figure 61 – LTFM due diligence sensitivity recommendations

£'000	FY18	FY19	FY20	FY21	FY22
HHCT (deficit)/surplus	(8.0)	(5.7)	(1.6)	1.1	2.6
PSHFT (deficit)/surplus	(30.1)	(28.7)	(29.8)	(30.3)	(30.7)
Combined total	(38.1)	(34.4)	(31.4)	(29.2)	(28.1)
Sensitivity					
Removal of SEP	0	(0.4)	(2.2)	(4.5)	(4.5)
HHCT CIP at PSHFT %	0.7	(3.2)	(4.3)	(4.6)	(7.2)
Sensitised HHCT	(7.3)	(9.7)	(8.1)	(8.0)	(9.1)
Sensitised Total	(40)	(36.2)	(37.5)	(39.5)	(40)

8.6.2 Legal due diligence

As PSHFT will acquire HHCT, Hempsons have been commissioned to provide a legal due diligence report on HHCT which identifies a number of other risks. They have assessed the information provided by HHCT and rated any identified risks as either low, medium or high.

Equipment

HHCT has three medium-life leased assets of high value:

- Optima 660 CT Scanner – NBV of £386,693.85;
- Zeiss operating microscope –NBV of £92,267.94; and
- Wolverson x-ray system – arcom – NBV of £109,147.50.

The leases for the Optima 660 CT Scanner and Wolverson X-ray system have been reviewed by Hempsons, but the contract for the Zeiss microscope has not yet been reviewed. There is a risk the lease not seen may expire before or soon after the transaction date.

Actions to mitigate the equipment risks

As part of the Business Transfer Agreement the Trusts will liaise to ascertain the impact of the proposed Transaction on the forecasted replacement costs of medical equipment.

Commercial

HHCT have confirmed that 10 quotations or tenders for HHCT to buy goods or services are currently being completed as at 23 August 2016. Some of the tenders are either terminated or are on hold. The most significant ongoing tenders are:

- Cleaning Services for HCCT and other trusts in the Cambridgeshire area
- Strategic Estates Partnership

Both of these contracts are live.

Actions to mitigate the commercial risks

The Trusts will liaise to ascertain the nature of these contracts and the impact this will have on the financial base case.

Contracts

HHCT has a total of 460 contracts listed on the contracts register; 31 of which were reviewed in detail by Hempsons either because they have a value of over £250,000 or because they had been identified by PSHFT for review. The contracts with the CCGs and NHS England were not recorded on the register (2 further contracts).

All contracts and associated rights and liabilities will transfer to PSHFT on the completion of the Transaction.

Hempsons were unable to complete the requested review of material contracts as five were not available to them. This represents a risk, as PSHFT may acquire liability for onerous or unusual contractual terms which have not been identified.

Hempsons did not identify any legal "showstoppers" amongst the contracts they reviewed.

The Customer Contract with the Pathology Partnership (Cambridge University Hospitals NHS Foundation Trust as host) lists 33 outstanding items to be concluded within 6 months of commencement. It is unclear whether these items have been dealt with.

There are a number of elements of the NHS Standard Contract with Cambridgeshire and Peterborough CCG (acting as lead commissioner for itself and on behalf of NHS Bedfordshire CCG, NHS Nene CCG, NHS West Norfolk CCG, NHS South Lincolnshire CCG and NHS South West Lincolnshire CCG) where it is unclear, from the documents we have received, that all envisaged contractual steps and variations have taken place as required. This represents a risk of sanctions (for breach of contract) and financial loss, if terms relating to finance cannot be agreed. The Risk Register for HHCT identifies that HHCT might suffer financial penalties as a result of its failure to meet QUIN requirements (and RTT targets and CIP targets).

Actions to mitigate the contractual risks

The Trusts will liaise further about the material contracts which were not made available to Hempsons and to answer outstanding queries.

Management, Staff and Pensions

HHCT has a high staffing vacancy rate. This is affecting some of the services delivered by HHCT more than others; for example, HHCT has a long term difficulty recruiting to permanent consultant posts (in particular for haematology, Emergency Department and stroke services) and has a 40% vacancy rate for middle grade doctors. These high vacancy rates are having a knock on effect on other areas, including a significant reliance on bank and agency staff and substantive staff undertaking additional hours.

Reliance on these temporary staffing solutions is increasing staffing costs as HHCT has had to agree higher overtime rates with medics and reported a large number of "break glass" breaches of the agency pay cap. If a sustainable solution to HHCT's high vacancy rates is not identified it has the potential to affect patient safety and care.

In addition, it appears from the documents disclosed as part of the due diligence process that there are staffing issues relating to employees with lapsed DBS checks and professional registrations, employees whose visas have expired and/or not having the right to work in the UK and a significant number of employees appear to be on long term sickness absences. HHCT has, however, advised that these issues are either not as significant as their disclosure suggests or the matters are under control.

Actions to mitigate the contractual risks

The trusts are already working to address the vacancy factors through joint clinical working. They will work together to urgently address the issues related to DBS, professional checks and visas.

Estates

HHCT has entered a contract to sell land in 2014 which it now intends to terminate. If HHCT does so, it will need to return in the region of £1.35M to the purchaser.

There are estates arrangements including some related to the PFI which need to be clarified as prior to the business transfer agreement.

The Trust has confirmed it is a party to a PFI arrangement for the Hinchingbrooke Diagnostics Treatment Centre. Hempsons were informed that the PFI has a capital value of £22 million with an annual unitary payment of approximately £4.4 million. Kier Workplace Services provide both the Hard and Soft FM.

Hempsons understand that the HHCT's PFI has the same funders as PSHFT'S but they have not been supplied with the contracts for review as of 21 September 2016. The Trust has confirmed:

(i) the Trust has used PFI Standard Form Contract Version 1;

(ii) there is a Deed of Safeguard; and

(iii) the Standard Form of Contract has not been varied.

Assuming this is the case, then the transfer of the PFI contracts should not raise any issues. However, this will be confirmed once the contracts and deed of safeguard have been reviewed. The Estates and Facilities Director has also confirmed that all performance standards (as defined in the period project meetings, liaison board meetings and technical audit team reports) under the PFI arrangement have been fully complied with.

Environmental/ Health & Safety Matters

No significant health and safety matters were identified

Information Technology and Management:

No information about IT replacement is included on the asset register but information is included within HHCT's capital expenditure plan. The Data Centre is listed in the Capital Expenditure Headline Plan which HHCT has forecasted to replace.

Intellectual Property

HHCT have confirmed that they do not own any significant IP and that there are no proceedings, actions, challenges or claims (actual, pending or threatened) related to IP.

Insurance & NHSLA Scheme Membership

As at 9 September 2016, there are 60 on-going claims covered by the NHSLA.

Actions to mitigate the insurance risks

The Trusts will liaise to ascertain the extent of the liabilities that will transfer to PSHFT at the point that the Transaction Completes.

Governance, Disputes & Liabilities:

The latest CQC inspection stated that the Trust should be taken out of special measures and considered "good" and that it has updated all of its policies this year. Hempsons conclude that this suggests that robust processes are in place to deal with risks.

There are a high number of Serious Incidents at HHCT.

Urgent and Emergency Care Services are currently rated as 'requires improvement' by the CQC (as at August 2016).

Actions to mitigate the governance risks

The trusts will review the open serious incidents and obtain and assurances that they are being dealt with before the Completion Date. Clinical integration will support the emergency care services and make them more sustainable.

Data Protection

Overall, HHCT appears to be compliant with the DPA 1998.

Freedom of Information

There are no outstanding ICO investigations in respect of complaints arising under the FoI legislation, and no appeals arising under the FoI legislation. However there are currently 53 outstanding requests with 35 responded to outside of the statutory period (as at 8 September 2016).

Action to mitigate the FOI risks

HHCT will need to deal with the 53 outstanding requests prior to transaction.

9. Listening and feedback

9.1 Purpose

The experience of other mergers shows that they will only be successful if we listen to and act on the concerns raised by our key stakeholders. This section describes the engagement to date which has informed this business case and will shape the implementation plan. It also describes how we will continue to communicate with our patients, staff and the wider public once the business case has been approved.

9.2 Communications and engagement governance

Communications and engagement is one of the project business case work streams. A working group with an executive lead and membership from both trusts, reports to every Transformation Project Board. Joint decisions on stakeholder agreement, the communication plan, and level messages are agreed at the TPB.

9.3 Public engagement during FBC development

Since the outline business case was approved, there has been active engagement with public and staff by the CEOs and Deputy CEOs of both trusts. Presentations have focussed on describing the case for change and the preferred option using face to face meetings wherever possible. There have been invitations to submit feedback through internal and external websites, and on paper questionnaires handed out at the sessions.

The feedback to date can be summarised as patients needing reassurance that the merger will not lead to them travelling further to access services as a result of either services moving between the sites, or even one hospital closing to support the sustainability of the remaining two.

