A Hinchingbrooke perspective on our merger with Peterborough and Stamford Hospitals NHS Foundation Trust
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## Key merger facts

A Hinchingbrooke Health Care NHS Trust perspective

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<tbody>
<tr>
<td>1</td>
<td>HHCT &amp; PSHFT Boards approved a merger in principle in Sept subject to public consultation &amp; clinical senate review</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>If approved by both Boards &amp; NHS Improvement, the merger will happen on 1.4.17. HHCT staff will TUPE across to PSHFT</td>
<td>5</td>
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<tr>
<td>7</td>
<td>Merger clearly the best of 4 collaboration options from a detailed options appraisal. Lots of clinicians involved in developing plans</td>
<td>8</td>
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<tr>
<td>10</td>
<td>No services will move from HHCT as a direct result of the merger. In fact more services will be provided here</td>
<td>11</td>
</tr>
<tr>
<td>13</td>
<td>Benefits include: stronger services; better outcomes; greater recruitment; improved training; more clinical trials; career opportunities</td>
<td>14</td>
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Introduction

This document summarises the merger between Hinchingbrooke Health Care NHS Trust (HHCT) and Peterborough and Stamford Hospitals NHS Foundation Trust (PSHT) from an HHCT perspective. It explains:

- the rationale for merger
- why this is the best option for the future of services at HHCT
- the implications of not merging
- the benefits and costs of merger
- the governance structure in a new proposed organisation

In the main this is due to our size. HHCT is one of the smallest NHS hospital Trusts in the country and as a result we are struggling to provide modern health care services as we are unable to attract the calibre of clinicians needed. This is directly affecting our clinical sustainability in to the future.

Our size is also the major driver behind our financial unsustainability. In addition, the increased costs we are incurring from a high use of locums because of our clinical unsustainability is having a key impact.

"HHCT is neither clinically nor financially sustainable in its current form"

The clinical sustainability of HHCT and the ongoing provision of high quality hospital services on the Hinchingbrooke site has been the primary focus of the Trust Board for the last 12 months.

We have been working closely with PSHFT since December 2015 to determine any clinical and financial benefits from closer collaboration.

The HHCT Trust Board approved an Outline Business Case (OBC) at its meeting in May 2016 that showed the best opportunity to ensure the future provision of high quality hospital services at HHCT to be a merger of the 2 organisations (technically an acquisition of HHCT by PSHFT).

Between June and September, we worked closely with PSHFT colleagues to develop a Full Business Case (FBC) for merger. This was approved in principle at both Trust Board meetings in September 2016. The approval was subject to the output of the East of England Clinical Senate review of our clinical plans and the output from ongoing public and staff consultation and engagement.

A revised final FBC is planned to go to Trust Boards at the end of November 2016 for ratification of the September decision to merge. By this time there will have been more than 50 public and staff events (July – November) to discuss the merger and to listen to and respond to concerns.

If both Boards ratify the merger decision, a new organisation will be created on 1 April 2017.

The best solution for sustained high quality hospital patient care for Huntingdonshire residents is a merger of HHCT with PSHFT.
Current situation

HHCT has a strong history of commitment to the provision of safe, high quality and accessible services for the population of Huntingdonshire.

However, HHCT was rated ‘inadequate’ by the CQC in January 2015 and placed in special measures.

Since this time, there has been a strong focus on addressing:

- reporting of incidents
- embedding of new systems and processes
- an increased emphasis on learning
- a more visible and accountable senior leadership team

The CQC rated HHCT as ‘good’ following a formal inspection in May 2016, removing it from special measures.

HHCT is the 2nd fastest Trust to have got out of special measures and the only one to do so with a ‘good’ rating.

