National Audit Office

REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL

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Department of Health

The franchising of Hinchingbrooke Health Care NHS Trust

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National Audit Office

Department of Health

The franchising of Hinchingbrooke Health Care NHS Trust

Report by the Comptroller and Auditor General

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Amyas Morse
Comptroller and Auditor General
National Audit Office

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Hinchingbrooke Health Care NHS Trust is a small district general hospital in Cambridgeshire. The Trust has suffered financial difficulties and, between 2004-05 and 2007-08, developed a cumulative deficit of £39 million on an annual income of around £73 million.

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Contents

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This report can be found on the National Audit Office website at www.nao.org.uk/Hinchingbrooke-Health-Care-2012

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Key facts

£38m

was the size of the Trust's historic deficit as at 31 March 2012

£311m

is the saving Circle projects it will achieve over the ten-year life of the franchise

£31m

is Circle's projected franchise fee over the ten-year life of the franchise (excluding any performance payments or deductions)

£107 million	was the annual income of the Trust in 2011-12
£0	is the amount Circle will earn over the ten-year life of the franchise, unless the Trust achieves a surplus under its management
£5 million	is the amount of additional capital Circle has at risk if the Trust makes a deficit under its management
£9.9 million	is the current cost improvement plan target for the first year of the contract, which is greater than the £5 million savings anticipated in the bid
160,000	is the size of the local population served by the Trust
1,674	staff are employed by the Trust, as at 31 March 2012
£39.8 million	of working capital (cash) was given to the Trust by the Department in the form of public dividend capital between 2006 and 2008

Summary

1 Hinchingbrooke Health Care NHS Trust (the Trust) is a small district general hospital in Cambridgeshire with an annual income in 2011-12 of £107 million. The Trust has suffered financial difficulties and, between 2004-05 and 2007-08, developed a cumulative deficit of £39 million on an annual income of around £73 million.

2 Between 2006 and 2008, the Department of Health (the Department) gave the Trust around £40 million in working capital to support its cash position while it attempted to return to in-year financial balance. However, the Trust's financial recovery plans were unsuccessful and it required non-recurrent support from its main commissioner, NHS Cambridgeshire, and the NHS East of England Strategic Health Authority (the Authority) to achieve in-year financial balance and to prevent the deficit from increasing further.

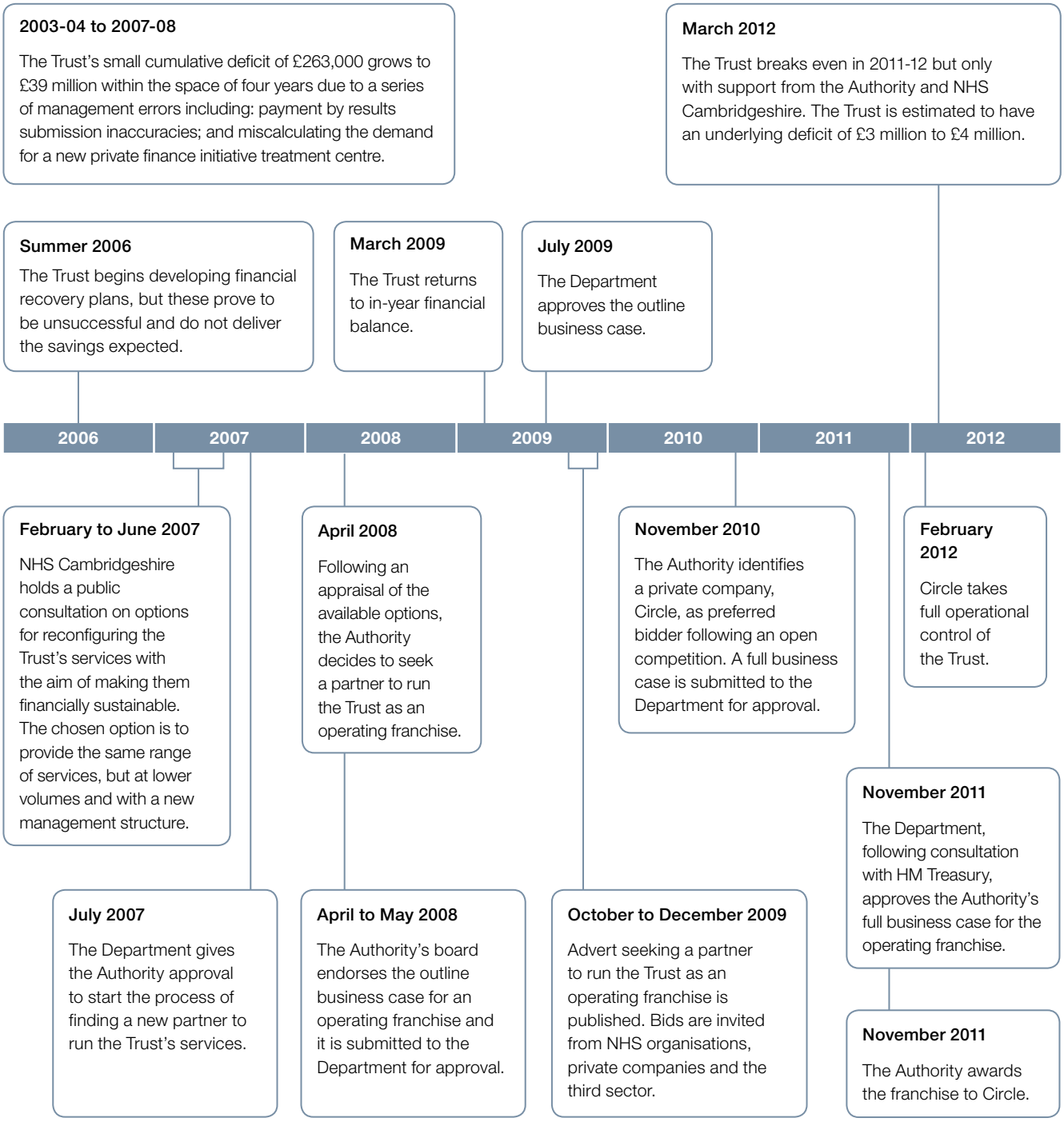
3 In 2007, the Department gave the Authority approval to explore options to implement a new management structure at the Trust, to make it financially sustainable and repay its cumulative deficit. In July 2009, after a public consultation and review by the Department, the Authority obtained approval from the Department to seek a partner to run the Trust as an operating franchise. The Authority invited NHS organisations, private companies and the third sector to bid. In November 2011, the Authority awarded a ten-year operating franchise to Circle, a private company. The key events leading up to the award of the franchise are set out in **Figure 1** overleaf.

4 An operating franchise is an innovative approach to running an NHS hospital and Circle is the first private company to have the management functions of an NHS Trust transferred to it. This report assesses how the Authority designed, initiated and managed the project to franchise the Trust. The report is in three parts:

- **Deciding to franchise the Trust:** When undertaking a project, public sector organisations should understand a range of options and be satisfied that the option selected best meets its strategic objectives.
- **Selecting the franchisee:** Before committing to a project, organisations should undertake a range of tests and processes to ensure that the project is fit for purpose.
- **Managing the franchise agreement:** Good contract management enables organisations to address change and unexpected circumstances.

5 The Trust is the first NHS trust to be run as an operating franchise. The Department, however, is also considering whether to give approval for the franchising option to be pursued for the George Eliot Hospital in Nuneaton and other NHS trusts are working with their strategic health authorities to consider whether to seek approval to procure a franchise partner. This report highlights early lessons that can be learnt from the procurement process and creation of the franchise agreement with Circle.

Figure 1
Key events in franchising the Trust



Source: National Audit Office

Key findings

6 The Authority's outline business case considered various options for implementing a new management structure at the Trust. The Authority shortlisted six options, assessed them against clearly stated criteria and monetised all options; including a 'do nothing' baseline option. The Authority considered some innovative options. However, as some of these options had not been tried before in the NHS it meant that there were a number of uncertainties and the Authority had to use a range of assumptions that were not directly informed by previous experience to develop the business case. The Authority clearly identified these uncertainties, and made adjustments for risk, but the assumptions were not made subject to independent or external challenge, beyond the project team or project board. The project board included representatives from the Department, primary care trust, Trust and the Authority.

7 The Authority assessed financial risk in a limited way, when evaluating bidders' proposals. The Authority compared the two final bids, from Circle and Serco, against how much of any annual surplus the Trust would retain, to pay off its cumulative deficit. The Authority incentivised bidders to include guaranteed payments by double-weighting these in the financial assessment but made no other adjustments to bidders' projected savings to account for risk. This approach may have encouraged bidders to make overly optimistic savings projections, and was in contrast to the risk adjustment applied to the trust comparator.

8 The Authority selected the bid that allowed the Trust to pay off the entire cumulative deficit, rather than the bid with a guaranteed payment. The two bidders, Circle and Serco, proposed very different payment schemes. Serco guaranteed a payment of £11.5 million in the first year of the franchise but required the Trust to achieve greater surpluses before it shared any further profits. This reduced the chance of the cumulative deficit being repaid in full. Circle did not guarantee any repayments but proposed a scheme that could pay off the whole deficit if all of its savings proposals were realised. The Authority selected Circle as its preferred bidder.

