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AUDITOR GENERAL

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Peterborough and Stamford Hospitals
NHS Foundation Trust

Peterborough and Stamford Hospitals NHS Foundation Trust

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Peterborough and Stamford Hospitals
NHS Foundation Trust

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Report by the Comptroller and Auditor General

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Amyas Morse
Comptroller and Auditor General
National Audit Office

22 November 2012

Peterborough and Stamford Hospitals NHS Foundation Trust featured as a case study in our 2012 report: *Securing the future financial sustainability of the NHS*. Following this, the Committee of Public Accounts asked us to look further at the circumstances underlying the Trust's serious financial difficulties.

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This report can be found on the
National Audit Office website at
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Key facts

£411m

the estimated total liability of the PFI scheme (build cost and finance costs) to the Trust, was **£411 million** when the hospital was completed

£45.8m

the Trust recorded a deficit of **£45.8 million** in 2011-12

£41.6m

the cost of the PFI scheme to the Trust in 2011-12, including adjustments

- £64 million** The Trust's current target for cumulative efficiency savings by 2016-17 is **£64 million**.
- 10 months** There was a gap of **10 months** between when the hospital became fully operational and when the trust was placed in significant breach of their terms of authorisation for financial reasons.
- £54.3 million** The Trust's forecast deficit for 2012-13 is **£54.3 million**.
- 5** There have been **five** CEOs at the Trust since identification of the preferred bidder for the PFI scheme.
- 142 per cent** The capital cost of the scheme as a proportion of turnover was **142 per cent, the largest in the NHS** (the two trusts with the next highest proportion – St. Helens and Knowsley NHS Trust, and Sherwood Forest Hospitals NHS Foundation Trust – are also in financial difficulty).
- £20.5 million** The strategic health authority paid **£20.5 million** of transitional support to the Trust for its PFI scheme in 2010-11, £10 million of it advanced from future years, to limit the Trust's deficit to £1.5 million.
- 22 per cent** The size of the Trust's deficit in 2011-12 was **22 per cent** of its turnover (South London Healthcare NHS Trust had the second highest deficit at 15 per cent).

Summary

1 Peterborough and Stamford Hospitals NHS Foundation Trust (the Trust) was authorised as an NHS foundation trust in 2004. It provides acute health services to patients in Peterborough, Cambridgeshire and Lincolnshire. It had a turnover of £208 million in 2011-12 and employs approximately 3,400 staff.¹

2 The Trust's main site is a 611-bed hospital. The Trust has streamlined its Peterborough operations on to one site from three through a private finance initiative (PFI) funded scheme. The new hospital became fully operational in December 2010, at a book value of £301 million and a total cost of £411 million, including financing. The whole scheme was known as the Greater Peterborough Health Investment Plan. The plan also included providing much smaller facilities for Cambridgeshire and Peterborough Mental Health Partnership NHS Trust and the Greater Peterborough Primary Care Partnership.

3 The Department of Health (the Department) approved the PFI scheme in June 2007. It did so even though Monitor, the foundation trust regulator, raised serious concerns about the affordability of the scheme, although these did not anticipate the scale of the problems that has since emerged. HM Treasury had previously approved the scheme, but only subject to the Trust addressing Monitor's concerns. The scheme was approved before the banking crisis in 2008, at a time of rapid growth in health spending. In the period since the hospital has been operational, health spending has been broadly flat in real terms.

4 The Trust reported surpluses each year from 2006-07 until making a small operating deficit in 2010-11 (after including £20.5 million of one-off support for the PFI scheme from the strategic health authority (SHA)).² The Trust's auditors raised concerns about its continued financial viability as an organisation as part of their certification of the Trust's 2010-11 accounts. The Department announced in February 2012 that it is one of seven trusts eligible to receive additional support with the costs of its PFI scheme. The deficit increased to around £46 million in 2011-12.

5 Peterborough and Stamford Hospitals NHS Foundation Trust featured as a case study in our 2012 report, *Securing the future financial sustainability of the NHS*.³ Following this, the Committee of Public Accounts asked us to look further at the circumstances underlying the Trust's serious financial difficulties.

¹ Full-time equivalents.

² Excluding technical accounting adjustments ('impairments'), which would have increased the deficit to £168 million.

³ Comptroller and Auditor General, *Securing the future financial sustainability of the NHS*, Session 2012-13, HC191, National Audit Office, July 2012.

6 Part One of the report looks at the Department's approval of the PFI scheme; Part Two looks at the serious financial problems that the Trust has faced in the years since; and Part Three examines why finances deteriorated so much, and what is being done to put things right.

Key findings

The Trust's PFI scheme

7 **In 2007 the Trust board failed to recognise that the scheme would place considerable strains on the Trust's finances for many years to come.** Formal responsibility for confirming the affordability of the scheme rested with the board. Interviews with board members in post, three of whom were involved in the decisions covered in the report, and our review of the minutes showed that they were committed to the replacing of existing Trust hospital sites in Peterborough. The board considered current facilities, spread across three sites, made clinical service delivery difficult and expensive. They accepted unrealistic projections of future Trust finances (see paragraphs 1.18 to 1.21).

8 **The Department evaluated the scheme but was not sceptical enough about its affordability.** Unusually among foundation trusts the Trust had recorded a deficit in 2005-06, and was instituting a financial recovery plan. The scheme has the largest build cost in proportion to turnover in the NHS. The Department had the power to in effect stop the scheme proceeding, by refusing to issue a deed of safeguard. One key criterion against which the Department assessed substantial schemes was whether the annual payments to the contractor would exceed 15 per cent of Trust turnover. The Department has told us that its judgement about the 15 per cent ratio was the result of a general assessment of the affordability threshold for trusts, based on its understanding of the developing PFI market and estates costs in the NHS at the time. Since the Trust's calculations showed that it would only just achieve the 15 per cent, its case was vulnerable to any changes in the underlying assumptions. One crucial assumption was that payments to the contractor would be offset by proceeds from a projected land deal (which did not subsequently take place). Advice to the Department by a consultant, brought in to assess schemes submitted to the Department on a consistent basis, was that the land deal presented a significant risk to the scheme's affordability, but that the scheme could proceed. The Department has since lowered the 15 per cent threshold to 12.5 per cent, and changed the calculation to include all estate costs rather than just the scheme itself (see paragraphs 1.12 to 1.17).

9 The Trust board and the Department failed to satisfy Monitor's concerns on affordability. Monitor identified significant likelihood of the scheme becoming unaffordable to the Trust if 'reasonable assumptions' were applied. However, it lacked the formal powers and influence to persuade the Trust board or the Department. Although the letter makes clear Monitor had concerns about affordability, no one expected that the Trust could face financial problems on the scale that has since arisen. The Department was satisfied that Monitor's response indicated that the Trust had adequately addressed Monitor's concerns, although the letter makes clear this was not the case. HM Treasury relied on the Department to see that the Trust met their key conditions for approving the deal, including that the Trust addressed Monitor's concerns. Monitor gained the power to halt projects of this kind following changes to the accounting rules for PFI projects in 2009. The 2012 Health and Social Care Act removes this power, but the Department will have the power of veto over projects (see paragraphs 1.8 to 1.11).

10 Monitor, and the Trust board, did not adequately maintain focus on the Trust's financial performance as assumed in the business case, between scheme approval and opening the new hospital. The method by which Monitor allocates its financial risk rating cannot take account of concerns about future events. Monitor therefore rated the Trust as being a very low financial risk after signing the PFI contract. Neither the Trust board nor Monitor reviewed the assumptions in the business case following the signing-off of the contract to check that the key assumptions about the scheme's affordability continued to apply. If it had done so, it would have seen that expenditure was significantly out of line with business case projections by the end of the 2009-10 financial year. On three occasions between February and October 2010, shortly before the new hospital became operational, Monitor discussed significant events involving the Trust's financial performance and on each occasion "concluded that an intervention would not necessarily improve or change the outcome positively." Monitor placed the Trust in 'significant breach of its terms of authorisation as a foundation trust' in October 2011. Monitor has accepted, and is implementing the recommendations of an internal audit review of its oversight of the Trust. The actual construction of the new hospital proceeded to time and budget (see paragraphs 2.20, 3.3, 3.7 to 3.12).

The Trust's wider financial challenge

11 The severity of the Trust's financial situation has been compounded by weak financial management. Forecasts in the Trust's business case showed that the PFI scheme would only be affordable if the Trust could absorb any cost pressures and deliver sizeable efficiency targets. The efficiency savings achieved by the Trust failed to offset the effects of rising costs and unfunded increases in activity. The Department has told us that it will continue to fund the Trust's day-to-day operations (see paragraphs 2.1, 2.2, 2.7, 2.8, 3.24).