Other concerns include how patients of each hospital will be given an equal voice through the Foundation Trust membership status.

Staff need reassurance that the number of staff required to work from a different base will be kept to a minimum. They are also understandably concerned about potential redundancies.

During the preparation of the FBC, we have gathered the views and feedback from as wide a variety of stakeholders as possible. A series of public events hosted by the CEOs and Deputy CEOs of one or both Trusts have been staged in South Lincolnshire, Peterborough and Cambridgeshire. A full list of events, is included in Appendix 11. The events began on 28 July 2016 and will continue into November 2016.

Alongside the public events, staff briefing sessions are being held regularly in both trusts through a variety of channels, such as face-to face briefings with the executive team, written updates sent to each staff member and intranet messaging. Staff engagement is a key part of the proposed merger process to ensure members of the workforce across both Trusts can be involved in any developments, whether the proposed merger may directly affect their department or not.

The CEOs/Deputy CEOs of both trusts are also providing regular updates to all local MPs and the local authority health overview and scrutiny committees/health and wellbeing boards.

Thanks to the support of Healthwatch Peterborough and Healthwatch Cambridgeshire, we have been able to identify and engage with a wider number of local groups who are actively involved in their local healthcare communities, which will serve as a real benefit to both Trusts both now and in the longer term.

Feedback from engagement events is captured and the key themes are described in the following section.

9.4 Listening and responding to feedback

From the engagement events to date, the following themes have been identified which are either already addressed in the Full Business Case, or will be addressed as part of the implementation plan.

They fall into four main categories, as listed in Figure 62:

Figure 62 - Concerns raised during engagement

Concern raised during engagement	• Response
Patient concerns: Travel to a different hospital due to: - potential hospital closure - diminished services at one of the three hospitals	•Plans in the business case describe strengthening services at HHCT, not reducing service on any of the three sites. •The CCGs have made a public commitment to the ongoing provision of safe, sustainable core acute services from Hinchingbrooke Hospital. Both CEO's agree with this decision. •Any CCG reconfiguration would be subject to full public consultation
Staff concerns - Move to a different base - Threat of redundancies - Imact on Stamford hospital development and HHCT Strategic Estate Partnership	•Some back office staff may change their base as a result of the merger. Some clinical staff may rotate between sites •Redundancies are accounted for in the financial plan, but we it is assumed that at least half of employees in posts at risk will be redeployed reducing reliance on temporary staff •The Stamford redevelopment and HHCT SEP will continue as planned
Financial concerns: - Do financial benefits outweigh the costs - How will PCH PFI debt be addressed without impacting HHCT	•Yes financial benefits of £9m are recurrent, the £13m costs of implementation only impact on the first two years •ThePFI debt has never affected patient care. Th DH funds it hrough a revenue subsidy of £10m and cash support of £15m. Part of the Trust's plan overseen by the regulator shows that this £15m will be converted to revenue support.
Other concerns - Is April 2017 too soon - Will patients of each hospital have an equal voice as FT members	•We have a sound implementation plan to deliver by April 2017. Delay would reduce clinical and financial benefits and increase cost •All members of the foundation trust have an equal vote. Governors will be elected by the public members and will represent geographical constituencies of the enlarged trust

9.5 Continuing the journey – a listening organisation

Following approval of the Full Business Case, a further programme of stakeholder engagement will be developed to run from December 2016 to April 2017

9.6 Process for merging websites and intranets in both Trusts

The Trust intranet and internet sites play key roles in communicating with our staff and the wider public.

Planning is under way to ensure that there will be a new website for the combined Trust that will go live on 1 April 2017. As Peterborough and Stamford Hospitals NHS Foundation Trust went live with its new website in May 2016, it is accepted that this newer system would be the preferred platform for a combined website.

The new site will showcase each of the three hospitals, for ease of navigation for web users.

The process to merge intranets (the internal website used mainly by staff) is unlikely to be complete by 1 April 2017. However, plans are in place to ensure the two separate sites will mirror each other from the date of the merger. It is vital that staff in both organisations have access to the same information at the same time. A single intranet solution will be a high priority to go live as close after 1 April 2017 as possible.

10. Moving forward

This chapter describes how the organisations will work together to deliver a fit for purpose merged organisation by day 1. It describes how governance and leadership will be in place and how Heads of Terms and Business Transfer Agreements will be agreed prior to the transaction date of 1 April 2017. As well as the approvals process, it describes the overarching programme management arrangements for the process, and the integration of teams from the two merging trusts.

If merger is approved, a detailed implementation plan will be developed for the November 2017 Trust Boards. This section focusses on the immediate steps and required processes.

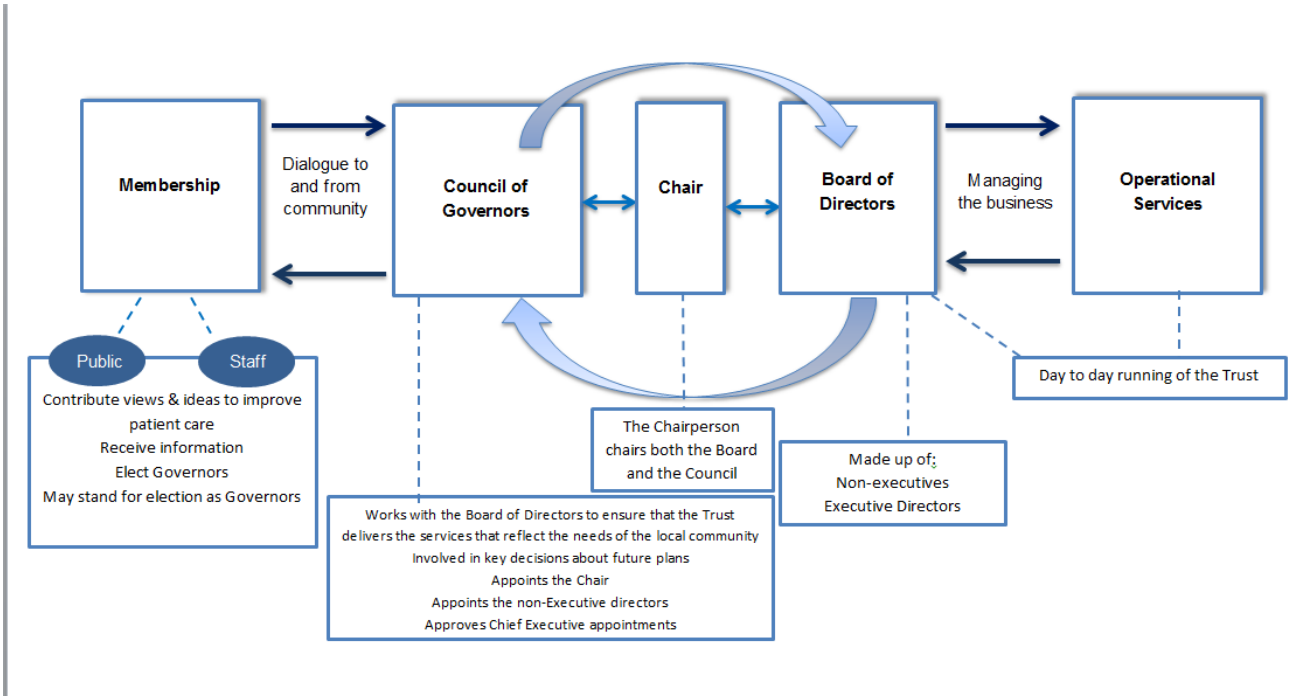
10.1 Governance

10.1.1 Introduction

Although Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) and Hinchingbrooke Health Care NHS Trust (HHCT) are considering a proposal for a merger, technically the legal process is an acquisition of HHCT by PSHFT. This means, should the application be successful, that HHCT will cease to exist and services/staff/liabilities etc. will transfer to PSHFT. However, so as to prevent any adverse service impact at one or both of the Trusts, the decision has been made to manage this as a merger. Overarching legal advice is being provided to NHS Improvement by Hempsons.

As an acquisition, the new combined trust will remain a Foundation Trust, subject to the law and governance arrangements which all FTs are expected to meet, and regulated by NHS Improvement (Figure 63).

Figure 63 - Foundation Trust Governance arrangements



The proposals for establishing the governance arrangements within an combined trust are described below.

10.1.2 Process for agreeing the name of the combined trust

The current names of both trusts are not appropriate for a new combined Trust. Peterborough and Stamford Hospitals NHS Foundation Trust relates to a specific geography, whereas Hinchingbrooke Health Care NHS trust is so named because it is located in what used to be the grounds of Hinchingbrooke House, a stately home next to the hospital. The Transaction Programme Board has agreed that as part of a merger, a new name will be agreed for the combined trust and that the individual sites will retain their current names - Peterborough City Hospital, Stamford and Rutland Hospital and Hinchingbrooke Hospital.

As part of our engagement we have asked members of the public to submit their suggestions on the name of the combined Trust. This is also discussed in the public engagement sessions. Staff in both organisations have also been asked to submit their suggestions.