9 The franchise agreement transfers demand risk and up to £5 million of financial risk to Circle. The franchise fully transfers demand risk to Circle as there are no guarantees over future activity levels. The franchise also transfers a good degree of financial risk as Circle is only paid if the Trust generates an in-year surplus. If the Trust generates a deficit, Circle must cover up to £5 million of the shortfall from its own resources. If the deficit exceeds £5 million either Circle or the Trust board, with the Authority's approval, can terminate the agreement. Alternatively, Circle can input more cash if all parties agree to continue. Circle also had to put £2 million into a security deposit account for the Authority to re-tender the franchise, in the event of termination. The Authority's total liability if it terminates the agreement for reasons other than franchisee default or full repayment of the cumulative deficit is capped at £10 million.

10 Circle's projected savings of £311 million over ten years are unprecedented as a percentage of annual turnover in the NHS. If delivered, Circle's proposal will make savings of over 5 per cent recurrently each year over the ten-year life of the contract. An essential element of the projected savings is an assumed annual 4.3 per cent efficiency saving from year four onwards. However, Circle's bid did not fully specify how it would achieve these savings. If Circle achieves the savings set out in its bid it will receive a franchise fee of around £31 million over ten years (excluding performance bonuses or deductions of up to 10 per cent a year). No fee is payable if a surplus isn't achieved. If successful, Circle will have achieved in-year surpluses at a far higher level than the Trust has been able to deliver over the last decade; the greatest of which was £0.6 million.

11 Twelve months passed between the Authority naming Circle as the preferred bidder and the signing of the franchise agreement. After the Authority announced its preferred bidder in November 2010, the Department and HM Treasury reviewed the project. The reviews focused on value for money for taxpayers, accountability and governance. The franchise agreement was signed in November 2011. The Department and HM Treasury have stated that the primary reason for the review process taking 12 months was the novel and potentially contentious nature of the proposal. The Trust has stated that the length of time taken to complete the review process hindered its ability to appoint permanent staff, which has had an impact on its financial position.

12 The governance, risk management and performance management arrangements for the franchise agreement are still being put into operation. The agreement refers to governance, risk management and performance management arrangements outside those stipulated in the NHS standard acute contract. As the contract progresses, the Trust board and Circle are seeking to clarify and strengthen these areas to better oversee the franchise. For example, the key performance indicators for the franchise focus only on patient satisfaction and annual workforce metrics, such as staff sickness absence rates. Over and above the requirement for all trusts to have in place a board assurance framework and corporate risk register, the Trust board agreed to develop a franchise management risk register to reflect the risks associated with the Trust board discharging its reserved powers even though the franchise agreement does not explicitly require the Trust board or Circle to have one. The franchise manager has now developed a risk register for the Trust board to use. The franchise manager is also working to agree a broader range of key performance indicators with Circle to enable the Trust board to review performance monthly.

13 The franchise aims are clearly stated in the franchise agreement, but stakeholders have contrasting views on what would constitute success and it is unclear how progress will be reported. The agreement states that Circle should aim to provide high quality clinical services and generate an annual surplus each year. If it generates an annual surplus as planned, the Trust will have achieved recurrent financial balance and the cumulative deficit will be paid by the end of the agreement. This goal is consistent with the aims stated by the Authority throughout the bidding process.

However, the Department, Circle, Trust board and HM Treasury, have different views on what would be a successful outcome and it is unclear how success will be measured. For example, some expressed a view that the cumulative deficit did not need to be repaid either fully, or partly, for the franchise to be considered a success. It is also unclear who will report progress, whether it will be reported publicly, and against which indicators.

14 The Trust has improved in some areas of clinical performance but there are a number of immediate financial challenges to address. The Trust's performance against accident and emergency, and cancer waiting times standards has improved since the franchise began in February 2012. By the end of September 2012, however, the Trust had generated an in-year deficit of £4.1 million, which was £2.2 million higher than Circle's financial plan to that point. Circle is expected to deliver £9.9 million savings in year one which is greater than the £5 million savings anticipated in its bid due to the Trust starting 2012-13 with an estimated underlying deficit of between £3 million and £4 million. This additional financial risk has been passed to Circle.

15 Other NHS trusts are considering entering into franchise agreements before the outcomes of the project can be assessed. Hinchingbrooke is the first NHS Trust to be run as an operating franchise. This approach is untested in the NHS and it is too early for the outcomes of the franchise agreement to be properly established and understood. However, other NHS trusts in the foundation trust pipeline are working with their strategic health authorities to consider the applicability of a franchise model.

Conclusion on value for money

16 In considering value for money, we should bear in mind that the Trust has been in financial difficulty for some time, and it was therefore reasonable to look to more radical options to turn things round. The Authority carried out a strategic evaluation of these options before opting for an operating franchise.

17 However, we have concerns about the winning bid for the franchise because most of the projected savings occur in the later years of the contract, and about how the risks associated with this were taken into account in the contract award decision.

18 If the contract goes well, it can deliver value for money, but it will need alert management by the Authority and the Trust board to monitor performance and intervene as necessary.

Recommendations

a **When assessing future savings schemes the procuring authority needs to apply consistent risk adjustments so that bidders are treated equally and that only realistic savings opportunities are considered.** The Authority let bidders risk adjust their own proposals, which means it cannot be sure it compared like with like when selecting its preferred bidder.

b **If further NHS franchises are to be let, the Department should establish which body is best placed to develop standard terms and conditions and ensure that they are developed to help minimise the length of time and costs of future procurements.** The Department and the Treasury took 12 months to approve the full business case for the franchise.

c **The Authority should ensure that the project's measures of success are clear to all stakeholders.** Our discussions with stakeholders highlighted various views of what would represent a successful outcome for the franchise. For example, there was a lack of agreement over whether it is necessary for the cumulative deficit to be repaid.

d **Public communication on the franchisee's performance should be balanced and based on a comprehensive set of indicators, covering clinical and financial performance, agreed between the Trust board and Circle.** Communication by the Trust board and Circle has focused on progress against measures of performance such as waiting times standards. However, it has not mentioned other important areas of performance such as financial progress.

e **The Authority should work with the Department to undertake a formal lessons learned process before agreeing any further franchise agreements.** The franchise for the Trust is the first of its kind in the NHS and it is important that future contracts are improved, based on lessons from the procurement process and early operational experience.

Part One

Deciding to franchise the Trust

1.1 When undertaking a project, public sector organisations should understand a range of options and be satisfied that the option selected best meets its strategic objectives. Our reports show that organisations commonly embark on projects without rigorously understanding the feasibility of delivery and without a good process to evaluate the pros and cons of alternative solutions. This part of the report examines:

- the decision to redesign the services provided by Hinchingbrooke Health Care NHS Trust (the Trust) and to implement a new management structure;
- whether the NHS East of England Strategic Health Authority (the Authority) used a robust process to evaluate the pros and cons of alternative solutions to achieving the project's aims; and
- what level of independent assurance and scrutiny the Authority applied to the proposals to test their feasibility.

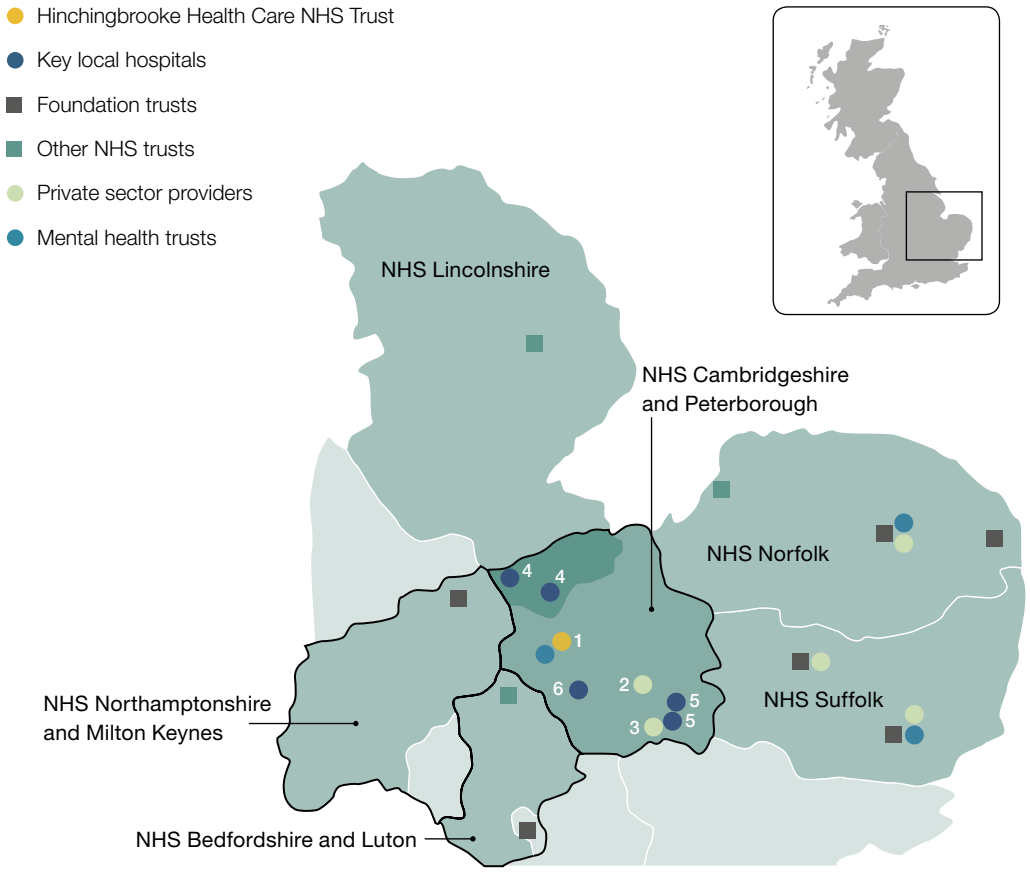
Nature of the Trust

1.2 The Trust is a small district general hospital in Cambridgeshire which provides a range of services to a population of around 160,000 people, including accident and emergency, orthopaedics, maternity and paediatrics. The Trust employs 1,674 staff (headcount) and is one of a number of NHS trusts located within the NHS East of England strategic health authority area (**Figure 2** overleaf). In 2011-12, the Trust had an annual income of £107 million.