Despite not being in special measures we are struggling to provide some services and recruit to key roles. In the main this is due to our size. The demand for these services is insufficient to attract the calibre of clinicians needed to run them well.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Consultant posts</th>
<th>Vacant posts</th>
<th>% vacant</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL (HHCT)</td>
<td>99</td>
<td>17.4</td>
<td>17%</td>
</tr>
<tr>
<td>Haematology</td>
<td>1.5</td>
<td>1.5</td>
<td>100%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>6</td>
<td>5</td>
<td>83%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>3</td>
<td>1</td>
<td>67%</td>
</tr>
<tr>
<td>Acute assessment</td>
<td>4</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>14</td>
<td>5</td>
<td>36%</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>4</td>
<td>1.4</td>
<td>35%</td>
</tr>
</tbody>
</table>

At the end of October 2016 we had 17.4 consultant posts vacant, 17% of our total. There is variation between specialities, with most of the surgical specialties not struggling to recruit, unlike many of the non-surgical specialties.

Many of the vacant consultant posts are filled with short-term temporary staff, enabling services to run. This is however an expensive, ineffective and unsustainable way to provide consistent and high quality care. It is also becoming increasingly more difficult to find suitable locums.

We also have a high vacancy rate across other professions.

This adds further pressure to the provision of high quality care. At the end of October 10% of all posts and 12% of trained nursing posts in the Trust were vacant.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total posts</th>
<th>Vacant posts</th>
<th>% vacant</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL (HHCT)</td>
<td>1,722</td>
<td>173</td>
<td>10.0%</td>
</tr>
<tr>
<td>Medical</td>
<td>224</td>
<td>23</td>
<td>10.3%</td>
</tr>
<tr>
<td>Nursing</td>
<td>552</td>
<td>65</td>
<td>11.8%</td>
</tr>
<tr>
<td>Other professional</td>
<td>164</td>
<td>10</td>
<td>6.1%</td>
</tr>
<tr>
<td>Non-clinical</td>
<td>264</td>
<td>15</td>
<td>5.7%</td>
</tr>
</tbody>
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Demand for our services, while lower than optimal, is increasing, both for A&E activity and GP referrals to the hospital for outpatient appointments.

The local population of Huntingdonshire is also increasing and is estimated to continue to increase (by 9%) over the next 5 years. The population aged 65+ in Huntingdonshire is expected to increase by 17% by 2021, taking the over 65 local population to 20% of the total population by 2021. As people live longer they are progressively more likely to live with multiple illnesses creating further demand for health care and hospital services.

<table>
<thead>
<tr>
<th>Huntingdonshire</th>
<th>2016</th>
<th>2021</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>177,800</td>
<td>193,400</td>
<td>9%</td>
</tr>
<tr>
<td>Over 65s</td>
<td>33,800</td>
<td>39,400</td>
<td>17%</td>
</tr>
<tr>
<td>&gt;65s of total</td>
<td>19%</td>
<td>20%</td>
<td></td>
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The amount of bed days occupied by patients aged 65+ at Hinchingbrooke is expected to increase to 89% by 2031/32 as a result.

<table>
<thead>
<tr>
<th>Bed days (&gt;65s)</th>
<th>2013/14</th>
<th>2016/17</th>
<th>2020/21</th>
<th>2031/32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hinchingbrooke</td>
<td>76%</td>
<td>79%</td>
<td>82%</td>
<td>89%</td>
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</table>

There was a collective deficit of NHS organisations in C&P of £150m in 2015/16. This is expected to increase to £250m by 2020/21 (including savings based on historic levels) if no changes are made.

Hospital services will not be able to cope with the increase in demand in Huntingdonshire and across C&P unless there is a change in the way health care is delivered.

The Health Campus development at Hinchingbrooke and the C&P Sustainability and Transformation Plan (STP), particularly the focus on ‘At home is best’, are fundamental developments required to manage this demand.

The future expected demand for hospital care is a key driver behind the STP’s Clinical Advisory Group’s decision that 24/7 urgent care, consultant–led obstetric services and consultant–led paediatric services need to remain at all 3 acute hospital sites in the county (Hinchingbrooke, Peterborough and Addenbrookes). There is insufficient capacity at other locations to close one of these services.