12 In 2011-12 the Trust's operating costs were around £58 million (31 per cent) higher than predicted in the scheme's business case. There were three reasons for this:

- The Trust failed to control its costs in the period following signing of the PFI contract. During this period there were increases in nearly all categories of staff, only some of which can be explained by activity increases; additional requirements resulting from changes to national quality standards; and new business developments which were not anticipated in the business case. Part of the reason that costs increased faster than income during the period can also be attributed to unfunded activity (see paragraph 14).
- The business case included unrealistic assumptions about the scope to control costs. The PFI business case, for example, predicted a net rise in staff costs of 8 per cent over six years. The actual figure was 40 per cent.
- The annual payment to the contractor, at 20 per cent of turnover, is broadly in line with the business case, but in absolute terms the outlay is much greater than predicted, partly because the business case included associated cost reductions that have not transpired (see paragraphs 2.14 to 2.21).

13 Between 2007 and 2011 the financial projections produced by the executive board proved to be inaccurate. In the years running up to the opening of the new hospital, the board papers and the Trust's submissions to Monitor did not accurately reflect the size of the financial risk faced by the Trust. Monitor is developing its regulatory frameworks to better ensure financial governance remains strong at foundation trusts (see paragraphs 3.4-3.6).

14 NHS Peterborough, the Trust's main commissioner, is not reimbursing the Trust for all of the healthcare it is providing. The level of activity the Trust undertakes is much greater than that envisioned in the business case. Activity levels have increased by more than 20 per cent in all main categories. However, NHS Peterborough has reduced payments to the Trust for underachieving against some national and locally-developed indicators of performance. This comes after NHS Peterborough struggled to stay within its Department of Health funding allocation and it adopted a more rigorous approach to contract management. In 2011-12 NHS Peterborough deducted approximately £9 million from payments through local penalties and other reductions and stayed within its allocated funding by £343,000. The Trust and local commissioners continue to discuss ways the Trust can be remunerated appropriately for delivering the right level of care in the right setting (see paragraphs 2.9 to 2.11).

15 Lack of cost control, a large increase in costs resulting from the new building (estates and financing) and underfunded healthcare activity have all contributed significantly to the Trust's financial deficit. We estimate that, as at 31 March 2012, failures to achieve efficiencies have contributed between £11 million and £14 million; large increases in costs resulting from the new building (estates and financing) £11 million and £26 million; and around £9 million of activity for which the PCT withheld payment (see paragraph 2.22).

The future

16 The consensus among those who have reviewed the Trust's current position is that long-term financial stability for the Trust depends on five factors (which are reflected in our recommendations):

- The Trust board needs strong executive and non-executive level leadership. It has already moved to bring in seven new executive and non-executive board members in the last year.
- The Trust needs to make significant efficiency savings without jeopardising patient safety or the quality of care provided. The Trust is forecasting to Monitor savings of £13.2 million for 2012-13.
- The Trust will need long-term financial support because its deficit is now too great for the Trust to balance its finances by managing its own resources. The Department announced in February 2012 that it will provide additional support to the Trust, together with six NHS trusts with unaffordable PFI liabilities, but has not yet explained how or how much.
- The commissioners, the Trust, other providers and wider stakeholders in the local health economy need to manage demand and fund activity in a financially sustainable way.
- The Trust is developing new business opportunities to take advantage of capacity released by better managing demand. The Trust is exploring the potential to create spare capacity within the hospital through more efficient working practices and developing plans to use the capacity to generate more income. The Trust will be assisted in this by the quality and attractiveness of the new facilities, which are already attracting patients from further afield (see paragraphs 2.11, 3.16, 3.19 to 3.23).

Conclusion on value for money

17 The Trust board developed, and enthusiastically supported, an unrealistic business case for the new hospital that incorporated overly optimistic financial projections. The Trust lacked the capacity and capability to deliver the financial performance improvements and cost control required to maintain financial sustainability. It therefore failed in its responsibility to secure value for money from its use of resources, even though the new hospital was delivered to time and budget.

18 In addition, the regulatory structure and approval processes put in place to evaluate major capital projects and regulate their implementation did not work as intended and did not ensure affordability. The Trust board's failure to respond fully to Monitor's early concerns about the affordability of the scheme was not addressed by the Department, and the Trust's deteriorating financial position was not responded to in a timely way by Monitor.

Recommendations

- a** **Where an oversight body has raised concerns about a business case, the Department should not give approval until they have been addressed.** Monitor raised serious concerns about the affordability of the Trust's PFI scheme with the Trust board, Department and HM Treasury. The scheme was approved, however, without these concerns being resolved to Monitor's satisfaction. The Department and Monitor learned lessons from Peterborough, and shortly after the approval of the Peterborough scheme, Monitor and the Department issued a joint protocol on their respective roles in the assessment of future schemes of this type.
- b** **When assessing the affordability of major capital projects, the Department and trust boards should place less reliance on benchmarks and test more rigorously the realism of projected cash flows.** One key test the Department used to approve the Trust's scheme, and from which the Trust board took assurance that it was affordable, was that the annual payments did not exceed 15 per cent of the Trust's annual turnover. Not only was the basis for choosing this threshold unclear, but it was a potentially misleading figure in that the Trust's financial projections showed that it would not achieve this until well into the life of the scheme. The Department should make decisions using metrics with a strong evidence base, and, when considering the impact of schemes on trust finances, require robust plans to cope with Monitor or Department of Health downside scenarios.
- c** **The Department and local commissioning bodies should work together with the Trust to address the Trust's serious financial difficulties and return the Trust to financial stability without undermining patient care:**
- The Department will need to commit to giving the Trust long-term financial support at a level that provides stability for the Trust.
 - Local commissioners everywhere should have to demonstrate that their plans consider the overall needs of the local health economy. In Peterborough, for example, commissioners have struggled for a number of years to fund health services while staying within their budget allocation. Commissioners have an important role to play in helping to provide a stable financial environment within the local health economy through measures to discourage inappropriate hospital attendances and funding based on realistic assessments of likely activity levels. Given the failure of the Trust and PCT to achieve agreement on the appropriate funding of activity, there is a need for an independent body to take the lead in developing a strategic solution for the local health economy.
 - Notwithstanding the above, the Trust will need to achieve demanding levels of efficiency savings over a number of years without adversely affecting patient care.

d Monitor should strengthen its oversight of the foundation trust sector.

Monitor raised concerns about the affordability of the scheme at an early stage, and began raising concerns again in 2010, but this did not impact on events.

To make sure it is better able to respond Monitor needs to:

- quickly implement the recommendations from the internal audit review it commissioned of the scheme;
- maintain a key role in the approval of major financial commitments for individual trusts beyond 2013; and
- develop a regime of regular in-depth reviews of existing foundation trusts to ensure that they continue to display the strong governance that originally earned them foundation trust status.

Part One

The Trust's hospital development

The Trust in context

1.1 Peterborough and Stamford Hospitals NHS Foundation Trust (the Trust) was one of the first wave of NHS trusts to be authorised as a foundation trust in 2004. As a foundation trust it has a greater level of financial and managerial freedom than NHS trusts. It first demonstrated strong financial management to Monitor (the independent regulator of foundation trusts) as part of the process of being authorised. Foundation trusts have more independence from the Department of Health than NHS trusts, and have powers to retain surpluses and borrow to invest in new services. The Trust is directly accountable to Parliament for its decisions through its chief executive. The Trust has had five chief executives since the Trust's selection of a preferred bidder for the PFI scheme in 2005. In the first six months of 2012-13 the Trust achieved 19 of 26 performance indicators set by the Department or contained within Monitor's compliance framework, and regulators have no safety concerns.

1.2 The Trust provides hospital care to inpatients and outpatients, commissioned on behalf of their local populations by six main primary care trusts (PCTs), to a population of around 350,000. It had an income of £208 million in 2011-12, slightly below the median value for foundation trusts, and employed approximately 3,400 staff⁴, in Peterborough City Hospital (611 beds) and Stamford Hospital (22 beds). Peterborough City Hospital is a new building funded under the private finance initiative (PFI). It combines services previously supported on three separate sites. The capital cost of the scheme had a book value of £301 million (the total including finance costs was £411 million). The new hospital became fully operational in December 2010. This part of the report explains how the scheme was developed and approved.

The development and approval of the Trust's PFI scheme

1.3 In July 2000 the government announced that it would provide investment for 100 new hospitals by 2010.⁵ The Department has previously told the Committee of Public Accounts that the only way to achieve this was through PFI, which the Committee reflected in its report.⁶

4 Full-time equivalents.

5 *The NHS Plan: a plan for investment, a plan for reform*, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960

6 Available at: www.publications.parliament.uk/pa/cm201011/cmselect/cmpublic/631/631.pdf

1.4 In February 2001 the Department approved the strategic Greater Peterborough Health Investment Plan. The plan was designed to address the outdated care facilities within the Trust and financial inefficiencies from operating inpatient services in Peterborough across three sites. The schemes also proposed bringing on to the site mental health facilities provided by Cambridgeshire and Peterborough Mental Health Partnership NHS Trust and older people's services provided at that time by the Peterborough PCTs. The scheme was supported by commissioners and the local mental health trust. The options looked at centralising services on either of the two main hospital sites in Peterborough into a single operation.