All suggestions are recorded and will be presented to the board of both Trusts for further discussion once it is agreed that we will merge.

It is anticipated that there will be shortlist drawn up from which the name of the combined trust will be chosen by undertaking an electronic survey of staff and public members of the combined Trust.

10.1.3 Membership and key appointments

Membership

The existing membership covers PSHFT. As it is not a foundation trust HHCT has no defined membership. PSHFT is leading work to increase membership to provide representative coverage. This work needs to be alongside consideration of extending the current membership catchment. This is currently managed on county boundaries including Peterborough Unitary Authority, Cambridgeshire, Lincolnshire, Leicestershire, Northamptonshire, Norfolk, and Rutland Unitary Authority. A review of patient flow into both Trust's suggests that this should be extended to include Bedfordshire and ensure any growth in PSHFT patient catchment is included.

Whilst counties are included the search for membership would be in those parts of the counties that match current patient flow e.g. St Neots rather than Cambridge, Stamford rather than Lincoln.

Governors

The council of governors is made up of elected and appointed governors. Governors are volunteers and are not paid.

Elected governors are elected by distinct constituencies:

- public governors are elected by members of the public constituency
- staff governors are elected from the staff body and
- patient, carer or service user governors are elected by members who are patients/service users and/or their carers.

Appointed governors represent stakeholder organisations such as the local council or local charities. If the foundation trust wants governors appointed by an external organisation, this must be specified in the constitution.

Governors are not directors. The governors' duty to "hold the non-executive directors, individually and collectively, to account for the performance of the board of directors" does not mean that governors are responsible for decisions taken by the board of directors on behalf of the NHS Foundation Trust. Responsibility for those decisions remains with the board of directors, acting on behalf of the Trust.

PSHFT currently operates with a single public constituency and a single staff constituency. As an NHS trust, HHCT does not have governors.

It is proposed that there are three public and staff constituencies with three classes in each to ensure balanced representation from the Stamford, Peterborough and Huntingdon areas. This is currently part of the public engagement to ensure that the process for local accountability is clear.

The number of governors for each constituency and division will be considered to ensure it is proportionate. This is part of the public engagement and will be influenced by the catchment analysis, but initial thoughts are that we would increase the Council of Governors to 30 (from 26) plus the Chairman.

In order to ensure that the expanded/combined trust has a representative Council of Governors from the day of inception (planned to be 1 April 2017), elections are to be held for these new arrangements with results to be available mid/late March.

The timetable for elections is shown in Figure 64.

Figure 64 - Governor election timetable

Election Timetable	
Notice of Election (start date for receipt of nominations)	Wed 25 Jan 17
Final Nomination closing date	Fri 10 Feb 17
Nomination Publication	Mon 13 Feb 17
Candidate Withdrawal	Wed 15 Feb 17
Notice of Poll (Ballot papers to members)	Wed 1 Mar 17
Close of Poll	Wed 22 Mar 17
Announcement of Results	Fri 24 Mar 17

Governors plan to consider the enlargement as a significant transaction in October and are being briefed on the proposals as they develop on a monthly basis.

10.1.4 Board appointment process

The aim is to appoint the most capable and experienced Board, with members who are committed to leading the enlarged Foundation Trust to achieve clinical and financial sustainability

Considerations

Legally the merger is an acquisition; and as a result Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) becomes an enlarged Foundation Trust.

All staff, Governors, stakeholders, the public, and NHS Improvement need to have confidence in the new Board. Therefore the Board appointment process will need to have close regard for relevant employment law considerations (in particular as they relate to TUPE, redundancy and unfair dismissal) whilst at the same time ensuring appropriate account is also taken of risks, liabilities and any financial costs arising. The process will include Council of Governors involvement where appropriate.

After Full Business Case (FBC) approval, a reconfigured Transaction Programme Board (TPB) will be convened to follow through on FBC recommendations and the implementation plan.

Both Trusts must not lose focus on their operational performance post FBC approval.

Process and Key Steps

1. **Member Recruitment and appointment of Governors**

Members and Governors will be recruited and appointed using current best practice employed by PSHFT so that they represent the constituencies of all 3 hospitals. This will be achieved through the following process which will be supported by the Governors Way Ahead Committee.

a. Recruitment of Members started August 2016
b. Governor Election process takes place 25 January 2017 to 24 March 2017
c. Council of Governors of the enlarged Foundation Trust appointed on 1 April 2017

2. **Appointment of Chairman**

Given the merger will be achieved through an acquisition, in the normal circumstances, the Chairman of the acquiring Trust would become the Chairman of the enlarged Foundation Trust. This needs to be approved by the current PSHFT Governors and supported by NHS Improvement. This will be achieved through the following process.

a. PSHFT Governors agree appointment of Chairman of enlarged Foundation Trust at Private Governors meeting on 15 September 2016.
b. After approval of the FBC at the September 2016 Board Meetings, NHS Improvement need to confirm support of the Chairman of the enlarged Foundation Trust by Friday 7 October 2016.
c. PSHFT Governors ratify, in public, the appointment of Chairman of the enlarged Foundation Trust at the Council of Governors meeting on 25 October 2016.

3. **Appointment of Non-Executive Directors (NEDs) – Excludes Chairmen**

From 1 April 2017, NEDs from both Trusts (up to 10) will be appointed to the Board of the enlarged Foundation Trust. From 1 April 2018, 6 NED Board members will be in place. This will be achieved through the following process.

a. PSHFT Council of Governors meets on 15 September 2016 to approve.

i) Inviting all 4 HHCT NEDs to join the enlarged Foundation Trust Board from 1 April 2017 for 12 months
ii) All 6 Existing PSHFT NEDs continue as members of the enlarged Foundation Trust Board for 12 months from 1 April 2017

b. All NEDs will be notified before 22 September 2016 that they will be invited to join the Board of the enlarged Foundation Trust for 1 year from 1 April 2017 and all appointments from 1 April 2018 will be agreed by the enlarged Foundation Trust's Governors' NED Appointments and Terms of Service Committee in December 2017.

c. The enlarged Foundation Trust's Governors' NED Appointments and Terms of Service Committee meet in December 2017 to decide on the 6 NED board members from 1 April 2018.

4. Executive Directors Appointment

The Appointment process of Executive Directors for the enlarged Foundation Trust will be decided by PSHFT Remuneration Committee (RemCom) in consultation with 2 NEDs from HHCT RemCom, who will be invited to join the expanded committee (with non-voting rights). This will be achieved through the following process.

a. The expanded RemCom will meet w/c 31 October 2016 to receive and discuss constitution and legal advice on Board Executive appointment for the enlarged Foundation Trust. A Board Executive appointment process will then be agreed.
b. The expanded Remcom will meet on 2 Dec and agree appointment of the Chief Executive of the enlarged Foundation Trust. PSHFT Governors, all Board Members, and NHS Improvement will then be informed. From 2 Dec the Board Executive Appointment process will commence.
c. PSHFT Governors will meet soon after 2 Dec 2016 and ratify the appointment of Chief Executive of the enlarged Foundation Trust.
d. All Executive Directors will be informed of the outcome of the Executive Directors appointment process by no later than 12 December 2016.

5. Development/ Delivery of Implementation Plan from FBC approval to 1 April 2017

Following FBC approval at the September 2016 Board meetings, the Implementation phase will commence. The Transition Programme Board (TPB) will be reconfigured to become the Implementation Board (IB). It will report into both Boards until the FBC is ratified at the November Board meetings after which it will be accountable to the PSHFT Board. This will be achieved through the following process.

a. TPB will become the Implementation Board from 3rd October 2016. It will focus on the FBC recommendations, the Implementation Plan. As it proceeds it will also take into account feedback from the engagement and due diligence process between Sept FBC approval and final approval of the FBC at November Boards.
b. At least 1 NED from each Board will remain as member of the IB. Other NEDs from both Boards will also give assurance on key work streams.
c. By 12 December 2016, the IB will be chaired by the appointed Chief Executive of the enlarged Foundation Trust and each work stream will be led by the appointed Executive Directors who will sit on the Board of the enlarged Foundation Trust.

d. Both Boards will hold the IB to account and decide on recommendations from the IB. After 12 December the IB will report into the PSHFT Board.

6. New Board in Place

a. New Council of Governors of the enlarged Foundation Trust meets and ratifies the Chair, NEDs and CEO (already approved by PSHFT Governors) on Saturday 1 April 2017.
b. New Board of the enlarged Foundation Trust in place on Saturday 1 April 2017.

10.1.5 Organisation-wide governance arrangements

Key corporate governance policies and procedures have been identified:

- Trust Constitution
- Standing Orders (including Standing Financial Instructions)
- Business Conduct Policy
- Terms of Reference for Board Committees

As part of the Transition Programme Board, the Governance work stream has carried out a formal Well Led Governance Review across both organisations to ensure that a "best of both" approach can be taken to governance including the Board Assurance Framework, committee structure, performance management and escalation of any issues of which the Board should be aware.