The financial challenge at HHCT is also significant. We ended 2015/16 with a deficit of £17.1m, one of the largest % deficits in the country. As with our clinical sustainability this is largely driven by the small size of the Trust causing relatively high overhead, infrastructure and back office costs compared with a larger hospital.

The added problem of high temporary staff usage due to the clinical unsustainability is driving further financial pressures.
HHCT is financially unsustainable in its current form.
Doing nothing is not an option

HHCT is neither clinically nor financially sustainable in its current form.

There are a number of specialties that we are struggling to provide at the level we would all expect. Without a change in service provision the sustainability of these services is a real risk.

HHCT is too small for modern NHS healthcare provision. Better clinical outcomes are achieved through increased specialisation, with fewer activities performed more often. The catchment population of HHCT precludes this happening effectively in a number of specialties.

Clinicians need to be part of teams of a sufficient size to work compliant rotas and to develop sub-specialty skills to maximise the safety of care provided. The demand for a number of specialties at HHCT means they are running at sub-optimal size. This will continue to worsen with the drive to provide services across the whole week (7 days) to ensure their consistency whatever day of the week they are required.

Many patients, particularly older people, have a number of other illnesses (co-morbidities). To manage their care well, a range of specialist input is required. This is also true for a large proportion of non-elective attendances and admissions.

Consequently good care for many patients is provided by many different specialists with most hospital services inter-related and dependent on the advice, input and knowledge of others.

This is particularly true with regard to providing high quality urgent care services through an Emergency Department and high quality care for older people. The inability to provide services like haematology and cardiology would significantly impact on the case mix of patients that can be safely managed by the hospital.

We cannot stop providing some of the smaller specialties if we are to remain a fully functioning hospital with a 24/7 A&E.

If we do nothing we will run the very real risk of all of the following:

- Impact on ability to continue with 24/7 A&E
- Reduction in quality of care
- Reduction in clinical safety
- Increase in clinical incidents
- Return to special measures (clinical or financial or both)
- Inability for the local Board to manage the destiny of the hospital services locally
Options for HHCT

HHCT was identified in 2006 as being clinically and financially unsustainable in its current form. As a result, in 2009, the Strategic Health Authority announced that it would tender HHCT as a franchise. This was won by Circle who began managing HHCT in 2012.

When Circle withdrew from the franchise in March 2015, citing unsustainable losses, HHCT was still clinically and financially unsustainable.

Consequently a 3rd option (effectively a ‘Plan C’) for sustainability is required.

Before the start of the national STP programme, the C&P system had started to work together (from September 2015) to determine how to improve the future sustainability of health and social care services in C&P.

The Dalton review informed the possible changes of organisational form across C&P to support this (see diagram on page 9).

A wide range and large number of options were considered and evaluated, including ‘buddying’, ‘contractual partnerships’, ‘chains’, ‘horizontal integration’, ‘vertical integration’ and ‘system wide’ solutions (eg: Accountable Care Organisation (ACO)).

Through this process, an ACO solution was identified as the long term goal of the C&P system with an incremental / staged approach to getting there.

Lessons from other organisational form changes in the NHS suggest that collaborating with others in the same sector and geographically close are more likely to be successful. So within the ‘horizontal integration / acute merger’ section, 6 options were reviewed (3 including HHCT).

This work identified the greatest likelihood of clinical and financial benefits being achieved was through closer collaboration between HHCT and PSHFT.

Following this, HHCT and PSHFT signed a Memorandum of Understanding in December 2015, to develop an Outline Business Case (OBC) exploring options for collaboration between the 2 Trusts.

The 4 options were evaluated against 2 quality criteria (8 sub-criteria) and 2 financial criteria (6 sub-criteria). Option 4 scored significantly
higher in all 4 main criteria than the other three options.

One option that was not explicitly reviewed was maintaining separate organisations and separate executive teams but collaborating clinically through Service Level Agreements (SLAs). This has worked poorly in the past at HHCT. There is a history of the ‘host’ organisation issuing notice on the SLA when pressures on their own services start to impact the quality of care provided to their local population. As a result this was not felt to be a sustainable option.