Roles and responsibilities

1.5 The role of each party in the investment approval process for foundation trusts is shown at **Figure 1**. These roles were codified in a protocol issued jointly by the Department and Monitor on 21 June 2007, three days after the Department wrote to the Trust giving approval for the scheme to proceed.

Figure 1
Roles in approving the Peterborough and Stamford PFI scheme

Besides the Trust board, a number of other stakeholders had important roles in approving the project

Stakeholder	Area of responsibility
Monitor	To review the proposals and assess their potential impact on the Trust's financial viability, as measured by Monitor's financial risk rating.
Department of Health	To satisfy themselves a deed of safeguard could be issued for the scheme, which guarantees that the Secretary of State will underwrite the scheme should the Trust be unable to meet its payments to the PFI contractor. Without the deed, the scheme would not proceed.
The board of the Trust	As a foundation trust, the board of directors were formally responsible for approving or rejecting the proposals.
North and South Peterborough PCTs (Peterborough PCT from October 2006)	To confirm that the activity levels projected in the business case agreed with the intentions of the PCT.
Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (East of England SHA from July 2006)	To review the credibility of the Foundation Trust's future activity assumptions and consistency with PCT plans (a key factor in the affordability of the Trust's proposals). Also required to review the affordability of the proposals as they would affect the other two NHS partners in the contract, since they were not foundation trusts.
HM Treasury	The Department needed the Treasury's approval before it could sign the deed of safeguard.

Source: Department of Health and Monitor

1.6 The timetable for the scheme, with key interventions by stakeholders, is shown in **Figure 2**.

1.7 In the following paragraphs we examine how each of the parties with a role in the approval process for a foundation trust discharged their responsibilities.

Monitor's actions

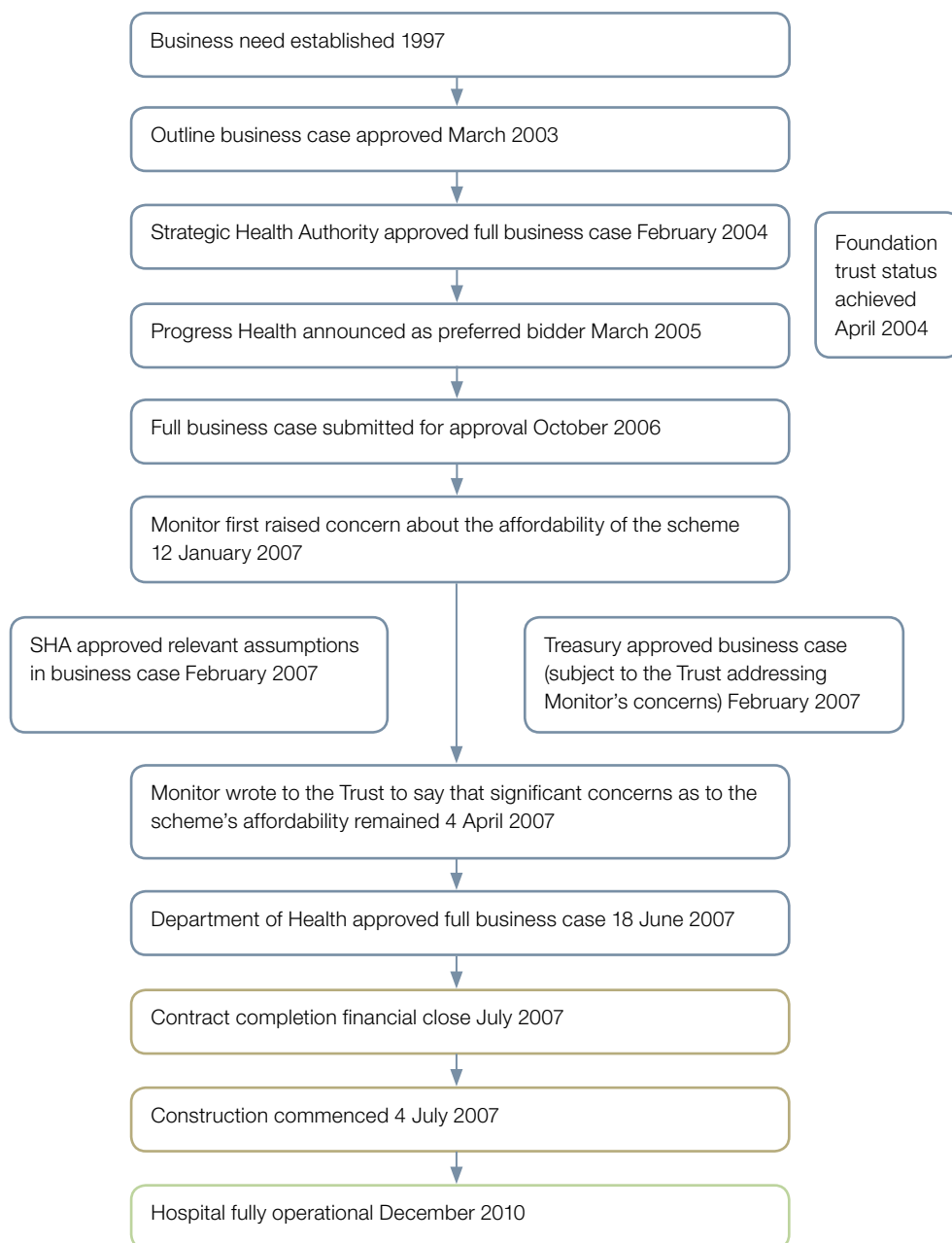
1.8 Monitor raised well-founded concerns about the affordability of the Trust's scheme but was unable to influence the Trust board or Department to address these concerns. Monitor had no powers to stop large capital investments by foundation trusts when this scheme was passing through the approvals process. On 12 January 2007 Monitor wrote to the Trust stating that it believed the long-term affordability of the proposal was in significant doubt, although no one expected that the Trust could potentially face financial difficulties on the scale that has subsequently emerged. Monitor copied the letter to the Department and HM Treasury. In particular, Monitor raised concerns about the following:

- The ability of the Trust to make strong financial surpluses during the construction period to prepare it for higher costs when the scheme was operating. The Trust forecast that its financial performance would be as strong as any foundation trust in the country. This contrasted strongly with the fact that it was currently executing a recovery plan to improve efficiency and productivity.
- Compared with the Department's published guidance on financial assumptions, the financial model underestimated the rate of pay and non-pay inflation, and overestimated the tariff payments from commissioners.

1.9 The Trust replied on 16 March 2007 that if Monitor's financial projections were correct this would indeed make the scheme less affordable. However, the financial challenge would continue to exist for the Trust (and other trusts) irrespective of the PFI deal. The board considered its approach was "prudent and reasonable", based on further stress testing of the business case. It reiterated that there was no alternative to using the PFI approach, which would only increase costs "over the status quo by £3 million to £4 million per annum". However, this was the difference between the PFI and public sector comparator options in the business case, not the additional costs to the Trust of the PFI scheme.

1.10 Monitor's response on 4 April 2007 clearly indicated continued scepticism about the Trust's ability to deliver sustainable improvements in performance which would make the annual payment to the contractors affordable. The Trust board minutes record, however, that the Department and the strategic health authority (SHA) were satisfied that Monitor's response indicated that the Trust had adequately addressed Monitor's concerns. Monitor considered that its statutory powers of intervention were very limited, and that use of them would be inappropriate.

Figure 2
Timeline of the PFI procurement



Source: National Audit Office

1.11 In 2009 changes to the accounting rules for PFI projects would have allowed Monitor to stop the scheme if the contract was not already signed. If the Trust had put the project forward after the changes were introduced, the value of the project would have had to be less than half the total liability represented by the actual PFI scheme in order for it to be accepted. Monitor decided that it had no alternative but to accommodate existing schemes like Peterborough's within the new system. Following the passing of the Health and Social Care Act 2012, Monitor's power to stop proposed schemes through this route will end from April 2013, although they potentially do now have the power to intervene through scrutiny of trusts' performance against Monitor's newly introduced provider licence. Foundation trusts will, however, have to gain the Department of Health's approval when seeking to borrow money.

The Department of Health's actions

1.12 The Department evaluated the Trust's PFI scheme but was not sceptical enough about its affordability. The Department carried out its own analysis of the business case on several occasions during 2006 and 2007, to satisfy itself that it could sign the deed of safeguard for the scheme (see Figure 1). The deed's function is to provide assurance to contractors that the government will fund the costs of a scheme should the trust fail. The Department and Monitor's protocol (see paragraph 1.5) made it clear that "without the deed of safeguard there would be no commercial deal".