Trust Constitution

Foundation trusts are required to agree a Trust Core Constitution which describes how the Trust will be accountable to the local population through their membership. It defines the composition of our Council of Governors including the various representative constituencies, the role of Council members, and terms of office. It also defines the decision making powers of the Trust Board and its' committees within the Trust.

Both trusts have agreed that the current PSHFT constitution will not permit adequate public representation in the new combined trust and a new model constitution is proposed which has been considered by the Transition Programme Board. As part of this it is proposed that the newly formed Council of Governors accepts the Shadow Board as the Board for the combined Trust.

A model constitution has been drafted which will be considered by the shadow Board for approval by the Council of Governors.

Standing Orders (SO) and Standing Financial Instructions (SFI)

Standing Orders and Standing Financial Instructions are key trust documents. Standing Orders (SO) regulate the proceedings and business of a trust and are part of our corporate governance arrangements. In addition, as part of accepted Codes of Conduct and Accountability arrangements, boards are expected to adopt schedules of reservation of powers and delegation of powers. These schedules are incorporated within the Trust Scheme of Delegation.

These documents, together with Standing Financial Instructions, Standards of Business Conduct, Budgetary Control Procedures, the Fraud and Corruption Policy and the procedures for the Declaration of Interest provide a regulatory framework for the business conduct of our trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation, Standing Financial Instructions and Budgetary Control Procedures provide a comprehensive business framework that is to be applied to all activities, including those of the Charitable Foundation. Whilst the same rules will apply to all charitable funds regarding receipt and expenditure, it is important to note that those funds provided to Hinchingbrooke Hospital will only be used for the Hinchingbrooke site and those funds for Stamford Hospital will only be used for the Stamford site. A comparison of the SO's and SFI's for both organisations has been carried out which identified only minor differences between the two organisations.

The standing orders, business conduct policy and terms of reference for Board committees will be approved by the shadow board when it has formed. These will be publicly available as part of the Board papers.

Trust policy alignment

Work to integrate policies has identified where current policies are already aligned. Where they are not, there is a risk based programme of alignment to align key policies before the transaction date; by 31 December 2017, or on their review date depending on the level of risk.

A programme for policy alignment is included in Appendix 12.

Corporate records

The corporate records for the pre-merger trusts will be archived with records retained and made available to public record depositories. The trust accounts and annual reports will be completed in line with the Annual Report Manual guidance provided by NHS Improvement (Monitor). HHCT records will be preserved to ensure continuity of service agreements.

An audit of corporate records has commenced and will be completed by the end of October. This will identify the location, type (electronic or paper), and the responsible officer for individual record types across both trusts. On completion of the audit, a working group will agree how records will be stored.

From 1 April 2017, there will be a revised process for creating and managing records for the combined trust. This will include method statements and staff training to ensure that all staff are aware of how policies and important documents will be managed. A draft policy has been prepared which described how future policies will be developed and standardised as part of the implementation. If merger is approved, this will be ratified by the PSHFT Trust Management Board and HHCT Hospital Management Committee.

Based upon the recent IGA best practice document ' Records Management Code of Practice for Health and Social care 2016' published in July 2016, a high level review of all corporate records, both paper and electronic, has identified the various types of important records held by each trust. An audit of where these records are held and how they are currently archived

will be completed by October, and a process for future storage and archiving will be agreed by March 2017. This will:

- secure historic corporate documentation from PSHFT and HHCT;
- provide a clear structure and process for the new organisation.

10.1.6 Risk Assessment and management

Executive directors will review assurances against strategic objectives within their designated remit on a monthly basis as part of the Board Assurance Framework. This will ensure action is taken to address gaps in controls and proactively identify evidence of positive assurance.

Clinical and Corporate Directors will take responsibility for specific risk areas within their Directorates. The Audit Committee will monitor assurance processes and seek internal audit assurance on the risk management process in order to provide independent assurance to the Board of Directors that risks are being properly identified and appropriate controls are in place.

The newly formed Trust will employ a range of specialists to lead on the implementation of risk management including specialists in quality governance, information governance, corporate governance, business and emergency planning.

The responsibility for risk management will be embedded across all levels in the Trust; from Board members, through Clinical Directors to all managers and staff. Named directors will have specific responsibilities and accountability for risk.

Risk Management will be introduced into staff culture immediately upon employment. Staff education and training on risk management will be carried out commensurate with their roles. All new staff will receive corporate induction, which will include risk management and incident reporting, alongside health and safety, manual handling and infection control training as appropriate to their duties.

Staff with management responsibilities will be required to ensure the implementation of the Trust's health and safety and risk management policies, procedures and codes of practice through their directorate management structure, ensuring that communication pathways are clear and explicit at all levels of employment, in order to maintain the health, safety and welfare of employees or others who may be affected.

To ensure that risks are identified, evaluated and controlled formal structures will be required within the Trust. The Board will have overall responsibility for risk management, although this may be delegated to an appropriate committee which will have responsibility for scrutinising and challenging risk management, alongside the Audit Committee which will ensure that processes for risk management are effective.

The three main elements of the Trust's risk approach will be:

- Board Assurance Framework
- Risk Register
- Risk Assessment

Board assurance framework

Prior to transaction, the shadow Board will consider how it will maintain a Board Assurance Framework. A comparison of the two existing BAF's highlighted that both organisations have appropriate systems of control in place, with a few minor differences. The risk scoring system is slightly different, representing the different appetites for risk. These will be aligned prior to the creation of a shadow board.

A hybrid of both BAF's is proposed but with the introduction of the PSHFT monthly action cards which are used to monitor and manage the risks to strategic objectives.

Risks to quality and performance will be on the risk register and the Board Assurance Framework.

Risk register

Operational risks are recorded on the corporate risk register which includes risks from individual divisional risk registers. Risks rated as high or significant will be reviewed by Board committees. The combined trust risk register is described in the Quality and Performance Management and Governance strategy. The Trust will use a risk register to log current and new risks and the management arrangements to minimise them.

Board monitoring of action taken and future plans to manage and/or mitigate risks is dependent on the level of risk; it is monthly for high risks.

Committees of the Board will be allocated specific responsibilities to assure Board members of the adequacy of the risk register and risk management processes. These committees will receive the risk register and management reports which include quality and performance risks.

10.1.7 Due diligence – Well Led Governance Review

Both PSHFT and HHCT have been rated as good against the well-led standard by the CQC. As an extra assurance as part of due diligence, a Well Led Governance Review has been jointly commissioned with separate reports for both trusts.

A joint summary showing the initial findings has been received (Figure 65) which highlighted no significant issues of concern. They did highlight a number of areas for further improving governance arrangements at both Trusts. These areas are outlined in respective reports for each trust and a number of the recommendations will be further refined during phase 2 of the work

A summary of the ratings as well as well as the rationale for these ratings is outlined below. Feedback from the trusts on the draft reports was not available at the time of writing although both trusts have agreed to include these ratings in the FBC.

Figure 65 –Well led governance review summary findings

PSHFT

	Rating	Rationale
Strategy & Planning		
Does the Board have a credible strategy and robust plan to deliver	A/G A/G	Clear strategic direction being proactively pursued but potential for improved horizon scanning of future risks Potential for enhancing quality assurance reporting of cost improvement schemes.
Capability & Culture		
Does the Board have the skills and capability to lead the organisation	A/G	Non-Executive style and focus of challenge Need for greater Board development Inconsistencies in Board appraisal processes
Does the Board shape an open, transparent, and quality focused culture?	A/G	Many examples of good practice in this domain Stamford staff indicated a sense of isolation
Does the Board support continuous learning and development across the organisation?	A/G	Inconsistencies in team meetings between sites Training opportunities at Stamford Sharing of lessons learned
Process & Structures		
Are there clear roles and accountability in relation to board and quality governance?	A/G	Committee assurance reporting to the Board Board and Committee administration
Are there clear roles and accountability in relation to board and quality governance?	A/G	Impact of lack of clear accountability framework Impact of Trust Management Board and engagement/leadership skills of Clinical Directors
Are stakeholders actively engaged on quality, financial and operational performance?	A/G	Feedback to staff Communication of concerns
Measurement		
Is appropriate information on organisational and operational performance being analysed and challenged?	A/G	Absence of Integrated Performance Reporting Potential improvements to information presented at divisional/service level
Is the board assured of the robustness of information?	A/G	Limited visibility at Board level of underlying data quality

HHCT

	Rating*	Rationale
Strategy & Planning		
Does the Board have a credible strategy and robust plan to deliver	A/G A/R	Historic weaknesses in business and annual planning processes Ongoing enhancements to risk management arrangements Lack of post implementation scrutiny for CIPs
Capability & Culture		
Does the Board have the skills and capability to lead the organisation	A/R	Interim nature of several Board positions Gaps in induction and succession planning processes Capacity and capability gaps in corporate functions
Does the Board shape an open, transparent, and quality focused culture?	A/G	Negative feedback from staff survey on number of 'cultural' areas Clinical engagement issues
Does the Board support continuous learning and development across the organisation?	A/G	Scope for enhancing performance information Sharing of lessons learned
Process & Structures		
Are there clear roles and accountability in relation to board and quality governance?	A/G	Variations in governance arrangements at sub-Board level
Are there clear roles and accountability in relation to board and quality governance?	A/G	Impact of divisional performance reviews Gaps in clinical audit function
Are stakeholders actively engaged on quality, financial and operational performance?	A/G	Patient voice, staff and clinical engagement challenges External stakeholder relations
Measurement		
Is appropriate information on organisational and operational performance being analysed and challenged?	A/G	Refinements to Board reporting including more granular analysis, benchmarking and forecasting Improvements to information presented at divisional/service level
Is the board assured of the robustness of information?	A/G	Historic under investment in IM&T

The outcome of the initial reports will focus the next stage of the review to be completed by November. This will inform how the best of both governance systems can be used in shaping the processes for the enlarged Trust.