1.3 The Trust provides services for seven primary care trusts, but around 90 per cent of its income comes from NHS Cambridgeshire, which acts as the Trust's lead commissioner. As lead commissioner, NHS Cambridgeshire ensures that clinical services are commissioned each year in line with national and local policy frameworks. It also oversees associate primary care trusts' commissioning priorities and investment in the Trust's clinical services.

Figure 2

Location of the Trust within the NHS East of England health economy



1 Hinchingbrooke Health Care NHS Trust

2 Spire Cambridge Lea Hospital

3 Nuffield Hospital

4 Peterborough and Stamford NHS Foundation Trust (Peterborough District Hospital and Stamford Hospital)

5 Cambridge University Hospitals NHS Foundation Trust (Addenbrookes Hospital and Rosie Hospital)

6 Papworth Hospital NHS Foundation Trust (Papworth Hospital) – Specialist

Source: National Audit Office

1.4 The strategic health authority, NHS East of England (the Authority) is the regional headquarters of the NHS, and provides strategic leadership to all NHS organisations across Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. It ensures that the £8.1 billion spent on health care across the region delivers the best services and value for money for patients and the taxpayer. The Authority also ensures that the primary care trust-led health systems operate effectively by, for example, shaping the structure of local supply and assessing capacity requirements.

The Trust's financial position deteriorated substantially between 2003-04 and 2007-08

1.5 In 2003-04, the Trust had a small cumulative deficit of £263,000 which the Department of Health (the Department) did not consider to be material as it did not exceed the threshold of 0.5 per cent of income. However, the Trust expenditure exceeded its income in each of the four following years and its financial position deteriorated substantially. By 2007-08, it had a cumulative deficit of £39 million on an annual income of around £73 million (**Figure 3** overleaf). The Trust's deficit accumulated for two main reasons:

- In November 2005, the Trust opened a new £22 million private finance initiative treatment centre. The Trust's income predictions for the centre, which were based on a shift in referrals to the Trust by local primary care trusts, failed to materialise.
- The Trust submitted baseline data to the Department which contained significant errors during the introduction of the national payment-by-results tariff system. These errors lead to substantial reductions to the Trust's income in 2006-07 and 2007-08.

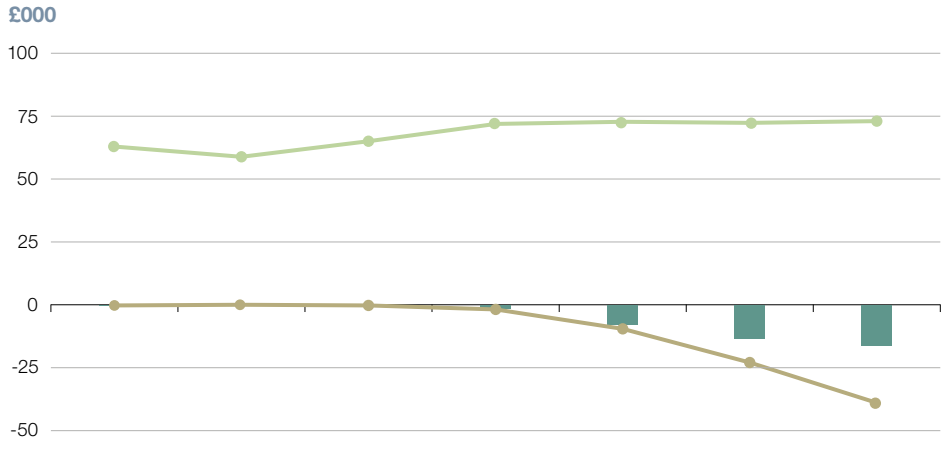
1.6 The Trust initiated a turnaround process and produced a financial recovery plan but did not make the expected savings. In March 2008, the Trust's external auditors identified that it would not achieve its statutory duty to break even over the five-year period from 2004-05 to 2008-09 without external support.[1] The external auditors issued a public interest report and made a referral to the Secretary of State.

1 The National Health Service Act 2006 requires NHS trusts to break even over a rolling three-year period. However, in exceptional circumstances the break-even duty is assumed to be met if the cumulative deficit being recovered is covered by subsequent surpluses over a five-year period. The Authority therefore granted the Trust a two-year extension to its three-year break-even duty.

Figure 3

The Trust's financial position between 2003-04 and 2007-08

By 2007-08 the Trust had a cumulative deficit of £39 million on an annual income of £73 million



	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Turnover	62,912	58,859	65,026	71,911	72,763	72,357	73,006
Break-even cumulative postion	-220	1	-263	-1,829	-9,581	-22,935	-38,972
Break-even in-year position	-220	221	5	-1,566	-7,752	-13,354	-16,037

Source: The Authority

The Department gave the Trust £39.8 million in public dividend capital, in 2006-07 and 2007-08, to support its cash position

1.7 A major source of support to some NHS trusts in financial difficulties is additional public dividend capital provided by the Department which directly strengthens their balance sheet. Public dividend capital represents the Department's investment in the public assets of NHS bodies. Public dividend capital is the equivalent of share capital, so a trust's public dividend capital will only increase with an injection of cash to either purchase assets or support working capital.

1.8 Public dividend capital issued by the Department, to support operational cash requirements, is designed to help trusts maintain the amount of working capital they need when they cannot access a working capital loan. Between 2006 and 2008, the Department gave the Trust public dividend capital totalling £39.8 million. The Department gave the public dividend capital to the Trust temporarily, but without any repayment timetable. The Department's main focus was to return the Trust to year-on-year break even without any detrimental impact on service quality.

NHS Cambridgeshire decided that the Trust should be redesigned to make it financially sustainable

1.9 By early 2007, NHS Cambridgeshire was facing financial challenges of its own and was projecting a shortfall of £50 million for 2007-08. It had identified that levels of demand for acute hospital care at the Trust were high, compared with England averages (41 per cent above for inpatient stays and 34 per cent above for new outpatient appointments). This was despite a relatively healthy population. Also, the level of activity and expenditure at the Trust was unaffordable after it introduced payment-by-results because the national tariff prices were higher than those previously charged.

1.10 In February 2007, NHS Cambridgeshire issued a public consultation on options to reconfigure services at the Trust. One of the key aims of the consultation was to develop services that were financially sustainable for the Trust as well as the overall Cambridgeshire health system. The consultation considered four options:

- Do minimum, to provide broadly the same range of services but at lower volumes.
- Provide broadly the same range of services at lower volumes through a major redesign of how services are provided across the hospital and community setting.
- Transfer significant elements of patient services to other hospitals and significantly reduce activity on the hospital site.
- Close all services on the hospital site with the exception of inpatient surgery and outpatient services in the new treatment centre.

1.11 Complete closure of the hospital was not considered, but all options except 'do minimum' included proposals to dissolve the Trust and have another NHS organisation manage the clinical services previously provided by the Trust. None of the consultation options addressed the Trust's cumulative deficit but focused instead on actions to return it to recurrent in-year financial break even.

NHS Cambridgeshire proposed to transfer Trust management to another NHS body and reduce its activity

1.12 NHS Cambridgeshire considered each of the options on the basis of three criteria: clinical viability, how far they enabled local services to be maintained and their financial affordability. The options were monetised. Financial affordability was assessed against the potential for the option to achieve recurrent in-year financial balance by making annual savings of up to £14.5 million within three years. There were, however, no scoring criteria for the options considered and projected savings were not adjusted for risk or optimism bias.[2]

2 There is a well demonstrated, systematic, tendency for project appraisers to be overly optimistic. To redress this tendency appraisers should make explicit, empirically based adjustments to estimates of project costs, savings and timetable.

1.13 NHS Cambridgeshire chose the option in June 2007, after the consultation ended, to reconfigure the service. It chose this option as it would enable the Trust to move to a recurrent break-even position by making savings of exactly £14.5 million within three years, while maintaining the same range of clinical services. Dissolving the Trust and transferring management to another NHS body was expected to contribute to a recurrent saving of £1.9 million in management costs. NHS Cambridgeshire's commissioning plans and the consultation document envisaged an overall decrease in activity at the Trust of around 20 per cent from 2005-06 levels. This reduction was to be achieved by NHS Cambridgeshire investing £2.5 million in community based services, to reduce high levels of demand for hospital care from the relatively healthy population.