1.13 The Department's final submission on the project stated "we are satisfied the Trust has responded to Monitor's concerns adequately" even taking into account Monitor's continuing disquiet. Internally, the Department took the view that "real pressure will be placed on the Trust if cash-releasing efficiency savings continued to be requested [beyond 2009-10], however such pressure would exist regardless of whether or not the PFI scheme was undertaken", so it did not consider the potential impact of this on the affordability of the scheme. The scheme was approved prior to the banking crisis at a time when the NHS was experiencing significant real terms funding increases.

The Department's measure of affordability

1.14 The capital cost of the scheme, at a book value of £301 million, represents 142 per cent of the Trust's 2011-12 turnover (the total including finance costs was £411 million). The two trusts with the next highest proportion of cost against turnover for an NHS PFI scheme are also facing financial difficulties:

- St. Helens and Knowsley NHS Trust will, like Peterborough, be eligible to receive additional support from the Department on account of its PFI scheme (PFI scheme cost 131 per cent of turnover); and
- Sherwood Forest Hospitals NHS Foundation Trust was placed in 'significant breach of its terms of authorisation' as a foundation trust by Monitor in September 2012 (PFI scheme cost 138 per cent of turnover).

1.15 In appraising the proposed scheme, the Department deemed the annual payment to the contractor by the Trust to be at the threshold of affordability. The Department's maximum acceptable level for the charge was 15 per cent of Trust turnover.⁷

1.16 The Department applied the '15 per cent rule' across PFI projects of all kinds that were intended to replace a substantial proportion of a trust's existing estate. It included those covering the scheme's build costs to those also covering supply of services to operate the building and the clinical services within it (as in Peterborough and Stamford's case). The Department has told us that its judgement about the 15 per cent ratio was the result of a general assessment of the affordability threshold for trusts, based on its understanding of the developing PFI market and estates costs in the NHS at the time. The threshold was also intended to cover equipment replacement costs whether within or outside the scheme and in this case some of the equipment replacement costs were not included. Their inclusion would have breached the 15 per cent threshold. In our report on the foundation trust 'pipeline'⁸ we noted that the PFI schemes in the most financial difficulty could have annual payments in their first year of operation varying from 6 per cent to 20 per cent.

1.17 In June 2006 the Department brought in an external consultant to review outstanding PFI business cases submitted by trusts on a consistent basis. In his assessment, the reviewer highlighted an assumption in the business case that income from developing land through a joint venture with developers could net around £5 million off the contractor's annual payment from 2013-14.⁹ This assumption was critical to determining whether the Trust's financial projections met the Department's 15 per cent threshold. The reviewer said that "I remain of the view that [the land sale element] is a significant risk to the affordability of this PFI scheme." He nevertheless recommended approving the scheme. Disposing of the land will not now generate the income envisaged.¹⁰ The Department has now reduced this affordability threshold from 15 to 12.5 per cent of turnover, and changed the calculation to include all estate costs rather than just the scheme itself.

7 That is, the relevant estates payments made by the three NHS signatories to the deal should be below 15 per cent of their turnover in each case.

8 Comptroller and Auditor General, *Achievement of foundation trust status by NHS hospital trusts*, Session 2010-2012, HC 1516, National Audit Office, October 2011.

9 At 2005-06 prices.

10 In the business case, this income was only expected to commence in 2013-14 and so does not make up part of the current variation from the business case.

The Trust board's actions

1.18 The Trust board was committed to replacing existing hospital sites in Peterborough. The business case assessed the capital cost of implementing new NHS building standards and dealing with the existing maintenance backlog at over £200 million if a PFI solution was not pursued. However, it failed to recognise the full extent of the strain that the scheme would place on the Trust's resources in the longer term. It understood that it was formally responsible for approving the scheme and had identified a preferred bidder in March 2005. On the back of a £7.7 million deficit in its first year as a foundation trust, the Trust board decided in November 2005 that the scheme was unaffordable. After reducing the scope of the scheme, including removing 98 inpatient beds and ten critical care beds, the board certified that the scheme was affordable in May 2006.

1.19 When it came to scrutiny by the Department, the board was aware of the crucial importance of meeting the Department's 15 per cent threshold if it was to approve the project. The board was focused on achieving the agreed project sign-off date with the contractor. It was conscious that any delay could increase the price and compromise the affordability.

1.20 A few weeks before the deadline for signing the contract the board approved a change to how the Trust would pay the monthly instalments of the contractor's annual payment. Normally the payment for each month would be made on the final day of the month in question. With this revision, the payment would be made on the final day of the preceding month (that is, in advance). The board agreed to this in June 2007 in order to accommodate a late increase in the proposed scheme cost, without increasing the value of the annual payment. This was important because the scheme was only achieving the Department's affordability threshold by a small margin. The board had previously resisted this concession, saying that it would affect cash flow and had concerns that the Department and HM Treasury would not accept such terms, though these concerns were not borne out.

1.21 The board's commitment to the scheme, their desire to progress the project given its long gestation period, and clinicians' dissatisfaction with the existing buildings, took precedence over considerations about the disproportionate cost of the scheme relative to the turnover of the Trust. The business case required a very tight grip on future increases in the Trust's cost base and the need to make increasing efficiency savings.

The Strategic Health Authority and Primary Care Trusts' actions

1.22 The SHA and PCTs confirmed that projected revenue increases contained within the business case were reasonable. The Trust factored 'conservative' increases in patient activity levels into the scheme. The two main commissioners, North and South Peterborough PCTs¹¹, approved these increases as adequately reflecting likely demand due to population pressures and an ageing population. The East of England SHA, which oversees the PCTs, confirmed that these increases were affordable to the PCTs and that modelling of demand and capacity in the full business case appeared to be robust. In confirming that the activity projections were in line with the Trust's strategic approach, it did not commit itself to the specific numbers in the business case. In fact, the actual population of Peterborough in 2011 was some 11 per cent higher than predicted in 2003.

1.23 The East of England SHA was not officially responsible for confirming the affordability of the Trust's scheme, although it too said that Monitor's concerns would have to be met for it to give formal approval.

1.24 Internal Department documents reported that the SHA acknowledged an excess of acute capacity in this north western corner of the region over which it has strategic supervision, and that "the Trust has not factored into its capacity assumptions the impact of the ongoing review of acute services in the region that is being led by the SHA. It should be noted though, that the SHA has indicated that the likely result of this review will be a managed reduction in acute provision overall accompanied by a net transfer of activity to [Peterborough]... there already exists excess capacity within the local health economy (which the SHA review is intended to address)." The SHA, however, told us that there was no review as such, but that this is probably a reference to a consultation about the future of Hinchingsbrooke Health Care NHS Trust undertaken by Cambridgeshire PCT. This proposed a possible transfer of activity from Hinchingsbrooke to other local providers such as Peterborough and Stamford, but the SHA abandoned this approach as not viable after business case approval.

HM Treasury's actions

1.25 The Chief Secretary to the Treasury approved the project in February 2007, subject to the following conditions:

- The Trust should break even in the period up until the scheme becomes operational.
- The Trust addressed Monitor's affordability concerns.
- The scheme is affordable to the acute Trust and, over the course of the contract, the annual cost to the Trust would be within 15 per cent of Trust turnover.

HM Treasury required the Department to satisfy itself that these conditions had been met. The Trust wrote to the Department at the point the contract was signed to confirm that, in its view, it had met these requirements.

¹¹ On 1 October 2006 they combined to create Peterborough PCT, later NHS Peterborough.

Part Two

The Trust's financial crisis

2.1 In 2011-12, the Peterborough and Stamford Hospitals NHS Foundation Trust's (the Trust's) first full year of occupancy of the new hospital coincided with a collapse in its finances leading to a deficit of around £46 million (**Figure 3**). This represented 22 per cent of Trust turnover. By comparison, the next worst proportion of deficit to turnover in the NHS is 15 per cent (South London Healthcare NHS Trust, for which a Trust Special Administrator has been appointed under the Department of Health's [the Department] unsustainable provider regime). The Trust had increasing problems maintaining income levels while controlling its cost base. The implications of this were obscured prior to occupation of the new hospitals through the use of 'transitional support'. As a result, the Trust was already in a very weak position when it started to incur the unsustainably large additional costs of the private finance initiative (PFI) scheme.

Figure 3

The Trust's reported financial position, 2005-06 to 2011-12

Surplus or deficit (£m)



NOTES

- 1 Surplus or deficit after removing impairment costs. In 2010-11 the impairment charge was £167.4 million.
- 2 The small 2010-11 deficit was achieved through the bringing forward of transitional support of £10 million for the PFI scheme from future years. Total transitional support for the year was £20.5 million.
- 3 The figure for 2010-11 is the restated deficit following national accounting guidance changes.

Source: Peterborough and Stamford Hospitals NHS Foundation Trust

2.2 In 2011-12 expenditure increased by 17.2 per cent while income increased by under 1 per cent (**Figure 4**).¹² During the period before the scheme became operational income flattened out after 2009-10 while costs increased steadily. Some of this was due to the knock-on effects of the 2008 financial crisis. This left the Trust unable to absorb the additional costs associated with the scheme when it began. The annual payment to the contractor, however, was in line with expectations when the contract was signed (see paragraph 2.22).