The detailed report from the reviews are included in Appendix 13.

10.1.8 Quality governance arrangements

The new organisation will have one Quality and Performance management and governance system drawing on the strengths of systems and processes in place in the existing trusts and learning lessons from where improvements have been required.

A Quality and Performance Strategy and Governance Framework outlines the measures that will be in place to monitor quality of care and performance against the regulatory and local quality and performance standards. It includes systems and processes from 'ward to board', and the framework to develop strategy, risk management, capability, culture, structures, processes and measurement relating to quality and performance.

These measures will be in place as the new organisation begins to provide care, ensuring that quality and performance are maintained during the transition to one combined trust. This will be important for the local population's confidence in care provision, along with maintaining commissioner and regulator assurance.

We will mitigate the risks associated with merger, through the following actions:

- Clear executive accountability for quality and performance with robust leadership and management of clinical and non-clinical teams;
- Internal due diligence of the key governance functions, highlighting existing strengths which we will retain as well as areas for improvement/areas of risk;
- Align key clinical policies across both trusts;
- Harmonise the approach to reviewing staff levels and skill mix across the combined trust,
- Use the combined efforts across the combined trust to recruit to essential posts;
- Review quality and performance governance staffing infrastructure and systems and processes ensuring monitoring and reporting is maintained;
- Create a single shared definition of performance measures and the way the data will be monitored
- Confirm accountability for accuracy and validation of submitted data;
- Aligning monitoring and reporting methods including dashboards, ensuring these meet CQC requirements and the proposed NHS Single Oversight Framework.

Governance arrangements will be consistent between the specialties, directorates and divisions, providing standardised reporting through the Trust's framework. All quality and performance groups will have terms of reference and ultimately report to a committee of the Board.

Where areas of care are identified as needing improvements, the support of the corporate governance teams will be available to clinicians.

10.1.9 Performance management

Quality and performance are key elements of achieving the Trust's strategic priorities. The Quality and Performance Strategy when it is agreed will outline the strategic goals set to promote achievement of the Trust's vision of quality, i.e.

Right care, first time, every time

As often as possible, public board meetings will include a patient story and/ or a presentation from staff about a specific quality of care aspect to provide context, illumination of specific issues and education for Board members.

Annual priorities will be agreed and documented within the Trust Annual Plan and Quality Account. They will be developed with stakeholder involvement so that they reflect any local issues or concerns are included and aligned with national quality improvement initiatives. For the first year of the newly formed organisation, this will have been undertaken through existing staff and public engagement activities.

It is proposed that at each Board, a quality and performance report will be presented which has been scrutinised in detail in an appropriate Board committee. The report will be presented in line with the five domains of quality and performance, providing regular feedback on the priorities identified each year together with any other key quality and performance issues requiring reporting to the Board. This enables Board members to track progress regularly and to identify and challenge any early warning signs that emerge. This same report is distributed widely and used across the Trust in key operational quality improvement groups and by Clinical Division Quality and Performance Governance groups.

The table in Appendix 14 identifies key sources of intelligence used to populate the Quality and Performance Report and available to the trust to monitor quality and performance. This will be reviewed on a regular basis and aligned to national guidance, for example the new Single Oversight Framework.

10.1.10 Financial control

During the implementation phase, both PSHFT and HHCT will continue to operate within their current schemes of delegation and Standing Financial Instructions (SFI's).

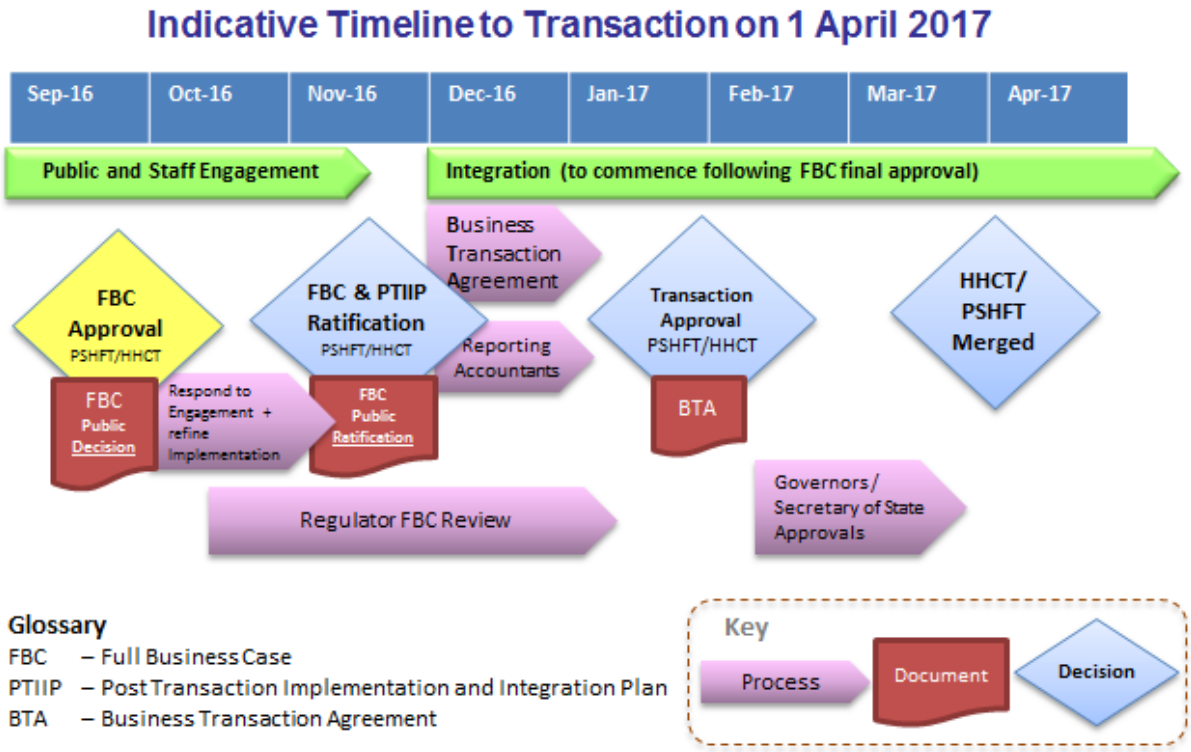
Following approval of the FBC, an appropriate Scheme of Delegation (SoD) and Standing Financial Instructions (SFI's) will be proposed to the shadow Board for adoption by 1 April 2017.

10.2 Transaction plan

10.2.1 Overview of transaction

The steps required for the transaction to take place by 1 April 2017 are shown in Figure 66. The legal steps are detailed in section 10.3 with the trusts also undertaking other key tasks between FBC approval and transaction date that will form part of the integration plan detailed in section 10.4.

Figure 66 - Transaction plan



10.3 Legal route to transaction

The dates for the legal route to transaction will be described in the Heads of Terms to be agreed by the two trusts and NHS Improvement. The indicative timescale is shown in Figure 67.