The HHCT Trust Board approved the OBC in May 2016 and agreed to develop a Full Business Case (FBC) in line with the preferred option of option 4, to create one organisation (IE: merger). This is effectively ‘Plan C’ for HHCT and the best of more than 20 options reviewed for its sustainability.

![Diagram showing level of integration and contractual partnerships/JV]

- **Contractual partnership to:**
  - Share back office and/or
  - Clinical support services

- **Horizontal integration**
  - Acute Merger
  - Chains

- **Vertical integration**
  - Primary care + mental health + community care + acute combinations

- **System wide**
  - Accountable care organisation

- **Level of integration**
  - Low
  - High

- **Lowest options:**
  - Bilateral organ combinations (x10)
  - All acute providers (x3)
  - All acute providers plus CQFT (x3)
  - All acute providers plus CCS (x3)
  - All acute providers plus CPFT and CCS (x3)

- **High options:**
  - HHCT+PSHT
  - HHCT+CUHFT
  - HHCT+Papworth
  - PSHT+Papworth
  - CUHFT+Papworth
  - CUHFT+PSHT

- **Additional options:**
  - 3 or 4 acute services in a multi-specialty chain
  - Clinical service level contract (Create Accountable Clinical Networks: Hospital Federation structure for all acute providers)
  - Out of area MH chain
  - Out of area Community chain

- **Accountable care organisation**
  - CQFT + all acute providers
  - CQFT + acute providers
  - CQFT + GP (MCP, Community and mental health integration)
  - CQFT + CCS (out of hospital estates)

- **Additional options:**
  - HHCT + GP (MCP, small hospitals)

- **Key organisation combinations:**
  - PSHFT
  - CUHFT
  - Papworth
  - CQFT
  - CCS
  - UCP
Sustainability and Transformation Plan (STP)

In December 2015, NHS England outlined a new approach to help ensure health and care services are built around the needs of local populations.

Every health and care system in England was required to produce a 5-year STP by 21 October 2016. They show how local services will evolve and become sustainable by 2021. As they are focused on their local populations, there will be different solutions and different changes in each STP, based on the needs of their local populations over the next 5 years.

There are 44 systems across the country. HHCT is in the C&P system, led by the C&P CCG.

The C&P system had already been working together before this new approach and had determined an ACO solution to be the long term goal, with an incremental / staged approach to get there.

In July 2016, C&P CCG released a ‘Fit for the Future: Working Together to Keep People Well’ document that explained how services across C&P are planned to change.

It indicates four priorities for change and a 10-point plan to deliver these.

The most significant part of the STP conversations that directly affect HHCT, have been the future of emergency care, consultant-led obstetric care and paediatric services.

Following clinician-led reviews of national guidance, evidence, and local needs, it was agreed that these services should continue at all three acute hospital sites across C&P.

This is clearly articulated in the ‘Fit for the Future’ document. It is supported by CCG comments in the Hunts Post and at the Huntingdonshire District Council Overview and Scrutiny Panel (Communities and Environment) Committee on 12 October 2016. It is also reflected in the merger FBC and is fully supported by the HHCT Board.
C&P CCG submitted the C&P STP to NHS England and NHS Improvement on 21 October. Post approval by the regulators, the STP will be made public in December 2016.

There will be public consultation on any future service reconfiguration that will take place.
Merger proposals, benefits and costs

A Programme Board has met fortnightly since January.

It has overseen the development of the OBC and the FBC and has received regular updates from the sub-groups that have been discussing and developing the detail.

Clinicians from 27 specialties have been involved in developing individual specialty plans for a merged organisation. These include what will be achieved over the first 2 years. Patient, staff, quality and financial benefits for the priority services have been identified.

A Clinical Advisory Group has determined the overall clinical case and benefits from merger. This has been externally reviewed by the East of England Clinical Senate.