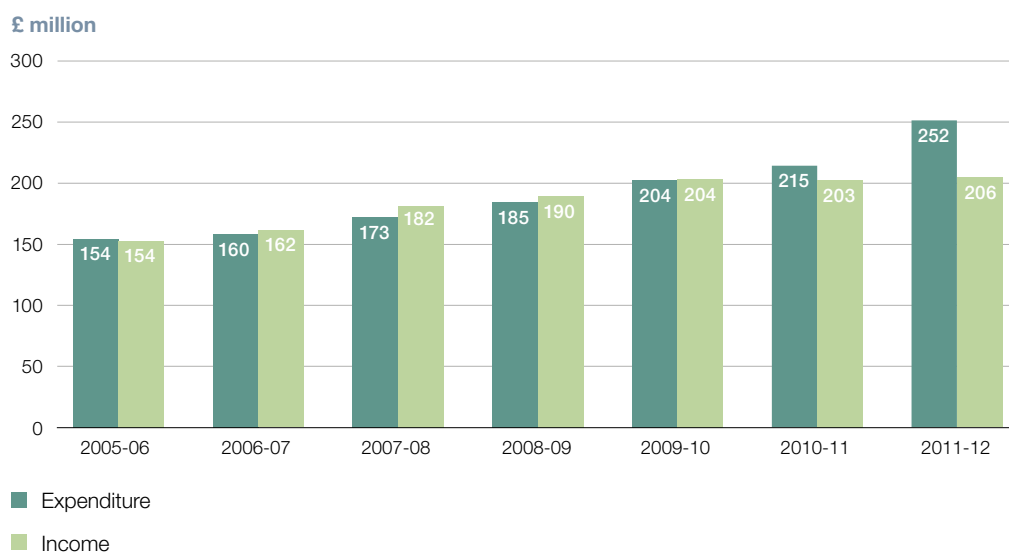
2.3 This part of the report explains that weaknesses in the Trust's financial position were attributable to a combination of:

- constraints on income (paragraphs 2.4 to 2.12); and
- failure to control costs, exacerbated by unrealistic assumptions in the business case, mandatory quality improvements and a number of business developments (paragraphs 2.14 to 2.21).

Figure 4

Income and expenditure, 2005-06 to 2011-12

Once additional PFI support from the strategic health authority (SHA) is removed expenditure has increased steadily while income is broadly flat



NOTES

- 1 These figures exclude impairments (technical accounting adjustments which do not affect the cash position). In 2010-11 the impairment charge was £167.4 million.
- 2 Income includes: income from patient care activities, other operating income and finance income. Income figures exclude transitional income: £0.8 million in 2007-08, £1.3 million in 2008-09, £3 million in 2009-10, £20.5 million in 2010-11 and £2.3 million in 2011-12.
- 3 Expenditure includes: operating expenses, loss on disposal of fixed assets, finance expenses and dividends payable to the Department. Expenditure figures exclude transitional costs: £0.8 million in 2007-08, £1.3 million in 2008-09, £3 million in 2009-10, £10.1 million in 2010-11, £1.2 million in 2011-12.
- 4 Figures have been rounded.

Source: Peterborough and Stamford Hospitals NHS Foundation Trust annual accounts

¹² These numbers exclude 'transitional' payments from the SHA associated with the PFI scheme.

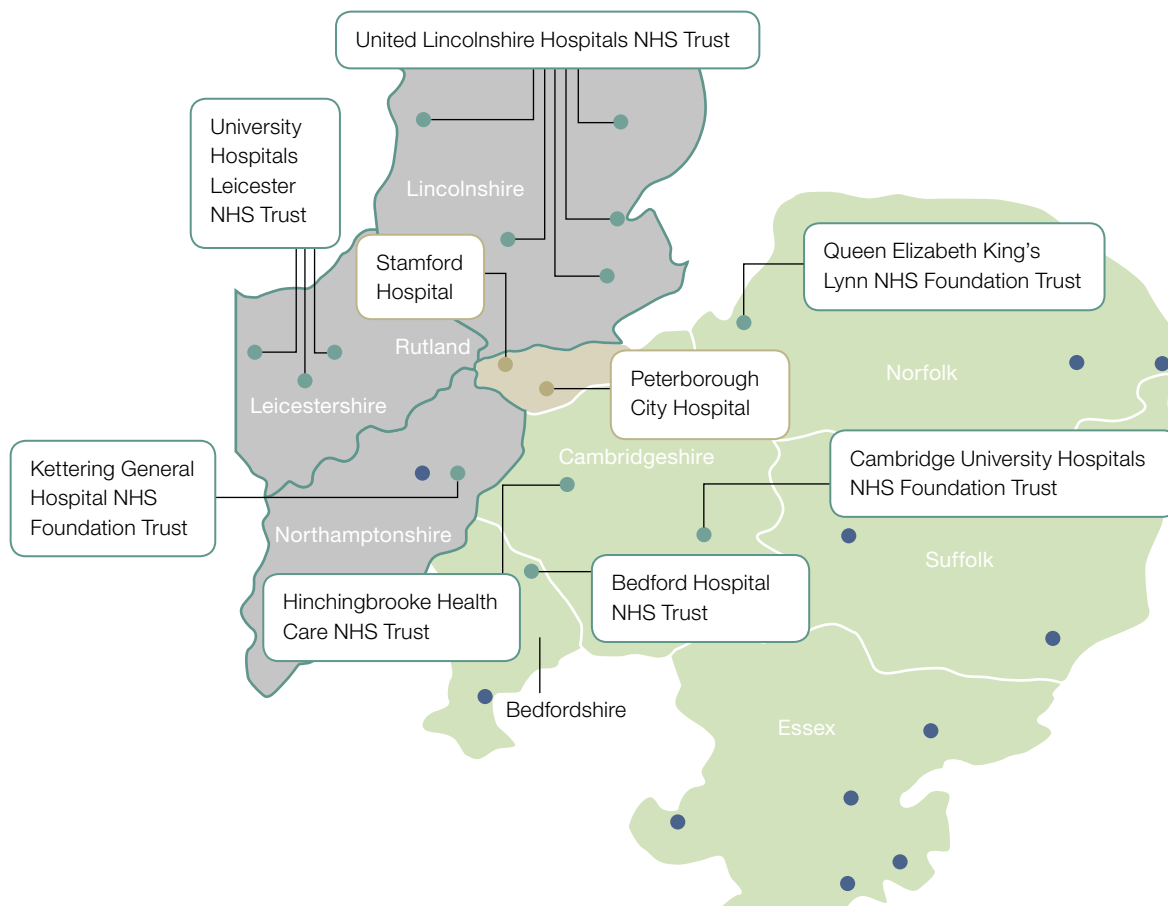
Constraints on income

2.4 There are four other NHS acute providers within 40 minutes' journey time of Peterborough, the closest being Hinchingsbrooke Health Care NHS Trust (Figure 5). There are 11 acute foundation trusts and seven acute NHS trusts in the East of England, which has a quickly growing population that, by 2010, had reached 5.8 million.

Figure 5

The local health economy and acute providers in the area

Peterborough and Stamford Hospitals NHS Foundation Trust is one of eight acute trusts in the area



- Peterborough and Stamford Hospitals NHS Foundation Trust
- Key surrounding acute hospitals
- Other acute trusts