Figure 67 - Indicative timeline to transaction

Date	Action
Sept 2016	PSHFT to complete legal, financial, IMT and governance due diligence
Sept 2016	FBC approved subject to conditions
Sept 2016	Parties to negotiate Heads of Terms
End Sept 2016	Parties to sign Heads of Terms
End of Sept 2016	PSHFT to submit final FBC to NHS Improvement subject to public and staff engagement
Sep to Nov 2016	Public and staff engagement
Mid Oct 2016	PSHFT to secure Council of Governors approval of proposed significant transaction
	PSHFT to amend Constitution on the assumption that the Transaction goes ahead to reflect the combined businesses of the Trusts
Oct 2016	Further focused governance reviews
Oct 2016	Clinical senate review of clinical case
Oct 2016	PSHFT to agree funding package with NHS Improvement and Commissioners
End of Nov 2016	FBC to Boards for final ratification with enhancements from engagement

Date	Action
End of Nov- Dec 16	Parties to agree a legally binding Transaction Agreement setting out the process for effecting the Transaction and the terms on which assets and liabilities will transfer to PSHFT.
Dec 2016 - early Jan 2017	Outcome of regulators risk assessment
Jan - late Feb 2017	PSHFT to secure Council of Governors and Board of Directors approval for the Transaction, enter into the Transaction Agreement, and to make a joint application to NHS Improvement to acquire HHCT
	HHCT to secure Board of Directors approval for the Transaction, enter into the Transaction Agreement and to make a joint application to NHS Improvement to acquire HHCT
	NHS Improvement to approve the Transaction, to enter into the Transaction Agreement and to make a recommendation to the Secretary of State to support the Transaction
	NHSE/CCG approvals
Late Feb 2017	An application made jointly by the Trusts to NHS Improvement for HHCT's acquisition by PSHFT accompanied by:
	Written support of the Secretary of State for the Transaction
	Copy of PSHFT's proposed amended Constitution
[TBC]	Secretary of State confirms support for the Transaction
End of Feb 2017	Parties to execute the Transaction Agreement
Mar 2017	NHS Improvement grants the application by making the Grant of Acquisition which specifies that the Grant will come into effect on the Completion Date
1 Apr 2017	Completion of the Transaction occurs by the Grant of Acquisition coming to effect, at which point:
	If applicable, NHS Improvement's Transfer Order for the transfer of HHCT's staff to PSHFT takes effect
	All property and liabilities of HHCT are transferred to PSHFT
	PSHFT's amended Constitution takes effect
	The Aquiree is dissolved
	HHCT's order establishing it is revoked.

Heads of Terms

The Heads of Terms describe the process by which we will progress from agreement on the full business case to the final arrangements as set out in the Business Transfer Agreement. Draft Heads of Terms have been reviewed at the Transaction Programme Board and a small working group representing both Trusts and NHS Improvement.

Business transfer agreement

The Business Transfer Agreement will document the final arrangements and basis on which Peterborough and Stamford Hospitals NHS Foundation Trust will acquire Hinchingbrooke Health Care Trust. This will be finalised prior to statutory authorisation of the acquisition and will make clear the basis for the acquisition including any required support funding and how any known liabilities are to be covered.

10.4 Integration plan

This section sets out the key elements of work that will be undertaken following FBC approval in September. Following staff and public engagement events in October and early November, a full and detailed integration plan will be worked up and presented to both boards for ratification in November 2016.

10.4.1 Programme overview

Following FBC decision, a process to appoint a Chair commence as described in section 10.1.3. Following FBC ratification, board members will be appointed and before merger, they will operate as shadow board. The existing Trust Boards will remain accountable for the existing trusts, with the shadow board beginning to take on decision making functions for the post-merger trust.

It is proposed that the TPB oversees the delivery of the integration plan until day 1 and oversees the full implementation and realisation of benefits that have been proposed in the merger.

10.4.2 Programme team and governance

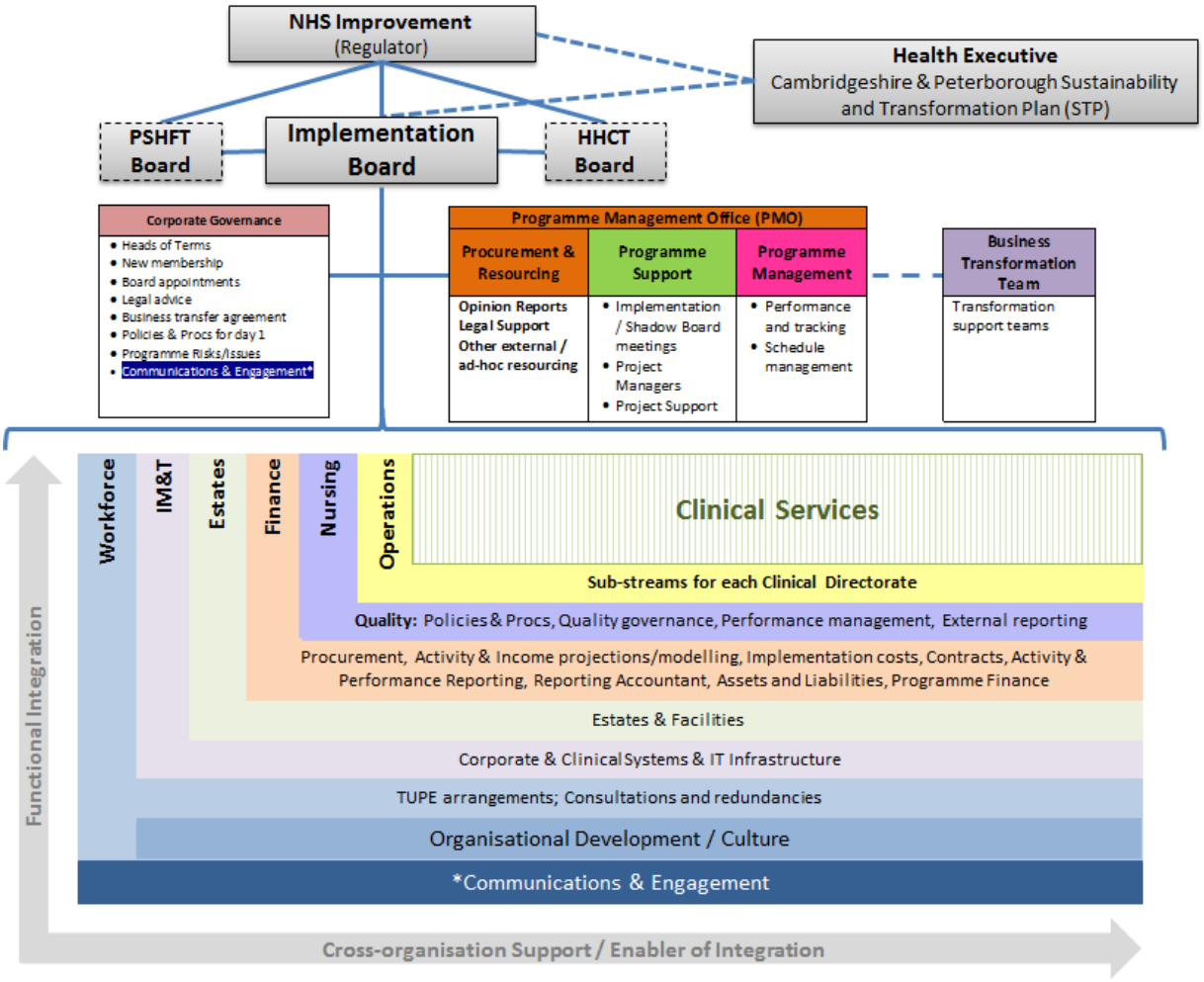
An Implementation Director will be appointed with the skills and experience to guide the new board and the rest of the organisation through the full merger benefits realisation, including the integration of clinical teams and the corporate back office departments.

This role will be supported by a programme management office which oversee the programme timeline ensuring progress against the agreed milestones and provide support resource to the separate work streams described in section 8.6.

Figure 68 shows the proposed programme management structure including the work streams to deliver both the transaction and implementation.

The governance structure will be agreed by TPB and ratified by the shadow board once merger is agreed and the shadow board is in place. It may change following transaction and when implementation plans are fully operational.

Figure 68 - Merger programme management arrangements



10.4.3 Staff and Public Engagement

There is a strong commitment following FBC approval to engage with staff, patients and all stakeholders on the approved plans to merge. An expanded membership of the trust will also form a vital source of feedback as to the matters deemed most important to those who work and use our services.

A series of external engagement events throughout October 2016 have been published in local press in Huntingdon, Peterborough and South Lincolnshire to ensure as much of the population as possible are aware of the events and have the opportunity to contribute. As well as a presentation and a question and answer session at each event, issues raised which are not already adequately answered within the FBC will be included for the final November version.

Staff communication and engagement events are also planned throughout October and onwards at both organisations to give all staff an opportunity to hear from Executive Directors, raise concerns and contribute their thoughts. These will be run at various points in the day and in different locations to maximise the range of opportunities for staff to attend. There will continue to be the 'Ask CEO' email facilities available to all staff who are unable to attend an event or would prefer to ask questions and raise concerns in a confidential manner.

Throughout the remainder of 2016/17 as the transaction elements of the process are taking place there will be a continued strong commitment to maintaining regular staff engagement events, with progress of the merger remaining part of team briefings and staff communications on all sites for the future.

All frequently asked questions and themes will continue to be available on both trust websites.

10.4.4 Organisational Development

As set out in detail in section 7.3, from FBC decision onwards there will be a strong commitment to organisational development where all teams and individuals work together to an agreed set of values and with supporting behaviours for the benefit of our patients and our staff.

10.4.5 Clinical service integration

Chapter 5 describes the vision for clinical services and the priority services which have been identified for immediate work post FBC ratification to address current sustainability issues. It also describes why these priority areas were identified and actions that will be undertaken in each of these services as part of the integration and implementation of the merger.