The Authority considered options to introduce a new management structure and delivery model

1.14 In July 2007, the Department gave the Authority approval to start finding a new partner to run the Trust's services. In October 2007, the Authority established a project team to examine options for implementing changes to the Trust's management structure. The project team consisted of representatives from the Trust, NHS Cambridgeshire and the Authority. The project team was overseen by a project board made up of senior representatives from the Trust, NHS Cambridgeshire, the Authority and the Department, and a patient representative. The project team were given a number of objectives, including:

- ensuring the ownership structure for the Trust is fit for purpose, and is value for money;
- making the Trust financially sustainable and maximising repayment of temporary loans and/or public dividend capital provided to the Trust; and
- developing health services following best practice while maintaining a robust local health economy.

1.15 The Authority and the members of the project board agreed to widen the options around the future management of the Trust's services from dissolving the existing Trust and transferring the services and assets into another NHS body. They examined other options to allow the Trust to maintain as many services as possible while achieving a financially sustainable position.

1.16 The Authority and the project board developed a long list of nine options, which included: a baseline option of 'do minimum'; selling the Trust to the independent sector or an NHS organisation; merging with another NHS organisation; management franchise or operating franchise.[3] The project team and project board assessed the long-listed options in February 2008. They assessed options qualitatively against three weighted criteria based on their relative importance to the aims of the project: clinical (30 per cent), achievability (20 per cent) and financial sustainability (50 per cent). These criteria were broken down further into ten weighted subcategories such as net annual cost of services, ability to address cumulative deficit, and feasibility.

1.17 Each participant at the workshop scored the long-listed options against the criteria on a scale of 0 (failed to satisfy) to 10 (satisfied perfectly) and discussed scores until they reached a consensus. Six options were shortlisted for economic analyses, including a 'do minimum' option against which to judge the relative pros and cons of other options.

The Authority and the project board carried out an economic appraisal for the six shortlisted options but some assumptions used were untested, as the options were innovative

1.18 The Authority and the project board undertook an economic appraisal for each of the six shortlisted options including the 'do minimum' option, and based it solely on their assumed ability to contribute towards repaying the accumulated deficit. The Trust's income was projected over the ten-year period from 2009-10 to 2018-19 using financial assumptions such as increases in payment-by-results tariff prices, increases in operating costs, and activity growth. The Authority and the project board then made further adjustments to the forecasts using a range of assumptions about the potential for each option to make cost savings, comparative operating margins, and the likely cost of any procurement exercise required.

1.19 Although some comparative data were available on the operating margins of some of the options considered, there was a lack of reliable or comparable financial information upon which to base the economic appraisal because of the untested nature of some of the options being considered. The Authority and the project board sought comparative financial information during a two-day market sounding process to test market appetite for the options considered, but the information was unavailable. As a result, the Authority and the project board had to make assumptions not directly informed by previous experience about the anticipated levels of performance for each option. Members of the project team, the project board and stakeholders agreed these assumptions in April 2008 and the Authority's internal audit department reviewed them. The assumptions were not subject to independent or external expert challenge.

3 In an operating franchise the franchisee performs the functions delegated to the Trust as if the franchisee were the Trust.

1.20 Having undertaken an economic appraisal for each of the six shortlisted options, the Authority and the project team made adjustments for various risks according to their probability and their likely cost impact. These risks related to needing further intervention, for example, if an option failed to contribute to the cumulative deficit as projected, or the risk of termination if a franchise was awarded. The options were not adjusted for optimism bias.

The Authority's preferred option was an innovative operating franchise which was new in the NHS

1.21 The Authority's preferred option was an operating franchise (**Figure 4**). To test the robustness of the margin between the first ranking and second ranking options the Authority undertook a sensitivity analysis. This analysis identified that ranking the options would change according to small changes to the assumptions relating to projected cost savings (0.2 per cent), the arrangements for sharing any retained Trust surplus (5 per cent), and additional activity growth (0.25 per cent). The Authority noted that the preferred option had only a small winning margin over the second placed option given the "relatively untested nature of the assumptions used to construct the economic evaluation",[4] but an operating franchise remained its preferred approach.

Figure 4
Scoring of shortlisted options following economic appraisal

Option	Ranking	Projected contribution towards deficit repayment (£m)
Operating franchise	1	14.1
Sale (open to independent sector and NHS)	2	12.2
Sale (open to NHS only)	3	8.9
Merger with PCT provider arm	4	6.3
Management franchise	5	5.7
Do minimum	6	3.0

Source: The Authority

4 Hinchingbrooke Next Steps Project – Outline Business Case, May 2008, p22.

The Department took over a year to approve the outline business case

1.22 The project board approved the outline business case, which recommended procuring an operating franchise for the Trust, in April 2008. The Authority's board approved the business case at a public board meeting in May 2008. The Authority submitted the outline business case to the Department in May 2008 but the Department did not approve it until July 2009. The Department's approval letter said that it was "keen to work with NHS East of England to develop a model for franchising" [5] but did not mention the scope of its review. The year-long approval process was due to the Department and HM Treasury's review of retention of employment policy in contracts between the NHS and the independent sector. Once this review was concluded in early 2009, the staffing implications of the proposed franchise had been clarified and it was clear that they did not entail any retention of employment guarantees, the consideration of the outline business case was progressed to approval in July 2009.

5 Letter to NHS East of England from the Department, July 2009.

Part Two

Selecting the franchisee

2.1 Before committing to a project, organisations should undertake a range of tests and processes to ensure that the project is fit for purpose. Getting the judgements wrong makes it highly unlikely the project will achieve the objectives and longer-term benefits anticipated. During procurement, bids should be assessed against clear, relevant criteria. Organisations should also assess project risks and ensure they are placed with the party best able to manage them. This part of the report examines:

- the effectiveness of the Authority's procurement strategy;
- how well the Authority assessed bidders' savings proposals;
- how the Authority tried to share or transfer project risks; and
- how the Authority engaged with stakeholders and external reviewers.

The Authority followed a six-stage procurement process which generated much market interest

2.2 Following a two-day market sounding exercise, which attracted 21 attendees, the Authority advertised the franchise in October 2009. The aim of the project was to find a partner to provide sustainable health services at the Trust, in line with the outcome of NHS Cambridgeshire's 2007 consultation, and repay the Trust's cumulative deficit. The Authority subsequently followed a six-stage 'competitive dialogue' procurement process designed to maintain competitive tension. The competition attracted a good level of interest from both private sector and NHS organisations (**Figure 5**).

2.3 The Authority acted flexibly to maintain competitive tension during the competition. The two NHS trusts involved both withdrew at early stages of the process. Only one bidder, Serco Health (Serco), fully met the criteria at stage three so the Authority lowered the evaluation thresholds to enable two other bidders, Ramsay Health Care UK (Ramsay) and Circle Health (Circle), to progress to the next stage. At the next stage, Ramsay submitted a non-compliant bid so only the remaining two bidders (Serco and Circle) were shortlisted and invited to submit their final commercial and financial offers.

Figure 5
The Authority's six-stage procurement process

Stage 1 – expression of interest (October 2009)

An expression of interest form is issued to establish whether there is a sufficient number of competent, financially sound suppliers with adequate capacity to undertake the work being advertised:

- Advert issued October 2009.
- Nineteen expressions of interest received.

Stage 2 – pre-qualification questionnaire and memorandum of information

The pre-qualification questionnaire acts as a written reassurance that an applicant can provide the advertised service adequately. The memorandum of information sets out the objectives of the procurement and the service requirements.

Bidders were assessed against four criteria: clinical, workforce, legal and financial:

- Issued October 2009.
- Eleven responses received.
- Six organisations approved to move to the next stage.

Bidders: Cambridge University Hospital/Addenbrookes, Care UK, Circle, Interhealth, Ramsay, Serco

Stage 3 – invitation to participate in dialogue 1

Bidders were invited to discuss the project with the Authority and to develop potential solutions for the operation of the Trust.

Bidders were assessed against four criteria: clinical services, workforce, information management and technology, estates and finance:

- Issued December 2009.
- Only one bidder met the Authority's criteria.
- The Authority lowered some evaluation thresholds in order to maintain competitive tension.
- Three bidders shortlisted.

Bidders: Circle, Ramsay, Serco

Stage 4 – invitation to participate in dialogue 2

Bidders were required to: provide more detail on their proposals; demonstrate experience of providing similar services; and show how their skills could be used to run the Trust.

Bidders proposed savings initiatives assessed for clinical, financial, and operational viability:

- Issued April 2010.
- Three responses received, one of which was non-compliant.
- Two organisations approved to progress to the next stage.

Bidders: Circle, Serco

Stage 5 – invitation to tender

Bidders were required to provide their final commercial and financial offer.

Bidders were asked to confirm their proposed initiatives and their value, provide a proposed corporate structure, confirm any funding requirements, and agree to termination costs:

- Issued October 2010.
- Preferred bidder announced following approval by the Authority's board in November 2010.

Bidder: Circle

Stage 6 – approvals

The Authority's recommendation as to the preferred bidder is scrutinised by the Department:

- Full business case issued to the Department in November 2010.
- Contract award and signature, November 2011.
- Service commencement, February 2012.