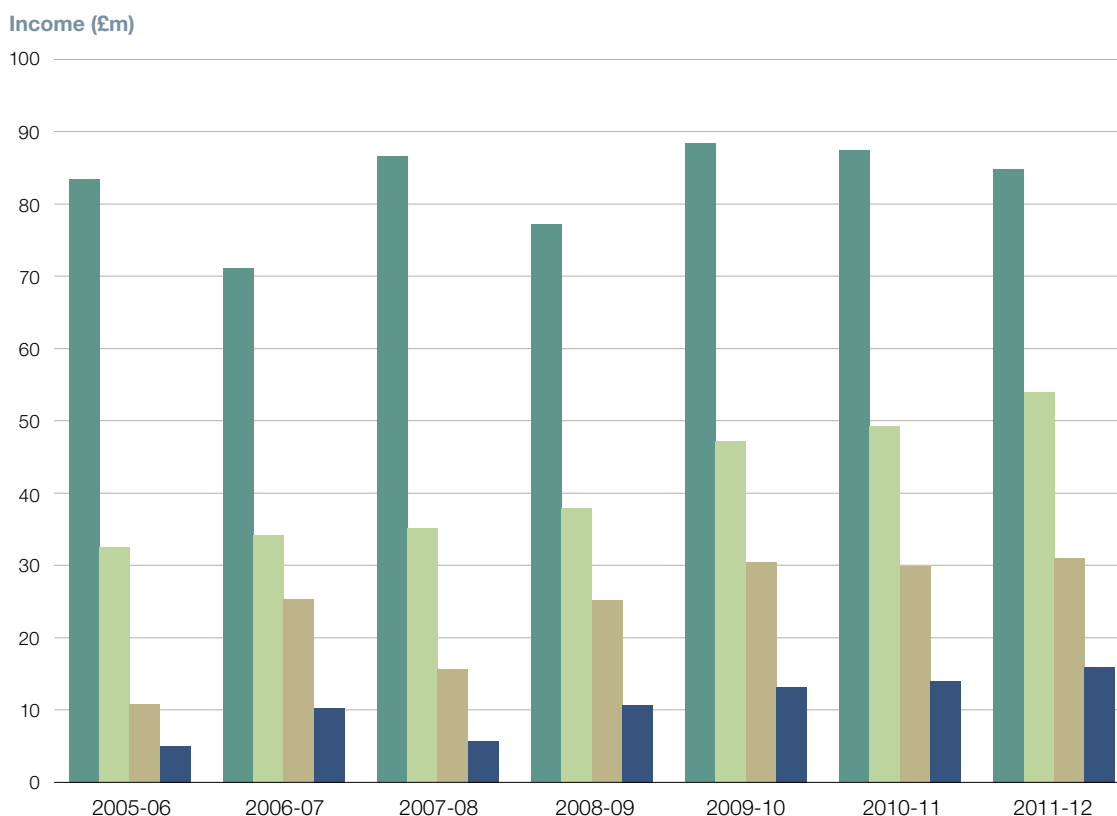
NOTE

1 The counties whose borders are dark green are part of the former East Midlands SHA. Light Green counties are part of the former East of England SHA. The two were combined in October 2011.

2.5 Ninety per cent of the Trust's contract income comes from NHS Lincolnshire, NHS Peterborough and NHS Cambridgeshire (the latter two now operate together as a single organisation).¹³ The Trust's income from patient care activities has continued to rise in recent years – by 3.6 per cent between 2009-10 and 2011-12. This increase is due to the Trust increasing income from NHS Lincolnshire and other primary care trusts (PCTs) on the periphery of the Trust's catchment area. Income from NHS Peterborough (the Trust's main commissioner), on the other hand, is now falling (see **Figure 6**).

Figure 6
Trust income by commissioner, 2005-06 to 2011-12

Income from the Trust's main commissioner has barely increased since 2005-06 in cash terms



	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
■ Peterborough	83.4	71.2	86.7	77.3	88.6	87.5	85.0
■ Lincolnshire	32.5	34.2	35.1	38.0	47.2	49.4	54.0
■ Cambridgeshire	10.8	25.3	15.6	25.1	30.5	30.0	31.0
■ Others	5.0	10.2	5.7	10.7	13.2	14.0	15.9

NOTES

- 1 In 2006-07 income from Peterborough fell while income from Cambridgeshire rose due to a redistribution of GP practices between the two.
- 2 The figures quoted reconcile with the Trust's audited accounts.

Source: Peterborough and Stamford Hospitals NHS Foundation Trust

¹³ At the end of 2011-12 the latter two were the only two PCTs with outstanding historic debts (of £21 million), which have since been cleared.

2.6 The Trust has experienced difficulties in growing, or even maintaining, its level of income due to:

- unplanned growth in activity which is not fully funded;
- the impact of downward pressure on contract payments by the lead commissioner; and
- the impact of changes to the timescale for the Trust's receipt of support for the scheme from the SHA.

Unplanned growth in activity

2.7 Unplanned activity growth weakens the financial performance and position of the Trust if commissioners do not fund this additional activity. The number of patients treated each year has consistently exceeded the levels agreed in contracts with commissioners. Some of this growth in activity can be explained by demographic changes, but the reasons for the rest are unclear. The Trust incurs costs of unplanned activity (for example additional staff), but reimbursement for activity above contracted levels has not been automatic. The Trust attributes increases in activity to the attractiveness of the new hospital to patients, improved road links and significant population growth, particularly numbers of older people.

2.8 Activity levels have increased by more than 20 per cent between 2005-06 and 2011-12 in each main activity category. **Figure 7** shows how the Trust's activity has increased at a faster rate than it had anticipated in its business case. For outpatients and for accident and emergency, activity has increased considerably rather than decreased as had been anticipated. The rate of growth in activity has exceeded the rate of income growth, partly due to changes in the way payments to trusts are calculated through the national tariff. The business case assumed that increased activity would generate additional income. In fact, the additional cost of treating these patients has exceeded the additional income.

Figure 7

Differences between business case assumptions and actual outturn for activity and income, 2005-06 and 2011-12

Activity or income category	What the business case predicted would happen to activity and income by 2011-12 (%)	What actually happened between 2005-06 and 2011-12 (%)
Elective activity	+8.9	+27.2
Elective income	+20.9	+18.8
Non-elective activity	+5.1	+24.4
Non-elective income	+17.8	-3.6
Outpatient activity	-13.7	+20.6
Outpatient income	-0.3	+17.5
Accident and emergency activity	-1	+22.2
Accident and emergency income	+6	+14.5

NOTE

1 Changes to the way that payments to Trusts are calculated since 2005-06 will impact, in particular, on non-elective income.

Source: National Audit Office analysis of Peterborough and Stamford Hospitals NHS Foundation Trust June 2007 business case data

The impact of downward pressure on contract payments by the lead commissioner

2.9 The Trust's income from NHS Peterborough PCT – the Trust's main commissioner – has reduced by more than 4 per cent in the last two years. Figure 6 shows how the amount of income from NHS Peterborough has varied year on year. The 15 per cent increase in payments from NHS Peterborough to the Trust in 2009-10 contributed to NHS Peterborough breaching its funding allocation by £12.8 million in that year. In May 2010 NHS Peterborough's board approved a financial turnaround plan designed to save an initial £20 million in 2010-11, with further savings thereafter. The plan identified spending on hospital services as the single largest factor in its 2009-10 overspend. NHS Peterborough has undertaken internal benchmarking which it believes shows it has a very high usage of hospital services compared to similar PCTs. The plan set out a programme of internal benchmarking, redesign of clinical pathways and reviews of the appropriateness of hospital admissions to reduce costs and improve quality and performance. Ernst & Young carried out a financial review for the acute Trust board in June 2010.¹⁴ They identified the PCT's financial difficulties as a risk and raised concerns that the Trust's financial plans for the year did not take account of this.

14 Ernst & Young, Peterborough and Stamford Hospitals NHS Foundation Trust: Financial plan, organisation and information review, 29 June 2010.

2.10 In implementing their turnaround plan NHS Peterborough PCT has disputed or reduced some payments to the acute Trust in two categories, which led to deductions of approximately £9 million (10 per cent) from payments to the Trust through local penalties and other reductions in 2011-12. NHS Peterborough stayed £343,000 within its funding allocation in 2011-12. The standard NHS acute contract contains provision to levy penalties for over-activity or poor performance to incentivise system improvements. NHS Peterborough has reduced contract payments to the Trust in connection with the following, with some subsequent improvement in performance:

- performance against national targets for stroke care;
- consultant-to-consultant referral rates; and
- time spent in the emergency department and the resultant level of admissions to a hospital bed.

2.11 In 2012-13, the Trust and NHS Peterborough and Cambridgeshire (who now operate together) agreed a contract broadly based on payment at full national rates (with some reductions) for a fixed level of activity, which both parties would work towards. Operational penalties would be reinvested in the Trust. However, demand is running significantly above contracted levels. Both parties are working towards contracting arrangements for 2013-14 that will reflect activity trends and national remuneration levels.

Financial support for the scheme from the Strategic Health Authority

2.12 It is standard practice for a trust implementing a new PFI scheme to receive 'transitional support' from the SHA to cover costs incurred specifically while developing and occupying a new hospital. The SHA agreed to provide £28 million of this type of support to the Trust spread over the period from 2007-08 to 2013-14. In 2010-11, however, the SHA allowed the Trust to bring forward transitional support from future years to a total of £20.5 million instead of the planned £10.5 million. The Trust therefore made a deficit of £1.5 million,¹⁵ much less than would otherwise have been the case. Trust board minutes record that it took this action to maintain an acceptable financial risk rating with Monitor. Having received this money in 2010-11, however, meant it was not available in future years. This was a major contributor to a fall in the Trust's income of more than £16 million in 2011-12.

¹⁵ As restated in 2011-12 accounts.