There will be no movement of services between sites as a direct result of a merger.

All current services at HHCT will remain provided as they are, with an increase in the provision of some services at HHCT as a result of a merger.

Whilst a merger won’t solve all the clinical sustainability issues at HHCT from day 1, it will resolve a number straight away and it is expected to resolve the others over time.

There has already been a successful recruitment of a locum haematologist at HHCT as a result of the expectation of a merged service with PSHFT. A fully consultant-led service will be in place before 1 April 2017 with cross-cover provided from PSHFT colleagues. A wider range of haematology services will be provided at HHCT as a result (eg: adolescent blood cancer service for which Huntingdonshire patients currently travel to PSHFT or CUHFT).

Urgent care / A&E services at HHCT will benefit from a merger through increased A&E consultant time and increased emergency nurse practitioner capacity. The greater case mix and variation of activity at PSHFT enables them to more successfully recruit to senior A&E roles and recruitment at HHCT is expected to improve as a result of a merger.

As part of a merged Trust with PSHFT and jointly working more closely with Papworth Hospital NHS Foundation Trust, cardiology and respiratory services at HHCT will be strengthened. This will enable the provision of more cardiology and respiratory outpatient and diagnostic tests at HHCT than are currently provided.

Substantive cardiologist consultant presence at HHCT will enable the reinstatement of trainee cardiology doctors, further improving the care provided to patients with heart conditions.

Clinical benefits at HHCT, for the population of Huntingdonshire, that will be achieved as a result of a merger include:

- increased senior medical and nursing presence
- reinstatement of some trainee doctor roles
- increased services provided locally with fewer services provided from other hospitals
- reduced consultant vacancies
- greater continuity of care
- improved clinical outcomes
- potential to develop some specialist services that currently are provided by other hospitals
(due to the combined catchment population and consequent demand)
- more opportunity to expand the number of clinical trials offered
- increased recruitment of patients into clinical trials
- improved training and education

Financial benefits as a result of a merger have been calculated to be £9m per annum recurrently. This is a relatively modest amount compared with expectations of other NHS mergers. It is realistic and aligned with the learning from other mergers about not overestimating financial benefits.

The financial benefits on their own are not significant enough to warrant a merger in their own right. On their own, they also do not resolve the financial sustainability problems of either HHCT or PSHFT.

The financial benefits do however help the Trusts achieve financial sustainability when aligned with internal efficiencies, Health Campus income (HHCT) and PFI income agreement (PSHFT).

A £9m annual reduction in expenditure of public money for improved clinical care is also a significant benefit to the taxpayer.

Just over 2/3rd of the £9m savings are expected to be achieved through the reduction of approximately 140 back office (non-clinical) roles. This is as a result of economies of scale.

Current vacancy and staff turnover rates across both Trusts are at a level that any redundancies would affect a much smaller number of staff than the 140 roles. We will keep the number of redundancies and associated costs to a minimum.

The estimated cost of the merger is a one-off cost of £13m. This figure includes the procurement and implementation of a new Patient Administration IT System (PAS) for the new organisation.

HHCT’s PAS system is nearly 25 years old and urgently needs replacing. PSHFT’s PAS system is different and also needs replacing. It is 22 years old. IT implementations are inherently risky and both Trusts will have to manage a PAS replacement in the near future regardless of a decision to merge. A merger provides an opportunity to replace both PAS systems with a modern system that is the same across both organisations.
The clinical and financial benefits of merger will be achieved over two years and not all from 1 April 2017. Similarly the costs of merger will be incurred over two years. This timeframe allows for a more successful implementation of all changes required; a lesson from other NHS mergers about being realistic and not overestimating timescales for delivery.

For sustainable high quality hospital care at HHCT, the clinical risks of merging with PSHFT are less than the risks of not merging or doing nothing.

**Health Campus**

The Health Campus enables the co-location of primary care (GP services), secondary care (hospital services), community care and social care (residential care and nursing home care). It also increases residential accommodation and improves staff accommodation facilities.