Bidder: Circle

Source: The Authority

The Authority sought bids with projected savings of at least £228 million over ten years but did not adequately assess risk

2.4 The Authority estimated that the Trust needed to make considerable savings to achieve in-year financial break even (that is, before any contribution could be made towards repaying its cumulative deficit). The Authority's estimate of the extent of these savings changed during the competition in response to the worsening state of the economy. By the final stages of the competition the Authority estimated that savings of £130 million over seven years, or £228 million over ten years, would be required for the Trust to break even. Bidders were asked to propose savings initiatives against these projections. Asking for bids over both seven and ten years allowed the Authority to assess which length of franchise term would achieve better outcomes.

2.5 Circle and Serco submitted proposals for a range of initiatives along with the projected savings they would generate. The Authority also produced a 'trust comparator' setting out the initiatives that the Trust could implement itself (**Figure 6**). Ten of the schemes included within the trust comparator were reviewed in detail resulting in a reduction for risk of 22 per cent in the value of the projected savings. A broad range of NHS staff (including clinical, management and finance representatives) helped to assess the viability of the bidders' savings proposals. However, the assessment focused on the viability of the initiatives rather than on how realistic proposed savings from the initiatives were. This may have encouraged bidders to make increasingly optimistic projections.

The two shortlisted bidders increased their bids by over 25 per cent during the final procurement stage

2.6 Upon entering the final stage of the procurement, Circle was projecting savings of £134 million over seven years and £244 million over ten years, while Serco was projecting savings of £110 million over seven years and £197 million over ten years. The Authority asked the bidders to update their projected savings although bidders were not allowed to submit any new initiatives. No further revisions were made to the savings schemes included within the trust comparator after the 22 per cent reduction in their value for risk. Both bidders increased their proposed savings by over 25 per cent. The franchisee is not committed to delivering the proposed initiatives submitted during bidding and this may have further incentivised increasingly ambitious bids.

Figure 6
Bidders' proposed savings initiatives

	Trust comparator	Circle	Serco
Number of approved initiatives	48	32	28[1]
Examples of savings initiatives	Reducing patients' length of stay Restructuring Trust management Adjusting capacity to meet demand Rationalising car parking	Reducing patients' length of stay Improving theatre productivity Consolidating work in the on-site private finance initiative treatment centre Streamlining emergency work through accident and emergency	Reducing patients' length of stay Increasing elective activity Changing the mix of work done at the Trust Expanding existing services and introducing new ones
Projected savings over ten years from proposed initiatives at stage four of the procurement (£m)	146[2]	244	197
Revised projected savings over ten years from proposed initiatives at stage five of the procurement (£m)	–	311	249
Increase in projected savings between stages four and five of the procurement (%)	–	27	26

NOTES

1 In addition, Serco submitted a further initiative which failed the evaluation criteria.

2 Projected saving of £186 million net of 22 per cent risk adjustment (figures do not sum due to rounding).

Source: The Authority

The Authority did not assess the level of risk in the bids

2.7 Projected savings over ten years are inherently uncertain as future work, income and costs may vary. The bidders were asked to adjust their figures to consider risk. However, the Authority did not ask for details of this risk adjustment and did not assess the relative risks of the two bids or seek to adjust the projected savings figures for risk (this is in contrast to the risk adjustments made to the trust comparator). Therefore, any significant difference in risk between the two bids would not have been reflected in the evaluation. This may have further encouraged bidders to submit increasingly optimistic bids.

The Authority had to choose between a guaranteed payment or a greater share of any Trust surpluses generated by the franchise

2.8 The franchisee is expected to take its fee from any in-year surpluses and bidders were allowed to submit their own proposals for a payment mechanism to share these surpluses with the Trust. Circle and Serco proposed very different payment mechanisms. Serco guaranteed an £11.5 million payment towards the cumulative deficit in the first year of the contract, which it would fund from its own resources. However, it did not propose to share any in-year surpluses with the Trust unless they exceeded £7 million and proposed to vary the amount of any surplus retained by the Trust depending on the year in which it was achieved, with the Trust receiving a greater share in the latter years of the contract. Circle did not guarantee any payment towards the cumulative deficit, but proposed sharing the majority of any in-year surplus over £2 million with the Trust (**Figure 7**).

2.9 There were considerable differences in proposed payment mechanisms. The Authority had to decide whether it preferred a guaranteed payment with less chance of further payments, or a possible repayment of the whole deficit but with no guarantee that any amount would be repaid. To compare the bids, the Authority calculated weighted average contributions to the Trust based on three different income scenarios. The Authority sought to incentivise bidders to include guaranteed payments by double-weighting these in the financial assessment. Serco's bid had a guaranteed amount, but Circle's higher savings projections and proposed sharing mechanism produced a greater weighted average contribution to the Trust. The Authority selected Circle as the preferred bidder. The profiled savings, Trust surpluses and repayments towards the historic deficit for both bids are shown in **Figure 8** on pages 26 and 27.

Figure 7
Circle's proposed payment mechanism

Bands of Trust annual surplus (£m)	The Trust's share of the surplus under Circle's bid (%)
0–2	0
2–6	75
6–7	67
7–10	67
10–12	75
12–16	75
16–22	75
Over 22	75

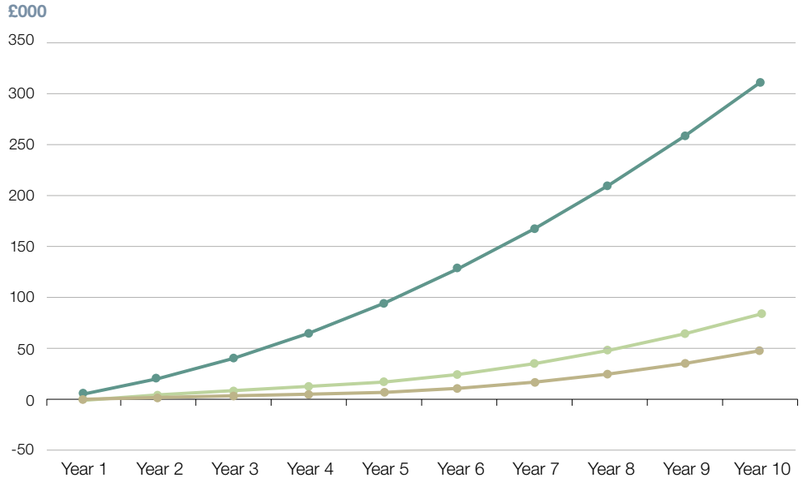
Source: The Authority

Figure 8

Comparison between Circle and Serco's bids over ten years

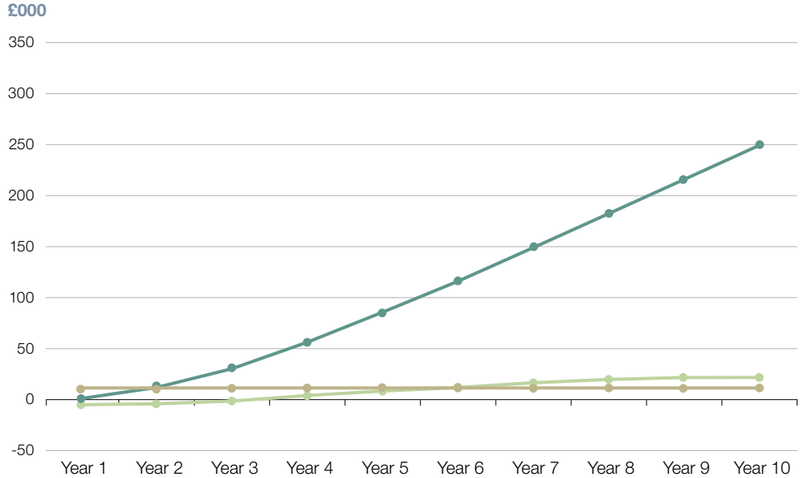
Circle's bid projected both higher savings and a greater contribution to the Trust's historic deficit

Circle's bid



	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Predicted savings from proposed initiatives	4,959	20,251	40,148	64,706	94,225	128,589	167,420	210,706	258,558	311,091
Projected Trust surplus/ (deficit) with initiatives	(1,132)	4,260	8,471	12,586	16,875	24,449	34,893	48,160	64,323	83,457
Retained by Trust to repay historic deficit	0	1,695	3,353	4,940	6,656	10,711	16,724	24,854	35,156	47,687

Serco's bid



	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Predicted savings from proposed initiatives	1,063	11,973	30,282	56,229	85,775	116,097	149,045	182,409	215,882	249,389
Projected Trust surplus/ (deficit) with initiatives	(5,029)	(4,019)	(1,396)	4,108	8,424	11,955	16,516	19,861	21,644	21,753
Retained by Trust to repay historic deficit	11,457	11,457	11,457	11,457	11,457	11,457	11,457	11,457	11,457	11,457

NOTE

1 Bidders submitted bids for seven and ten years. Only the ten-year bids are shown.

Source: The Authority

The cost savings projected in Circle's bid are unprecedented as a percentage of annual turnover within the NHS

2.10 Circle's projected savings of £311 million over ten years are unprecedented in the NHS as a percentage of annual turnover, rising from 5 per cent in the first year to over 50 per cent in the tenth year (**Figure 9**). To achieve its projected savings Circle will need to find new savings each year equivalent to at least 5 per cent of income (11 per cent in year two). Work by McKinsey and Company for the Department looked at efficiencies achieved in public and private hospital sectors in different countries. McKinsey and Company found that year-on-year savings of much more than 5 per cent had not been achieved so Circle's plans are therefore at the top end of what has been shown to be possible.