Integration of clinical services will be based on five areas of alignment:

- Workforce
- Activity management
- Clinical protocols and guidelines
- Governance
- Organisational development

A description for each of the levels of integration is included in Appendix 6 with the timelines for integration of the six priority areas in Appendix 7.

The actions required to move to increasing levels of integration vary from service to service, depending on the level of integration which already exists. Some services are also dependent on others or external funding approvals before they can change for example, a common IM&T infrastructure.

This approach will provide high level monitoring of the level of integration each service has achieved, and the required steps required to move to full integration.

It is fully recognised that clinical integration may take more time for some services than it does for others. Integration will be a medium to long-term programme of work and needs to be sustained as ‘business as usual’ for divisional leadership and management teams for at least two to three years. Ongoing support will be provided by the transformation team in areas such as mapping clinical pathways, assessing demand and capacity, or supporting business cases to secure investment.

Areas will also be provided with organisational development support to bring teams together to establish and secure a common vision for the merged service.

10.4.6 Corporate services

Following FBC ratification and the subsequent confirmation of the executive leads for the enlarged trust, each department will launch a full departmental staff consultation exercise. This will provide all staff with the opportunity to provide immediate feedback on how a merged department might function across three sites.

This feedback will inform executives who will have the opportunity to amend departmental plans to ensure the structure and function of their teams is effective and robust enough to deliver high performance in their area of specialty for the trust.

Early merger of these departments will ensure there is a single leadership team in place and staff will have a single point of reference for support, questions and concerns regarding the merger or day to day activities.

Over the first 12 months policies will be gradually assimilated by the leadership team. As alignment is being prioritised based on the level of risk non-alignment poses staff will be clear on key policy areas as the merged trust is formed.

Prompt integration of back office departments will also reduce the uncertainty that is often fostered in periods of change.

Each corporate area has identified some priority issues unrelated to work force that will be addressed before transaction date. Creating a single ledger was described in section 6.4 and will be implemented so that only one set of financial accounts is required from the start of the financial year. This is necessary for external financial reporting and internal operating efficiency.

To create a single ledger there are associated systems such as payroll services and electronic staff records that will need to be aligned by day 1, as well as internal processes such as the feeding of additional bank staff shifts into the payroll systems, that will also need aligning.

In the implementation plan for the, a full corporate team dependency map will be provided to give depth, detail and assurance to the November Trust Boards.

10.4.7 IM&T

Underpinning the successful integration of all clinical and corporate areas is the alignment of IT infrastructure and clinical systems. It is fundamental to safe delivery of patient care, particularly as staff begin to work across sites, that there is a resilient, connected IM&T infrastructure in place.

The plan to assimilate IM&T across the sites has been included within the costs of the transaction. The focus following FBC ratification will be to facilitate clinical and non-clinical teams working more seamlessly across sites, and to mitigate the risks with current systems and infrastructure.

10.4.8 IM&T due diligence

An external due diligence review of the current IT systems has been obtained as part of the preparation for the FBC (Appendix 15). The key findings of the review are:

Lack of IT investment at HHCT

Each trust has a current IT strategy aligned to the National IT Agenda with a focus on local service delivery as directed by their commissioners. PSHFT has invested in IT Infrastructure year on year however, maintaining a good standard and recognising the value IT has acted as a key enabler of change.

HHCT has made minimal investment, responding to the potential for critical component failure or breakdown which has resulted in a number of risks as detailed fully in the report.

Where investment has been made, the IT teams on both sites have worked hard to maximise the benefits that the investment can yield.

Unified communications is fast growing in information technology giving integrated communications technology to provide easy to use and seamless access to information, resources and people. The recent PSHFT eComms project is an example of this which should be built upon across the enlarged trust to see how such technologies can be used to improve cross-site working and drive up efficiencies.

PAS

The decision on a merged joint patient administration systems (PAS) is fundamental to all decisions on the other clinical systems as they all feed in or out of the central function. It will be vital to make this decision early and progress with the PAS solution in order that clinical service integration can be supported as early as possible.

Electronic mail

There is a notable difference in the approach to electronic mail. PSHFT has its own local solution built around the leading commercial solution whilst HHCT used the NHS national solution (NHS.net). A full benefit analysis will be undertaken post FBC decision and a recommendation made to the shadow board, so that the merged trust can have a single email system by day 1.

Key clinical systems at HHCT

Certain systems such as the maternity system and requesting diagnostic tests remains out of date at HHCT and clinical staff have reported to the external advisors that this puts significant pressure on clinical effectiveness and at times patient safety.

Data Centre

The primary data centre at HHCT has been reviewed as the most significant risk to IT services on the site and will require immediate work to upgrade it. Merger provides a more cost effective solution to a commercial off site solution in that the enlargement of the existing Computer Room 3 at PCH and improvement of the facilities at HHCT will offer lower cost, better value for money and reduced risk compared to a commercial hosting arrangement.

10.4.9 IM&T due diligence next steps

The recommendations from the due diligence report will be included in the more detailed implementation plan to be presented to the November Trust Boards.

10.5 Risks

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

10.5.1 Risk Management Process

Risk management is and will continue to be a key item covered in trust reports, including the financial and operational management reports. The principles of risk management will also be embedded in the trust's approach to business continuity planning, the internal and external audit reviews, local counter fraud services and security management. It will be used as a tool to drive decision making at all decision making levels in organisations, and therefore the identification and accurate reporting of risks needs to be embedded into staff culture at all levels, along with an understanding that risks reported will be acted upon appropriately by those in more senior positions.

Following approval to merge, the project will continue to adopt sound and tested risk management processes to allow the TPB and subsequently the shadow board to understand the project, transaction and post transaction risks and ensure there are adequate mitigations. Risks that are rated high or significant will continue to be deemed as unacceptable to trust boards and actions should be taken to ensure the risk becomes reduced over time.

All risks identified as part of the FBC process, including those arising from the due diligence reports have been categorised into three domains:

1. Current project risks – those that could affect the FBC decision, or that manifest as part of that process
2. Transaction risks – those that affect the transaction date of 1st April 2017
3. Implementation risks – those that would/could affect the organisation post transaction

Following an understanding of mitigating factors, every risk has been rated according to the current risk matrix scoring tool used by TPB; a copy of which is included in Appendix 16. Reasons for scoring the risks have also been included with those relating to patient safety and those relating to financial issues generally having a higher precedence, unless those mitigating factors are already in place.

10.5.2 Current project risks

Throughout OBC and FBC development, a number of risks have been identified related to the project itself, and these have been reported via a fortnightly risk register report submitted to TPB, where the risks and mitigating factors are discussed. Figure 70 describes the high and significant risks at time of FBC completion.

Figure 69 - High and significant project risks

Risk No	Risk description	Rating	Likelihood and Severity	Actions to Mitigate Risk	Reason for Risk
028	Failure to reach the same FBC decision by boards	12	Possible Major	External due diligence procured to establish assurance on FBC quality and financial outputs. Discussion on resolution to be finalised.	Quality and Finance risks associated with a do nothing scenario become apparent. Services remain unsustainable Reputational
004	Negative public opinion increases political influence and external stakeholders challenge any FBC decision	12	Possible Major	Robust communications and stakeholder management plan, regularly reviewed at TPB. Board decision taken in public so case for change can be made clearer. Regular external communication events to explain the current challenges	Reputational risk to trust
022	Agreed timescales are not met due to the time taken to procure external support, complete the work, and reflect findings in FBC / PTIIP	12	Possible Major	Clear project plan in place Work directly with execs to draw up specs.	Can reduce if FBC findings are accepted by boards
030	Failure to identify £9M cash releasing from Back office benefits realisation	12	Possible Major	£9M cash releasing identified from back office benefits realisation. Work being undertaken to review final structures and understand any CIP savings being made in 2016/17 and base case assumptions possibly impacting on double counting.	Can reduce if FBC findings are accepted by boards
015	Public communications between HHCT/PSHFT collaboration and STP work becomes confusing and leads to public misunderstanding.	12	Likely Moderate	Communications plan for STP needs to be linked to project communications plan. Comments from engagement have led to increased understanding. Requires reinforcement on a regular basis. Consistent messaging from both boards to the public, repeating the separation of the issues.	Remains a risk
023	Reduced leadership and management capacity to complete high performance on day to day tasks	12	Possible Major	Agree appropriate delegated back fill for daily tasks. Agree new board asap to allow for strong focussed leadership.	Remains a risk
016	Costs to FBC transaction and full implementation costs are significantly higher than set out in OBC.	12	Possible Major	Ensure detailed costs are worked up as first phase of FBC planning, taking lessons learnt from others into account. Regular financial reports and forecasts to TPB to highlight early any predicted variances.	Can reduce if FBC findings are accepted by boards
007	Not enough of the right skilled resource is available to deliver to project milestones.	9	Possible Moderate	Specification for external resource due 31st May for approval. Organisations to identify individuals for back fill.	Failure to realise stated FBC benefits to timescale is a reputational risk

Risk No	Risk description	Rating	Likelihood and Severity	Actions to Mitigate Risk	Reason for Risk
018	Agreed timescales aren't met due to the volume of work required internally	9	Possible Moderate	Ensure resource requirements are accurately mapped and set out. Apply for additional funding to meet the resource requirements.	As above

10.5.3 Transaction Risks

Risks associated with the transaction itself that have been identified predominantly through the due diligence work and summarised in Figure 69. If a decision to merge is taken there will be a significant amount of work to mitigate all of these risks for the acquiring organisation and/or to ensure that the transaction is completed to 1 April 2017 timescale.