It is aligned with expected population increases locally and necessary to meet the population increases outlined and supports hospital provision on the HHCT site in the future.

It is also aligned with government policy for public services to work more collaboratively and to utilise public service owned land more effectively.

It has strong support from health ministers and is a potential blueprint for small hospitals across the country for the 21st century.

The Health Campus will enhance patient care, better integrate health and social care, improve the flow of patients between different parts of the health and social care system (similar to an ACO) and support hospital care at HHCT.

**The Campus will be developed to provide:**

- 400 residential care and nursing care home units for older people / people with dementia
- a large GP practice (possibly 8 GPs) supporting a national drive to provide primary care delivery at scale
- a 30 bed hotel-type facility to support patients before and after planned operations who don’t need high levels of nursing care
- 250 units of key worked accommodation and staff residences predominately for junior doctors and nurses to support recruitment
- 40 units of medical and nursing student accommodation
- new education and research and development facility
leisure and wellbeing facilities and retail units for the benefit of local residents and HHCT staff

The Health Campus has been a number of years in the planning and has the support of Huntingdonshire District Council and Cambridgeshire County Council. It is also part of the C&P STP estates strategy.

A detailed site masterplan with outline planning consent from the District Council is expected to be achieved in early 2017.

The Health Campus will enable a potential annual income for HHCT / new merged organisation of between £5m and £7m through:

- long-term leasehold arrangement
- rental income from the accommodation facilities
- utilities income from the use of HHCT’s Combined Heat and Power plant
- income from the medi-hotel and the rental of some of the education facilities
- income from estates management (for example catering, laundry and linen)

To complete the Health Campus in full requires between £100m and £150m. HHCT’s annual capital programme is approximately £3.5m, to fund medical equipment (new and replacement) and ongoing maintenance of the estate. An alternative source of capital is therefore required.

We have been through a detailed OJEU procurement process to select a Strategic Estates Partner. Ryhurst have been appointed as our partner.

A Strategic Estate Partnership (SEP) is a government approved long term partnership between a Trust and a private sector partner (PSP). It has been devised to enable access to capital for major transformational projects and to maximise commercial benefits to both parties.

The SEP will be delivered through a Joint Venture (initially contractual and subsequently corporate) with 50:50 control between the Trust and the PSP.

Each building project will be undertaken separately with a separate business case approved for each. Individual projects will have different funding and commercial structures. The SEP validates each and optimises sequencing and simplifies procurement. The Health Campus will be a combination of up to 30 different projects.

The arrangement is not exclusive. The Trust does not have to deliver any projects through the partnership if a better arrangement can be organised with an alternative partner.

The use of a SEP does not burden HHCT with a long-term financial liability like a PFI scheme.

The Health Campus is fundamental for the future of HHCT.

Combined with a merger with PSHFT, the Health Campus provides a sustainable, integrated health and social care solution to meet the needs of the Huntingdonshire population in to the future.

Learning from others
Mergers are not risk free. To maximise the chance of a merger between HHCT and PSHFT being a success we have incorporated learning from other NHS mergers throughout our plans.

The two most recent publications on NHS mergers\(^5\) have recommendations that we have addressed in the FBC. In addition we have spoken to the Chief Executives of a number of organisations that have recently merged\(^6\) to get their perspectives.

The key recommendations identified, as a result of reasons why many mergers have failed, and how we have addressed them are:

**No clear rationale for merger** – HHCT has a very clear rationale and need for merger which is ensuring clinical sustainability of hospital services for the population of Huntingdonshire.

**Lack of a clinical case for change, little clinical due diligence and little articulation of clinical benefits** – the need for merger at HHCT is clinical sustainability so we have spent a long time developing a clear clinical vision and a plan for every specialty, focussing on the most challenged specialties. A Clinical Advisory Group has overseen this. We have also sought the views of the East of England Clinical Senate for external assurance that our plans are deliverable. Expected benefits to patients have been clearly articulated.