2.11 Circle's savings projections are based on the Trust income projections used to assess the bids. If future Trust income is higher than those projections then the scale of savings required will reduce and become more manageable. Trust income depends on the level of work done by the Trust and this is necessarily uncertain.

2.12 An essential element of the projected savings is an assumed annual 4.3 per cent efficiency saving from year four onwards. Details of how these savings will be achieved were not specified in the bid but the figure of 4.3 per cent was consistent with Monitor's forecasts across all foundation trusts at the time.

Figure 9
Circle's projected savings

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Projected Trust income (£m)	96	95	92	89	87	88	89	90	91	93
Total savings from proposed initiatives (£m)	5	15	20	25	30	34	39	43	48	53
Total savings as a percentage of income (%)	5	16	22	27	34	39	44	48	52	57
'New' savings (£m)	5	10	5	5	5	4	5	4	5	5
'New' savings as a percentage of income (%)	5	11	5	5	6	5	5	5	5	5

NOTE
1 Figures are based on a base case income scenario. Higher incomes would lead to greater savings.

Source: The Authority

2.13 In the past decade, the Trust has not achieved an in-year surplus above £0.6 million. We estimate the minimum total surplus the Trust needs to clear its historic deficit over the next decade is £73.4 million.[6] Circle's plans target a total ten-year surplus of £83 million. If it achieves this surplus, the Trust will receive £48 million, which is £9 million more than it needs to repay its cumulative deficit. Serco's bid only included a ten-year surplus of £22 million.

2.14 If Circle makes the savings projected in its bid, it will receive an income of around £31 million over ten years (based on the income projections in Figure 9 and excluding any performance bonuses or deductions of up to 10 per cent a year).

The franchise transfers risk well, but Circle is a relatively new company with financial risks

2.15 NHS Cambridgeshire has not guaranteed levels of future activity at the Trust so the franchise fully transfers demand risk to Circle. Circle has accepted the risk that projected activity levels, and therefore income, may change. The franchise also includes a good degree of financial risk transfer. Circle only receives payment when the Trust generates an in-year surplus. If the Trust does not generate a surplus in a given year, Circle must cover up to £5 million of the shortfall from its own resources. If the £5 million threshold is breached, either Circle or the Trust board, with the Authority's approval, have the option to terminate the franchise. However, if all parties agree the franchise can continue if Circle agree to provide the additional money required to cover the deficit.

2.16 Unless it voluntarily adds more money to cover a deficit in excess of £5 million, Circle's total liability is capped at £7 million. This is made up of the £5 million contribution to cover deficits described above and £2 million termination costs, which would enable the Authority to re-tender the franchise. To guarantee the termination costs Circle had to place £2 million into a security deposit account although this situation is subject to annual review and may change to reflect Circle's financial position. If the Authority terminates the franchise for reasons other than franchisee default or full repayment of the historic deficit, it is liable to pay Circle up to £10 million in compensation.

6 The exact total surplus achieved will depend on any annual surpluses achieved and how the payment mechanism acts on them.

2.17 As a relatively new enterprise, Circle has financial risks that a larger, more established company would not have. Founded in 2004, it now runs four private treatment facilities and one NHS treatment centre, which treat patients with planned admissions. Before winning the franchise it had no experience of managing a district general hospital, which treats patients with both planned and emergency admissions. Circle is 49.9 per cent owned by its employees through Circle Partnership Ltd and relies on institutional investors in Circle Holdings plc, which owns 50.1 per cent of the shares, for the bulk of its funding. Circle was listed on the Alternative Investment Market in June 2011 and it raised further capital at that time to improve its financial robustness which was critical to securing the Department and HM Treasury's approval. The franchise agreement contains provisions to ensure that the Trust board can continue to assure itself that Circle can meet its financial obligations. For example, Circle must provide the Trust board with its monthly management accounts.

The Authority actively managed stakeholders but external reviews delayed the procurement

2.18 At the start of the procurement the Authority developed a communication plan to provide public engagement in parallel with the procurement. Approaches included:

- a dedicated website;
- a regular project newsletter;
- a stakeholder panel;
- public meetings; and
- staff engagement programmes.

2.19 The extensive stakeholder engagement on the project was acknowledged by Cambridgeshire County Council's joint health overview and scrutiny committee. The Office of Government Commerce health gateway review team also described the clinical engagement as best practice.

Twelve months passed between the appointment of the preferred bidder and the signing of the franchise agreement

2.20 The Authority announced Circle as its preferred bidder in November 2010 with a view to the franchise starting in June 2011. However, the franchise agreement was not signed until November 2011 following a review of the project by the Department and HM Treasury. The Department and HM Treasury have stated that the review process took 12 months because of the novel and potentially contentious nature of the proposal and the need for an in-depth review to ensure the contract addressed the need to secure clinical quality and accountability to Parliament for the use of public funds.

2.21 The Department highlighted some issues about the realistic deliverability of the proposed savings, but saw it as the Authority's responsibility to assure itself of this, as a party to the proposed contract. The Department did take steps to ensure that the structure of the proposed contract would appropriately incentivise Circle to reduce the Trust's recurrent deficit. HM Treasury does not normally review projects as small as the franchise, but does review projects that are considered novel or contentious. HM Treasury's review focused on whether the franchise would be value for money for taxpayers, and issues around accountability and governance.

2.22 The Trust has stated that the length of time between the appointment of the preferred bidder to the signing of the franchise agreement hindered the Trust's staff recruitment resulting in additional consultant and locum fees (estimated by the Trust to be around £1 million) and prevented Circle from implementing its savings initiatives earlier.[7]

7 Based on partially audited figures from the Trust.

Part Three

Managing the franchise agreement

3.1 Projects inevitably encounter changes and unexpected circumstances arise. It is therefore important to establish good project management arrangements and clear review points when teams can assess progress against project objectives. This is particularly important for innovative projects where there is uncertainty at the outset, and where understanding of risk improves as the project proceeds. It is also important to have a single definition of success so that all parties are working to achieve the same outcomes. This part of the report examines:

- whether there are suitable governance, performance management and risk management arrangements to help achieve the project's aims and objectives;
- the franchise's performance to date; and
- how clearly the project's aims have been stated and whether there is clarity among stakeholders on how success will be measured.

Many of the functions of a standard NHS trust board have been passed to Circle but a trust board has been retained to monitor the franchise

3.2 Under the operating franchise model, the Trust's staff and assets remain within the NHS, but Circle has taken full operational control of the organisation and is responsible for meeting all performance requirements. The franchise does not affect the status of the Trust as an NHS body and it continues to provide services under the NHS standard acute contract. This means that Circle must operate under the same rules as an NHS provider.

3.3 Although the Trust's management functions have been passed to Circle, the agreement requires a trust board to be retained. The composition of the Trust board is, however, very different to a conventional NHS trust board and consists of only three non-executive members: a Chair, a financially qualified individual and a clinically qualified individual. Before the agreement started, the Trust board consisted of a chairman and six non-executive directors, and a chief executive and five executive directors, including a finance director, medical director, and a nursing director. The new board's role is not as extensive as the prior Trust board as certain responsibilities have been passed on to Circle.

3.4 Circle cannot make material decisions that could affect the long-term viability of the Trust without the Trust board's approval. These decisions include disposing of or selling the Trust's property or assets, making more than 20 staff redundant in any 12-month period, or amending the Trust's commissioning contract with NHS Cambridgeshire. The functions of the Trust board include:

- reviewing and monitoring the financial performance of the Trust against the annual budget and business plan;
- approving the Trust's statutory accounts;
- reviewing and monitoring the clinical performance of the Trust against applicable regulatory standards, as it deems fit; and
- monitoring, administering, and enforcing the rights of the Trust under the agreement.

3.5 The Trust board is responsible for performance monitoring the franchise agreement and does this through a franchise manager. Circle is responsible for meeting the requirements of the franchise agreement, and ensuring that safe and high-quality NHS services are provided to the public. The chief executive is the accountable officer for the Trust, is responsible for the day-to-day operation of the hospital and reports directly to Circle rather than the Trust board (**Figure 10** overleaf).