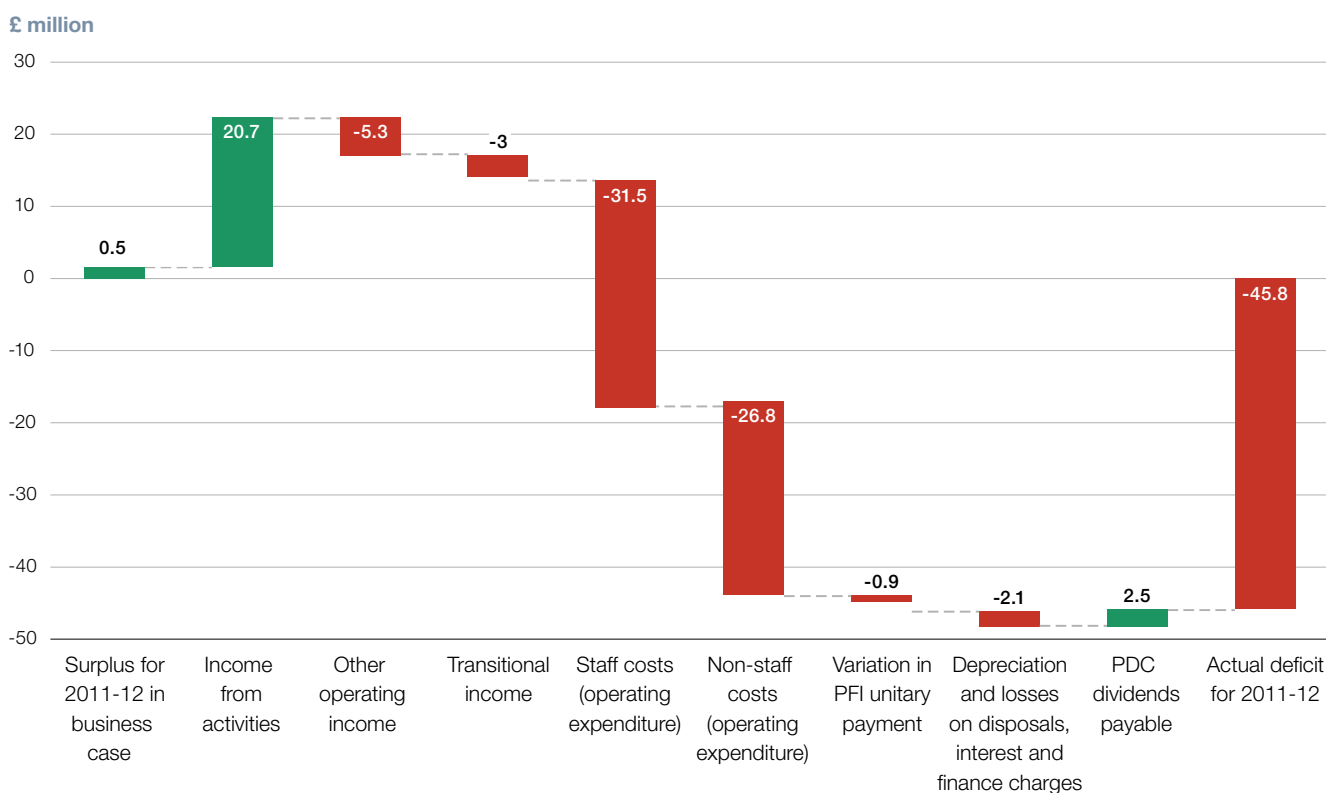
Failure to control costs

2.13 The Trust recorded a deficit of around £46 million in 2011-12, instead of the £0.5 million surplus projected in the business case. The main cause was that operating expenditure was some £58 million (31 per cent) higher than planned (**Figure 8**).

Figure 8

Difference between the Trust's actual financial performance in 2011-12, and the figure in the business case

Increase in operating expenditure was the major cause of the variance against the business case, not an increase in the annual payment to the PFI contractor



NOTES

- 1 Expected surplus from June 2007 business case.
- 2 The original forecast assumed that the annual payment to the contractor would increase by an estimated 2.5 per cent for inflation every year. A small element of the variation shown is due to the fact that over the period in question actual inflation has been higher.

Source: National Audit Office analysis of Peterborough and Stamford Hospitals NHS Foundation Trust data

2.14 The Trust has experienced these large increases in expenditure due to:

- failure to achieve required levels of efficiencies;
- large increases in staff costs, only some of which can be explained by increased activity;
- additional costs of running the PFI hospital (not just those within the annual payment to the contractor) and failure to plan for continuing estates and equipment costs outside the PFI contract; and
- several million pounds worth of quality improvements which the Trust had no choice but to implement and new business developments.

The situation was made worse by the fact that the business case was optimistic in its projections about a number of these costs.

Failing to make efficiency savings

2.15 The Trust's attempts to make efficiencies did not keep pace with expenditure increases (Figure 4 on page 21) and efficiencies built into the national tariff. The Trust set efficiency saving targets of approximately £3 million (1.7 per cent) each year until 2010-11, in line with its business case. Although it achieved this in 2009-10, more than half was actually due to increased income.

2.16 In 2008-09 the Trust had reorganised itself into six semi-autonomous clinical business units (CBUs) designed to improve clinical engagement. Ernst & Young's review of operating plans and the scope for efficiency improvements (see paragraph 2.9) reported that there were operating difficulties within CBUs. Each CBU was intended to operate as a 'mini foundation trust'. The board raised concerns about the operation of CBUs and failure to achieve savings early in 2009. These concerns increased through the remainder of 2009-10, as operating costs increased sharply.

2.17 In 2010-11 the Trust realised that it needed to make higher levels of efficiencies to reflect the more challenging financial environment but most business units failed to keep within their budgets and the Trust achieved only £5.2 million of the planned £9.3 million recurring savings. In 2011-12 the Trust achieved only £5.3 million of recurring savings against a planned £12 million.

Increased staff costs

2.18 Staff costs have risen year on year and by a total of 40 per cent from 2005-06 to 2011-12. In addition, £2.4 million was paid out in staff exit costs in 2011-12. The scheme's business case assumed an increase of only 8 per cent in pay costs net of efficiency savings. Among other things the business case assumed that national introduction of the electronic patient record would allow staffing efficiencies.

2.19 During this period there were increases in nearly all categories of staff, only some of which can be explained by activity increases or changes in operational requirements. The staffing implications of new ways of working in the new hospital had still not been finalised by mid-2010, only months before the new hospital was occupied. **Figure 9** shows how staff numbers continued to increase while the hospital was constructed and occupied.

Additional costs to the Trust of the new hospital

2.20 The increased costs of running the new hospital only account for part of the deficit. The business case predicted that the additional costs to the Trust attributable to the PFI scheme in the first full year of operation would be £17.3 million at 2011-12 prices. Cost reductions to the value of the additional PFI costs, attributed to single-site working and the ceasing of pre-PFI estates activities, were expected to offset these additional costs immediately, allowing the Trust to achieve a surplus in its first full year of the scheme's operation. The 2011-12 accounts show that premises costs actually increased by £26.7 million in 2011-12 compared with 2010-11. The new building was completed to time and budget but is smaller, overall than the pre-PFI estate. It has 20 per cent more clinical space for an almost identical number of beds. This is partly explained by a large increase in the proportion of single bedded rooms, which creates additional staffing costs.

Figure 9
Changes in staffing numbers since signing of PFI contract

Staff numbers of all types have increased

	2007-08	2011-12	Increase (%)
Medical and dental	305	417	37
Clinical administration staff	364	401	10
Administration and estates ¹	194	320	65
Healthcare assistants and other support staff	464	570	23
Nursing, midwifery and health visiting	932	1,152	24
Scientific, therapeutic and technical	420	471	12
Other	93	77	-17
Total	2,772	3,408	23

NOTE

¹ As at the end of 2011-12, 173 of the administration and estates staff remain on the Trust's payroll but are actually recharged at full cost to the PFI company. This does not impact on the headline unitary payment to the contractor. Approximately 50 of these staff were transferred from the previous cleaning contractor and were not within the 2007-08 figures although they were working in the Trust.

Source: Peterborough and Stamford Hospitals NHS Foundation Trust

2.21 Although the annual payment to the PFI contractor is higher than anticipated in the Trust's business case it represents broadly the same proportion of turnover as anticipated in the business case (**Figure 10**).

Relative contributions of higher costs and shortfall in income to the Trust's deficit

2.22 In **Figure 11** the NAO has attempted, after discussion with the Trust, Monitor and the Department, to provide some indication of the extent to which escalation in operating costs, the high costs of the Trust's estates and unfunded activity have contributed to the Trust's deficit. The level of under-achievement of efficiency savings and degree to which estate costs are excessive are open to a number of interpretations. We have therefore presented the ranges of values. The upper and lower ends of each range are based on reasonable assumptions about the additional costs, which could be used as optimistic and pessimistic estimates.