**Mergers should not be financially driven** – the proposed merger is not driven by a financial need, but by a need to ensure clinical sustainability for both organisations.

**Rigour required in assessing transaction funding** – the costs of a merger have been identified in the FBC as being £13.4m. This is higher than our OBC estimates. This includes £6.1m for the replacement of both Trusts’ very old PAS IT systems.

**Plan effectively** – a programme Board has met fortnightly since January 2016 to oversee the OBC and the FBC. Detailed pre and post-implementation plans are being developed and will be included in the final FBC going to the November Board meetings. These include integration plans over 2 years; a more realistic timeframe than other recent NHS mergers.

**Don’t underestimate the challenges of cultural integration** – an organisational development (OD) plan including how to integrate both Trust cultures has been developed. This includes a plan to develop a set of integrated values and behaviours. This will be implemented from December 2016. Cultural due diligence has been undertaken and the ideal culture for a new organisation has been agreed, around which the OD plan has been developed.

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5. The King’s Fund (September 2015); Foundation trust and NHS Trust mergers 2010 to 2015
6. Cass Business School and NHS Improvement (May 2016); Mergers in the NHS: lessons learnt and recommendations
7. Royal Free London NHS Foundation Trust, Frimley Health NHS Foundation Trust, York Teaching Hospitals NHS Foundation Trust
Mergers should not be as a response to financial or clinical failure – this is not the case for HHCT or PSHFT. Both Trusts are rated ‘good’ by CQC and both Trusts are performing well against national access and performance targets. The clinical sustainability challenges faced by HHCT now and by both Trusts in to the future are the key drivers for a merger. The financial sustainability issues both Trusts face will be addressed in part through a merger.

NHS Providers should develop place-based systems of care cutting across existing organisational boundaries – the proposed merger of HHCT and PSHFT is an incremental step towards developing a C&P wide ACO that creates a more integrated health and social care system for the county.

Council of Governors

Should HHCT and PSHFT merge, it will technically be an acquisition of HHCT by PSHFT. As PSHFT is a Foundation Trust (FT) the new organisation would be an FT.

NHS FTs are different from NHS Trusts and have a different legal form. Every FT must have a constitution that sets out its governance structure. Every FT must within its governance structure, have members, a Council of Governors and a Board of Directors.

Members of an FT are members of the public or staff who work in the FT. Any member can stand for election to be a governor, voted for by fellow members.

Governors are unpaid and are either appointed governors or elected governors.

Appointed governors represent key stakeholder organisations (eg: local authorities, commissioners, Healthwatch, universities).

Elected governors are elected to represent a constituency of either public or staff members; public governors are elected by members of the relevant public constituency and staff governors are elected by members of the staff of the Trust.

Governors hold the Non-Executive Directors on the Board of Directors to account for the performance of the Board of Directors. Governors are not responsible for decisions taken by the Board of Directors.

Governors are required to represent the interests of the members of the Trust and specifically their constituency members. Key responsibilities of the Council of Governors are outlined by Monitor and include:

- appointing or removing the Chair of the Trust
- appointing or removing the Non-Executive Directors of the Trust
- appointing or removing the Trust’s external auditors
- approving the appointment of the Trust’s Chief Executive
- receiving the Trust’s annual accounts and annual report
- taking decisions on significant transactions, including for example, mergers

The proposed configuration of the Council of Governors for a merged HHCT and PSHFT FT is:

- 30 governors in total
- 6 appointed governors
- 7 staff governors
- 17 public governors

Staff governor numbers and constituencies, based on staff numbers by site, are proposed to be:

- 3 Hinchingbrooke Hospital governors
- 3 Peterborough City Hospital governors
- 1 Stamford and Rutland Hospital governor

Public governor numbers and constituencies, based on population sizes, are proposed to be:

- 6 Huntingdonshire governors
- 6 Greater Peterborough governors
- 5 Stamford and South Lincolnshire governors

(Note: based on staff and population sizes, proposed Hinchingbrooke staff governor numbers and Huntingdonshire public governor numbers are greater than their relative proportions)

Closure of the vote would be on 22 March 2017 with results announced on 24 March 2017, in time for a new organisation starting on 1 April 2017.