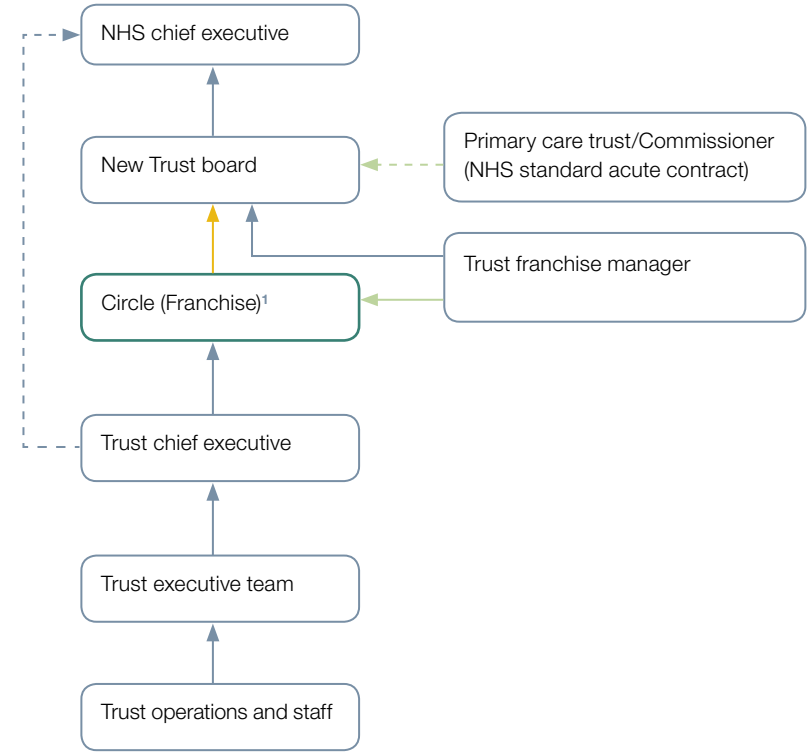
3.6 The Trust board may, with the Authority's approval, terminate the franchise agreement if Circle or any of its holding companies breach certain criteria. These criteria include getting into financial difficulties, if the Trust does not meet essential standards of quality and care set by the Care Quality Commission, if the Trust develops a deficit of more than £5 million, or if Circle commits a material breach of the agreement. Material breaches include Circle not providing management accounts to the Trust board each month and to the Authority every three months.

The Trust board has identified a number of areas which need clarification in the franchise's governance and risk management arrangements

3.7 The agreement includes governance arrangements which set out the Trust board's information and reporting requirements, audit provisions and its responsibilities. The agreement also set out the roles of the franchise manager and franchisee representative, as well as the performance monitoring roles of the executive team and the Authority. Since the franchise began, however, the Trust board has identified a number of areas which need clarification in the governance arrangements for the franchise and has requested amendments to the agreement (**Figure 11** on page 35). The Trust, Circle or the Authority (or the parties together at any given time) can initiate changes to the agreement during the franchise through a change request. If the change request cannot be agreed together then the agreement has a dispute resolution policy in place.

Figure 10

The Trust's governance arrangements following the start of the franchise



NOTE

1 Circle performs the functions delegated to the Trust as if it were the Trust.

Source: The Authority

Figure 11

Governance issues identified by the Trust board and Circle since the start of the franchise agreement

Issue identified	Change requested by Trust board
The role and function of the audit committee needs to be strengthened to reflect public sector policy and good health-care practice.	The Trust board has requested that the audit committee be chaired by the finance non-executive director to reflect the Trust's standing financial instructions and that the "appropriately qualified representative of Circle" should be invited (but not obliged) to attend.
There are no references to the integrated governance committee reporting arrangements in the franchise agreement. However the Trust's standing orders make a clear commitment to the Trust adopting an integrated governance approach.	The board recommended that the terms of reference for the integrated governance committee are strengthened by making clear that the committee will submit routine reports to the Trust board via the audit committee.
The franchise manager and franchise representative can manage and amend the annual business plan approval time without being formally agreed by the Trust board.	The Trust board has requested that material changes to the business plan are formally agreed between the Trust board and Circle.
The standing financial instructions do not reflect best practice within procurement and contracting and a number of revisions are proposed to reflect new procedures and processes.	Move to best practice for tendering and contracting procedure.

Source: Trust board paper

3.8 Under the agreement, Circle and the franchise manager are responsible for risk management. All NHS trusts are required to maintain a risk register, however, in the early stages of the agreement a new document to reflect the changed circumstances was not in place, leaving the Trust vulnerable to unanticipated problems. This was discussed by the Trust board at its February 2012 meeting where it was agreed further work was required by both the Trust and Circle to develop a board assurance framework in conjunction with a high-level corporate risk register to reflect the new arrangements. It was also agreed that a franchise management risk register needed to be developed to reflect the risks associated with the Trust board discharging its reserved powers. Drafts of both risk registers were presented to the audit committee in September 2012 where it was agreed the franchise management risk register would become the Trust board risk register to better reflect the Trust board's responsibilities identified in the franchise agreement.

The Trust will be performance managed by NHS commissioners

3.9 Commissioners will manage the clinical performance of the Trust, through the NHS standard acute contract in the same way as any other NHS trust. The NHS standard acute contract reflects the requirements of the NHS operating framework, which sets out the planning, performance and financial requirements for NHS organisations and how they will be held to account. National performance measures set out in the NHS standard acute contract include the four-hour accident and emergency waiting time standard and rates of the health-care associated infection *Clostridium difficile*. Breaches of these standards can result in commissioners imposing financial penalties against the Trust which would have an impact on its income and, by extension, Circle's potential franchise fee.

The Trust board is developing its performance management and public accountability roles under the franchise agreement

3.10 To support the Trust board in its performance management role, the agreement contains a small number of key performance indicators in addition to performance measures specified in the NHS standard acute contract. These indicators focus on workforce metrics such as reducing the annual sickness absence rates, improving staff recruitment, staff satisfaction and overall patient experience. Depending on annual performance against these indicators, any franchisee fee earned by Circle can be increased or reduced by up to 10 per cent. Circle can also be financially penalised for each breach of a range of stand-alone performance indicators covering patient confidentiality, maintaining patient records, human resources, and staff training.

3.11 In April 2012, the Trust board identified that if it was to effectively meet its performance management and its public accountability obligations, it needed to work with Circle to develop a more comprehensive range of key performance indicators that could be reported monthly. Such performance indicators would cover not only workforce metrics, but also financial indicators and indicators for areas such as clinical quality, patient safety, and service performance that are excluded from the NHS standard acute contract. The franchise manager is now developing a more comprehensive range of key performance indicators, in collaboration with Circle, so the Trust board can review performance on a monthly basis.

There have been improvements in some areas of the Trust's clinical performance

3.12 Performance data for the franchise indicate that improvements have been made in a number of areas:

- Having previously been considered the worst accident and emergency department in Cambridgeshire in terms of waiting times standards the department is now rated the best in the area covered by the Authority.
- The Authority recently launched a new inpatient satisfaction measure known as the 'net promoter score'. In May, Hinchingbrooke achieved the joint top score, however, this score has dropped since then. In August, of the 46 trusts in the region, the Trust was ranked twelfth.
- The Trust achieved cancer waiting time standards for five consecutive months between February 2012 and June 2012, having not done so since June 2010. Since then the waiting time targets were missed in July, but met in August and September.
- In 2011, some of the work carried out by the Trust's colorectal department was moved to another hospital after six serious incidents. Circle put in place a detailed action plan to address the Trust's failings in March 2012. Although it remains a work in progress, improvements have been made including appointing a new surgical tutor to support junior medical staff and a full time colorectal clinical nurse specialist.

3.13 Performance in other areas, however, has been less favourable. For example, at the end of September 2012, the Trust reported seven cases of *Clostridium difficile* against a planned 2012-13 limit of seven. This equals the total number of cases in 2011-12.[8]

8 The Trust altered its testing procedure in April 2012 in line with new guidelines, and now uses a two-tier testing system. This new system is likely to identify more Clostridium difficile cases than before.

The Trust's financial position is worse than projected after six months, with several immediate financial challenges to be addressed

3.14 Although the Trust has achieved in-year financial balance since 2008-09, it has only done so through combining one-off saving measures with financial support from the Authority. This means that Circle targeted £9.9 million savings in year one which is greater than the £5 million savings anticipated in its bid. The overall financial challenge for the Trust in 2012-13 is therefore substantial for four reasons:

- The Trust started 2012-13 with an underlying deficit of between £3 million and £4 million, which was covered with non-recurrent funding from the Authority and NHS Cambridgeshire in 2011-12.
- The in-built efficiency within the national payment-by-results tariff system whereby all trusts will receive 4 per cent less than they received for the same activity in 2011-12 places a further financial pressure on the Trust of approximately £4 million.
- Internal cost pressures within the Trust.
- NHS Cambridgeshire plans to reduce the level of activity in the hospital.

3.15 By the end of September 2012, the Trust had generated a deficit of £4.1 million, which was £2.2 million adverse to Circle's financial plan to that point. The main reasons for the financial position being worse than projected are as follows:

- The Trust overspent by around £1.6 million on agency and bank costs to cover staff vacancies including consultants. The Trust has appointed ten consultants who started between July and September which will reduce future agency costs.
- The Trust spent almost £1.5 million above planned levels on non-pay costs.

3.16 Circle also now expects to make only £7.5 million of the £9.9 million cost improvement savings originally targeted for 2012-13. It is, however, developing £2 million of new savings schemes to be implemented to cover the majority of the shortfall.

Circle is working with the Trust's staff to support the franchise and will offer employees shares as a performance incentive

3.17 Before the agreement began, more than 1,200 of the Trust's 1,700 staff attended a four-hour meeting to discuss their ambitions for the Trust's future with Circle. The result was a 16-point plan, with the overall aim of becoming one of the top ten district general hospitals in the country against a range of different measures. Targets on patient safety, patient experience, value for money and staff engagement have been set but are not included in the franchise agreement.