Figure 70 - Transaction risks

Risk type	Originating	Risk Description	Rating	Likelihood and Severity	Mitigation	Reason for Risk
Financial and legal	KPMG	SEP projections at HHCT are unachievable impacting on LTFM income position	16	Likely Major	Build in sensitivity analysis to remove SEP completely	£5m risk to FBC LTFM's and board approval of FBC
Financial and legal	Hempsons	Land sale contract fine of £1.35m not included in financial case	16	Likely Major	To include in liabilities report	Remains excluded from LTFM projections
Financial and legal	Hempsons	£600k of equipment asset, some of which have unknown lease dates and replacement may not be in capital plans	16	Likely Major	Identify lease dates for the Business Transfer Agreement	Could alter the capital plans included in the FBC
Financial and legal	Hempsons	Commissioner contracts unclear if agreed and signed leading to a risk over possible future penalties or sanctions	12	Likely Moderate	Work to ensure contract terms are understood and agreed with commissioners by transaction date	Needs commissioners to agree and sign new contracts in time for 1st April 17
Financial and legal	Hempsons	TPP has an unknown loss making amount not considered in LTFM	12	Likely Moderate	Ensure all detail is immediately collected post FBC decision so adequate time can be devoted to agreeing unknown contract terms and BTA can be updated accordingly.	Unknown impact remains
Regulator	Internal	Failure to obtain NHSI or secretary of state approval to board decision to proceed	10	Unlikely Catastrophic	Regular TPB attendance by NHSI and conference calls.	Would stop merger Reputational
Financial and legal	Hempsons	Some tenders at HHCT are currently in the process of being negotiated which could have an unknown impact on the acquirer	9	Possible Moderate	Get all details confirmed prior to transaction	Unknown impact remains

Risk type	Originating	Risk Description	Rating	Likelihood and Severity	Mitigation	Reason for Risk
Financial and legal	Hempsons	Contracts register is out of date leading to possible liability for onerous or unusual contract terms	9	Possible Moderate	Get all details confirmed prior to transaction	Unknown impact remains
Regulator	Internal	Agreed timescales aren't met due to regulator review delays post FBC decision	8	Unlikely Major	Working with NHSI to manage expectations and highlight issues early for resolution. FBC to be submitted after September Board approval. Confirmation from NHSI that timescales are acceptable.	Transaction date delays impact on ability to resolve quality and financial issues

10.5.4 Merger Risks

The risks from merger should the transaction be approved, will form part of the enlarged organisations risk register. These are summarised in Figure 70. If merger is approved then work can begin immediately on the mitigations. These will be managed by the shadow board and then the trust board.

Figure 71 - Post merger risks

Risk type	Originating	Risk Description	Rating	Likelihood and Severity	Mitigation	Reason for Risk
Quality	Hempsons	High number of serious incidents reported at HHCT	20	Almost certain Major	Ensure data is correct Investigate patterns before day 1 to establish key actions to reduce future incidents	Remains a high risk until data is investigated and verified
Financial and legal	KPMG	SEP, CIP and other financial projections at HHCT are unachievable	16	Likely Major	Build in sensitivity analysis to remove SEP completely	£5m risk to FBC LTFM's and board approval of FBC
Quality	Hempsons	High vacancy rate at HHCT in clinical area's causes patient safety risk.	16	Likely Major	Clear process in place for escalating of risk to single clinical leadership team.	Remains a risk until all staff are trained in escalation of risk
Finance	Internal	Inability to establish a single ledger by day 1 will impact on the organisations ability to function and run itself effectively	16	Likely Major	Begin work programme immediately and make potential suppliers aware.	Remains likely until FBC decision is taken and a decision is taken on ledger system.
Finance	IM&T reports	IT infrastructure and some clinical systems are inadequate and unsafe at HHCT requiring immediate investment.	16	Likely Major	Include anticipated costs in the merger financial scenario.	Capital costs of enlarged organisation will be significantly greater than planned.

Risk type	Originating	Risk Description	Rating	Likelihood and Severity	Mitigation	Reason for Risk
Quality	Hempsons	CQC rate HHCT ED as requiring improvement	15	Almost certain Moderate	Integration plans with PSHFT need to address the key issues and plan to become good to outstanding.	Remains an issue until the plans are implemented
Workforce	Hempsons	Some employees appear to have lapsed professional registrations, visa's or DBS checks.	12	Possible Major	Evidence to be collected prior to transaction to assure PSHFT that all relevant staff are legally and professionally employed.	Could have major quality and litigation implications until all staff are checked and confirmed.
Quality	Internal	Different policies, procedures, documentation etc at different sites leads to patient and staff confusion and possible patient safety risk	12	Possible Major	Ensure key policies and procedures are aligned by day 1. Ensure no clinical staff work in an areas without suitable induction.	Will reduce only when all staff are fully trained and one set of practises are in place
Workforce	Internal	Culture differences between HHCT and PSHFT impede the synergy realisation.	12	Possible Major	Agree OD programme and begin immediately post FBC decision. Start some synergies early to build trust.	Delay or lack of synergy realisation a major impact for the new trust both from a quality and financial viewpoint.
Workforce	Hempsons	High vacancy rate at HHCT requiring significant work to reduce	9	Possible Moderate	Merger should make posts more attractive to candidates so large recruitment communications campaign to highlight this.	May take some time to become a reality
Workforce	Internal	Significant delays after the FBC decision will cause uncertainty for staff in the affected areas, resulting in poor morale and staff choosing to leave the organisations	9	Possible Moderate	Both trusts will communicate with staff in a transparent way as possible and wherever possible engage staff within decision making process.	Remains a risk for certain individuals
Performance	Internal	Staff at any site become isolated from management	9	Possible Moderate	Commitment to dual site working for all corporate areas. Dedicated site allocated days of senior leaders and teams. Plans in place for a role to manage the site managers and patient flows on all the of the hospital sites	Remains a possible risk that some individuals will still feel more isolated than they do currently.
Workforce	Internal	During any period of change, the resulting uncertainty can prompt key talent to consider opportunities in other organisations. This can result in loss of organisational memory.	9	Possible Moderate	We will encourage all our staff to engage with the merger plans, by providing ideas and feedback on the changes which will be invaluable to the combined organisation and all our staff.	Remains possible that some key staff will find alternative jobs.
Performance	Internal	Focus on performance and/or quality standards dip if staff become distracted by merger implementation	9	Possible Moderate	Embed rigorous performance management system by day 1 for all areas. Negotiate a performance holiday with NHSI whilst systems and staff integrate. Strong OD programme to build a joint vision and motivation.	Remains a possible risk for some staff in some areas. With strong performance management systems in place the impact could only be moderate

Risk type	Originating	Risk Description	Rating	Likelihood and Severity	Mitigation	Reason for Risk
Workforce	Internal	Staff could get the impression that the significant work and effort they have put into the two existing OD programmes: Good to Outstanding "G2O" (PSHFT), and Good and Beyond (HHCT) will no longer be valid, which is not the case	8	Possible Minor	The organisations will retain and build upon the valuable outputs from these programmes going forward to enable the best of both to emerge for the combined organisation	Remains possible for some staff to feel disengaged but impact not significant.
Workforce	Internal	The effect that large-scale change can have on the morale and engagement of staff is of concern and a potential risk for the combined organisation	8	Likely Minor	Establish a strong communication system, to proactively give clear communication to our staff in a timely way and to avoid damaging rumours Strong OD programme to build a joint vision and motivation	Some staff will always be adverse to change
Workforce	Hempsons	Large number of long term sick at HHCT will consume additional resource to manage and backfill	6	Possible Minor	Align sickness and absence management policies to strengthen management oversight and actions	

10.6 Contingency arrangements

The most significant risks to the project will arise if there is a delay in transacting. Fragile services will become more unsustainable and even stop, transaction costs will increase, and the uncertainty for staff may lead to increasing vacancy rates. Continuity of the team supporting the project may also be affected.

Contingencies include:

- Continued public and staff engagement to update them on progress
- Early engagement with the regulators on any changes in the financial support requirement
- Continued engagement by clinical teams to explore ways of keeping services sustainable in the short to medium term
- Allocation of the existing project team to alternative interim projects within the two trusts.