Governors have an important role in ensuring the Trust is publicly accountable for the services it provides. Given the other key responsibilities outlined, Huntingdonshire residents and Hinchingbrooke staff will be able to have a greater influence on the provision of hospital services for their population than they do currently.

Notice of election for governors (start date for receipt of nominations) to a merged organisation would commence on 25 January 2017, with ballot papers issued to members on 1 March 2017.
Is there a Plan B?

HHCT was identified in 2006 as being clinically and financially unsustainable in its current form. As a result the Strategic Health Authority announced that it would tender HHCT as a franchise, which was won by Circle who began managing HHCT in 2012.

When Circle withdrew from the franchise in March 2015 HHCT was still clinically and financially unsustainable.

Consequently a 3rd option (a ‘Plan C’) for sustainability is required. Effectively Plans A and B have already been tried and proven to be unsuccessful at ensuring clinical and financial sustainability for HHCT.

As outlined in section 4, before the decision was made to explore opportunities for collaboration between HHCT and PSHFT a very wide range of options (more than 50, including more than 20 directly related to HHCT) was considered by the C&P system. These were based on the Dalton organisational forms and included 6 acute hospital merger options, 3 of which included HHCT.

Subsequent to this, 4 options of collaboration were evaluated as part of the OBC. Option 4 (a single organisation) scored significantly higher across all 4 main evaluation criteria than all the other 3 options. It was therefore the preferred option.

Through approval of the OBC by the HHCT Board, it committed to working this option up in detail.

Through a detailed review of all alternative organisational form options, merger with PSHFT has been identified to be the best and most likely solution to ensure clinical sustainability for HHCT.

There are very clear recommendations from 2 reports with regard to how to ensure mergers are successful. A large amount of work has been undertaken to address these recommendations, to determine the scale of the clinical benefits of a merger and to develop a detailed FBC with clinical plans for 27 specialties.

Given the immediate need to sustain clinical services at HHCT and that the option of a merger with PSHFT was clearly evaluated to be the best solution to achieve this, all efforts have gone in to developing this one option. To work up an alternative solution in parallel, that has been evaluated as being less likely to achieve the immediate need for Huntingdonshire residents, would have been a reckless use of public funds and time.

Should the Boards ratify the decision to merge in November, the most important thing for both Boards will be to ensure the maintenance of high quality care whilst integrating the two organisations. Full integration of all services is
planned to take 2 years. Should there at any point through this time be a risk to care provision due to the speed of the implementation of the integration plan, then this will be slowed down to ensure safe and high quality care is provided.

**Summary**

- **HHCT is neither clinically nor financially sustainable in its current form. In the main due to its size.**

- It has been unsustainable since 2006, as a stand-alone NHS Trust and also as a franchised Trust with Circle. Consequently a 3rd solution (Plan C) is required.

- Many possible organisational form solutions have been reviewed. Merger with PSHFT (technically an acquisition of HHCT by PSHFT) is the best solution for clinical sustainability, in conjunction with the agreement in the STP to keep 24/7 urgent care, obstetric-led maternity and paediatric services locally at HHCT.

- A new Trust would be a Foundation Trust with a governance structure that includes a Council of Governors. The Council will have a more than proportionate representation of Huntingdonshire public governors and Hinchingbrooke staff governors. By holding the Non-Executive Directors to account for the performance of the Board of Directors, this will enable local people and staff to have greater influence over the running of services at HHCT than they do currently.
To prevent or to delay a merger with PSHFT would significantly and quickly impact on HHCT’s ability to continue to provide the high quality hospital care that Huntingdonshire residents expect and deserve.

The HHCT Board has responsibility for and passion to find the best solution to ensure high quality hospital care in the future at HHCT for Huntingdonshire residents.