3.18 Circle is planning to offer all staff at the Trust the opportunity of receiving shares in Circle Partnership Limited. Shares will be issued to staff on the basis of their contribution. Circle anticipates that the first round of shares will be offered at the end of the 2012-13 financial year. There is no register of interests for the Trust, but the Trust board has identified this is an issue that needs to be addressed. Circle has confirmed that there are no local GPs within its partnership and that there will be no conflicts of interest related to GP referrals to the Trust.

The franchise aims are clearly stated but stakeholders have contrasting views on what constitutes success

3.19 Having a common understanding of success ensures that all parties are working to achieve the same outcomes. The agreement states that the aim of the franchisee during the term of the agreement should be "to both provide high-quality clinical services and to aim to generate a Trust Annual Surplus as set out in the relevant Budget in each Contract Year". If annual surpluses are delivered as planned, the Trust will have achieved recurrent financial balance and the cumulative deficit will have been paid by the end of the agreement in 2022.

3.20 During our interviews with the Department, HM Treasury, the Trust board and Circle, however, we were given a number of different views on what would be considered a successful outcome. These included:

- the Trust remaining open and providing high-quality clinical services;
- the financial position of the Trust not worsening as much as projected in the trust comparator scenario;
- the Trust returning to a recurrent position of in-year break even;
- part of the cumulative deficit being paid off; or
- all of the cumulative deficit being paid off.

3.21 A statement on progress after six months issued by Circle in August 2012[9] focused on the Trust's performance in areas such as waiting times, patient satisfaction, and on identifying procurement savings. It did not mention financial performance though the financial position of the Trust was reported in the Trust board papers. The Trust board is, however, seeking to establish a single set of performance metrics, as part of its review of the agreement's performance indicators, to ensure public reporting on progress is consistent and transparent.

Franchise agreements are being considered by other NHS trusts before the outcomes of the project can be assessed

3.22 Hinchingbrooke is the first NHS trust to be run as an operating franchise. This approach is untested in the NHS and it is too early to establish and understand the outcome. However, other NHS trusts in the foundation trust pipeline are working with their strategic health authorities to consider the applicability of a franchise model. Although the Office of Government Commerce health gateway review recommended that the project be reviewed, there has not yet been a formal lessons learnt exercise to inform future projects.

9 Available at: www.circlepartnership.co.uk/about-circle/media

Appendix One

Our audit approach

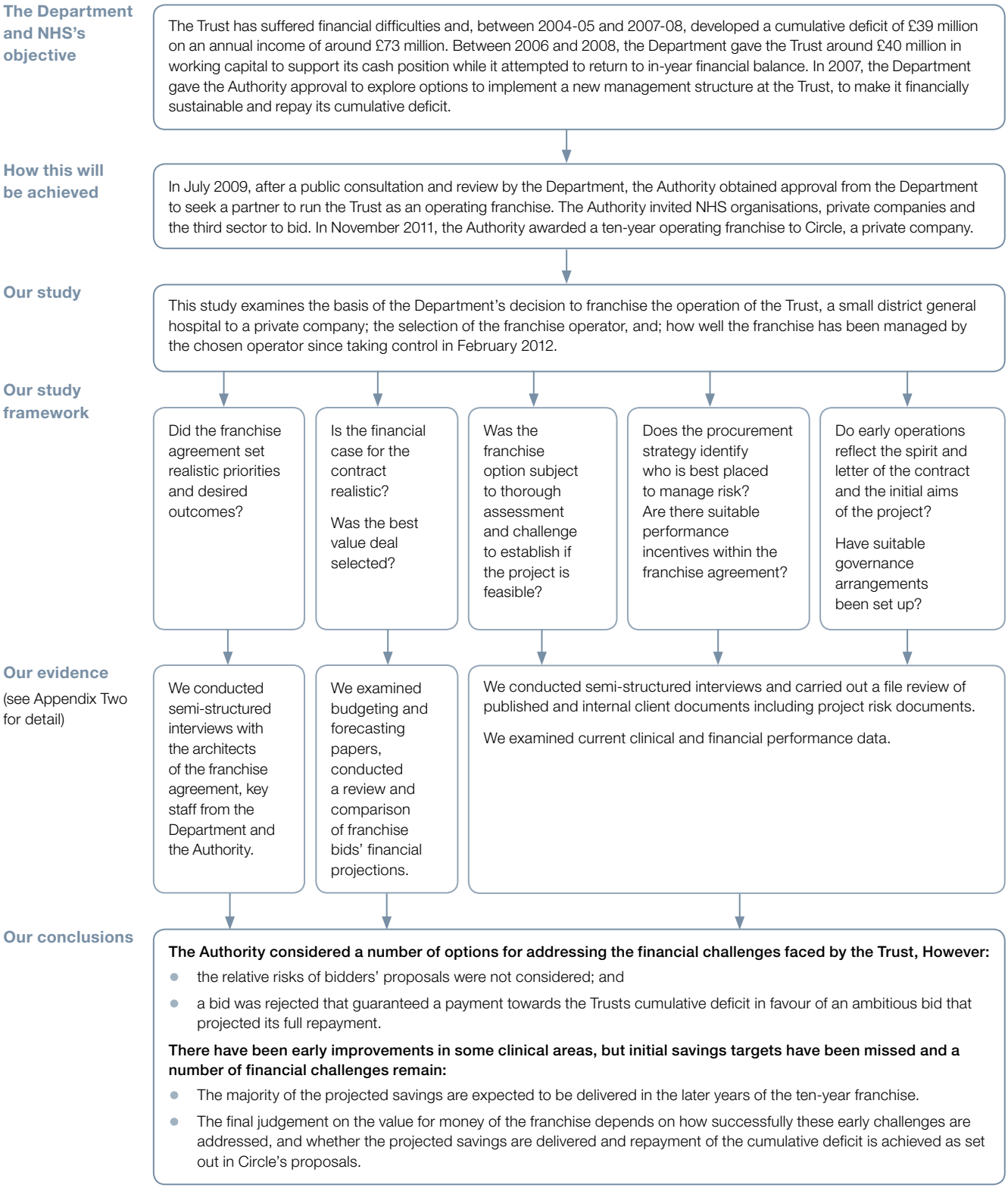
1 This report provides our view on whether the franchising of operations to Circle, a private company, is likely to give value for money to the Hinchingbrooke Health Care Trust. It looks at the way in which suitable private sector providers were identified, the procurement of Circle, the contract terms agreed and the safeguards over the quality of clinical provision.

2 The framework we used is based on the NAO's *Initiating Successful Projects* framework and focuses on:

- **Purpose** – Did the franchise agreement set realistic priorities and desired outcomes?
- **Affordability** – Is the financial case for the contract realistic? Was the best value deal selected?
- **Pre-commitment** – Was the franchise option subject to thorough assessment and challenge to establish if the project was feasible? Was it tested in any way?
- **Project set-up** – Did the procurement strategy identify who is best placed to manage risk? Are there suitable performance incentives within the franchise agreement?
- **Delivery and variation management** – Do early operations reflect the spirit and letter of the contract and the initial aims of the project? Have suitable governance arrangements been set up?

3 Our audit approach is summarised in **Figure 12** overleaf. Our evidence base is described in Appendix Two.

Figure 12
Our audit approach



Appendix Two

Our evidence base

1 Our fieldwork took place in August and September 2012.

2 We applied an evaluative framework to consider whether the process used to procure Circle as franchise operators was optimal and whether the franchise agreement is well placed to achieve value for money during the course of its ten-year duration. Our audit approach is outlined in Appendix One.

3 We examined whether the franchise agreement set realistic priorities and desired outcomes:

- We reviewed the outline business case, the full business case, the franchise agreement and board minutes to assess whether the aims were achievable and whether such goals would represent good value for the Trust. We also looked at the options that were considered prior to deciding on the franchise model.
- We undertook semi-structured interviews with stakeholders, including a senior manager of the Authority, Dr Stephen Dunn, HM Treasury, NHS East of England, local clinicians and Circle.

4 We looked at whether the financial case for the contract was realistic and whether the best value deal was selected:

- We conducted a sensitivity analysis of the two bids that were considered for the franchise (Serco and Circle) using a financial model and assessed them against what the projected Trust surplus/deficit would have been without initiatives and evaluated the assumptions made. In addition, we examined the meeting minutes which described how the decisions were made.

5 Was the franchise option subject to thorough assessment and challenge to establish if the project was feasible? Was it tested?:

- We drew on evidence from our previous work, for example our study on managing relationships in PFI contracts and rail franchising to establish whether the necessary due diligence was applied prior to deciding on the franchise model and looked at the alternative options that were considered.

6 Did the procurement strategy identify who is best placed to manage risk? Are there suitable performance incentives within the franchise agreement?:

- We looked at the project risk register and have examined the governance arrangements listed in the full business case and franchise agreement. We also reviewed board and Audit Committee minutes which highlighted omissions from the signed agreement. We looked at the key performance indicators specified in the agreement and looked at what level of performance improvement would be necessary to achieve them. In addition, we looked at whether the KPIs incentivised performance against the aims noted in the franchise agreement.

7 Do early operations reflect the spirit and letter of the contract and the initial aims of the project? Have suitable governance arrangements been set up?:

- The franchise agreement was signed in February 2012, so there is relatively little performance data available. We looked at the type of data being collected and whether that enables the Trust board to effectively performance manage the franchisee, as well as assessing the early clinical and financial indicators.

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