Figure 10

How the actual annual payments to the PFI contractor compares with those reviewed by the Department during the scheme approval process

Despite the Trust's large deficit, the headline payment to the PFI contractor is in line with expectations

	Figures reviewed by Department in June 2006 (£m)	Proportion of turnover (%)	Actual 2011-12 (£m)	Proportion of turnover (%)
Turnover	161.3		207.8	
Unitary payment	30.3	18.8	41.6	20

NOTES

- 1 Included in the unitary payment analysis above, an additional £2.1 million was paid to the contractor for variations and volume adjustment in 2011-12.
- 2 Turnover value for 2011-12 reflects the amount that the Trust was paid and therefore excludes the £9 million of revenue that was deducted by NHS Peterborough.
- 3 While the £41.6 million is the cost of the scheme in 2011-12 this does not reflect the charge to income and expenditure following previous changes to accounting rules.
- 4 The June 2006 figures excludes £1.3 million of medical equipment services which is included in the 2011-12 payments.

Source: National Audit Office analysis of Department and Trust data

Figure 11

Indicative values for contributory elements to the Trust's financial deficit, as at 31 March 2012

The three main areas identified in this part of our report have all made a significant contribution to the Trust's financial problems. One-off items of income and expenditure mean that a small part of the deficit might not be accounted for by these factors

Contributory factor	Likely level of contribution (£m)	Percentage of recurrent deficit ⁴
Cumulative impact of shortfalls in efficiency savings since 2006-07 ¹	11-14	27-34
Excess costs of estates functions, PFI and non-PFI ²	11-26	27-63
Activity unfunded by lead commissioner ³	9	22

NOTES

- 1 Shortfalls in efficiency savings against PFI business case assumptions (lower figure) and efficiencies built into the national tariff (higher figure).
- 2 The excess estates cost estimate is a comparison between the Trust's actual estates spending, at 24 per cent of turnover, and:
 - at the high end, the Departmental good practice figure that estates costs should constitute 12.5 per cent of turnover; and
 - at the low end, the business case assumption that the cost of the new hospital would be 19 per cent of turnover.
 The trust's actual estates spending figure includes all revenue estates costs but excludes capital elements.
- 3 Unfunded activity taken from paragraph 2.10 (the maximum payable in 2011-12).
- 4 These figures relate to a 2011-12 deficit of approximately £41 million when one-off items are excluded.

Source: National Audit Office

Part Three

Delays in identifying the financial problems and actions taken since

3.1 This part of the report explains:

- why Peterborough and Stamford Hospitals NHS Foundation Trust's (the Trust's) deteriorating financial position was not identified sooner, internally or externally;
- what happened once the board and Monitor were aware of the problems; and
- what further action is to be taken to stabilise the Trust financially.

Failing to identify emerging problems

3.2 The delay in the Trust identifying that the financial situation was far worse than predicted in the private finance initiative (PFI) business case or the Trust's financial planning process was due to shortcomings in its internal financial management and external oversight.

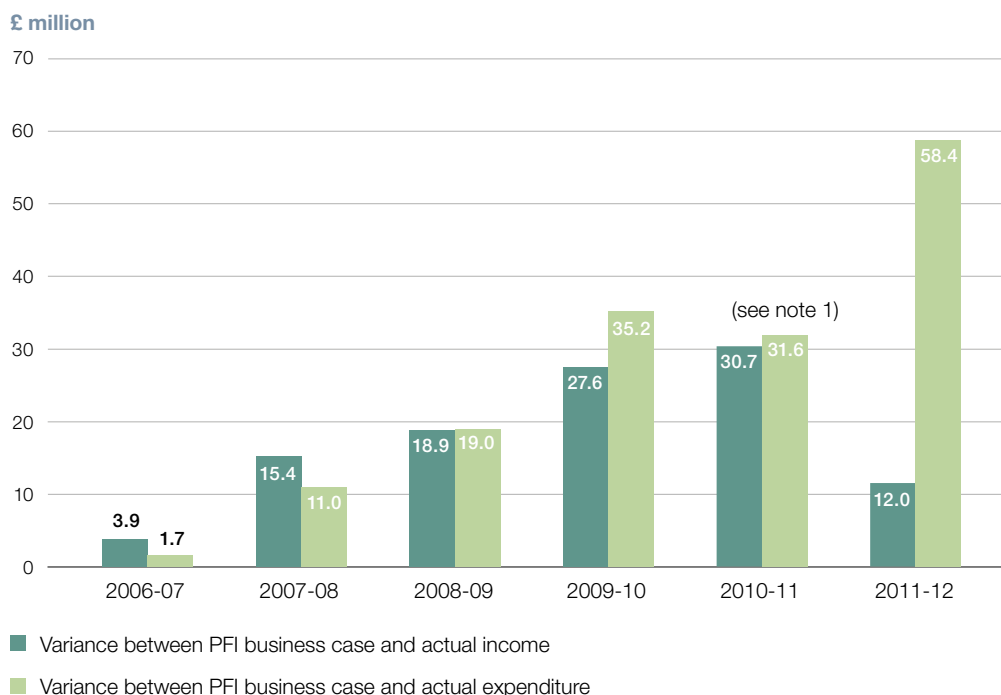
3.3 After 2008-09 the Trust's financial position deteriorated in comparison to projections in the business case (**Figure 12**). The Trust board were not aware that the Trust's expenditure was increasing each year much faster than predicted in the business case. This was because they did not monitor whether movements in the Trust's finances invalidated the assumptions in the business case after signing the contract in July 2007.

3.4 The increases in expenditure were partly shielded by increases in income. After 2009-10 additional income from activity was much harder to achieve, but in 2010-11 the Trust received £20.5 million of 'transitional support' during the year, £10 million of which was advanced from future years (see paragraph 2.12). Without this additional money, the Trust would have recorded the second highest deficit in the foundation trust sector in 2010-11. In this situation the Trust board was clear that Monitor would have amended the Trust's financial risk rating to 'unacceptable'. Finally, in 2011-12 only a small amount of transitional support was available while the new scheme greatly increased premises costs (see paragraph 2.20).

Figure 12

How the Trust's income and expenditure has varied from business case projections for each year

Increase in income failed to keep up with increases in expenditure after 2008-09

**NOTES**

- 1 The business case projected a full year of payments to the PFI contractor in 2010-11. In fact, the hospital only became operational at the end of 2010. Despite this, expenditure was around £31 million higher than the business case.
- 2 The variance figures include planned and actual 'one-off' income. The main effect was in 2010-11 where the net impact of transitional income and cost changes was to increase income by £6.3 million against the business case.
- 3 The variance figures exclude technical accounting adjustments in both planned and actual surplus or deficit.

Source: National Audit Office analysis of Peterborough and Stamford Hospitals NHS Foundation Trust accounts and June 2007 business case data

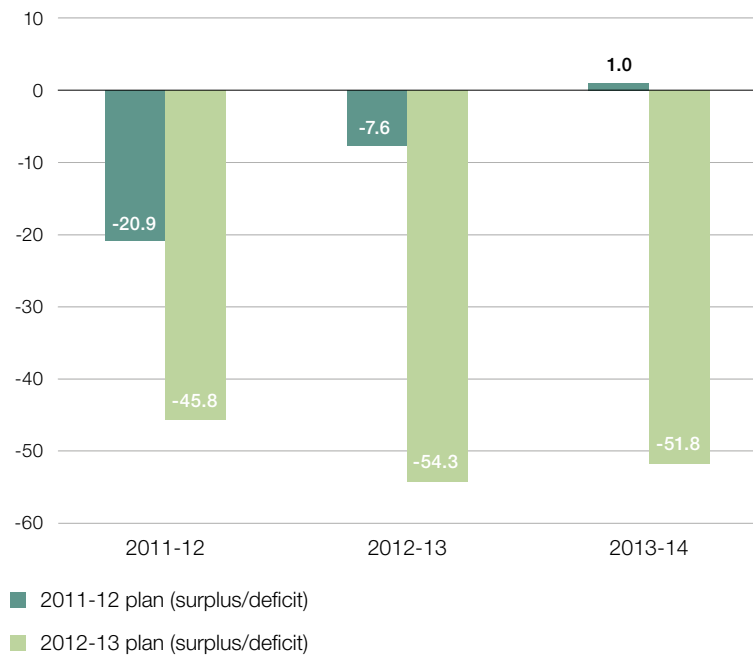
3.5 Over-optimistic projections about the Trust's projected deficits in 2011-12 can be seen in **Figure 13** overleaf. This includes a change in the Trust's projected 2012-13 outturn from a £7.6 million deficit to a £54.3 million deficit in Monitor annual plans 12 months apart. This is partly attributable to the 2011-12 plan assuming levels of new business and external support which were excluded from the 2012-13 plan due to being dependent on the actions of external stakeholders. If these items are excluded there was an increase in the like-for-like 2012-13 deficit between plans of £19.9 million.

Figure 13

Trust's planned surplus or deficit

Surplus/deficit planned varies by year

£ million

**NOTES**

- 1 The 2012-13 plan figure for 2011-12 is actual surplus or deficit.
- 2 The 2011-12 plan includes estimated amounts of Department of Health support, and new business developments which did not transpire.

Source: Forward plan strategy for year ending 31 March 2012 and draft business plan for financial years 2012-13 to 2016-17

Failures of the Trust's financial management

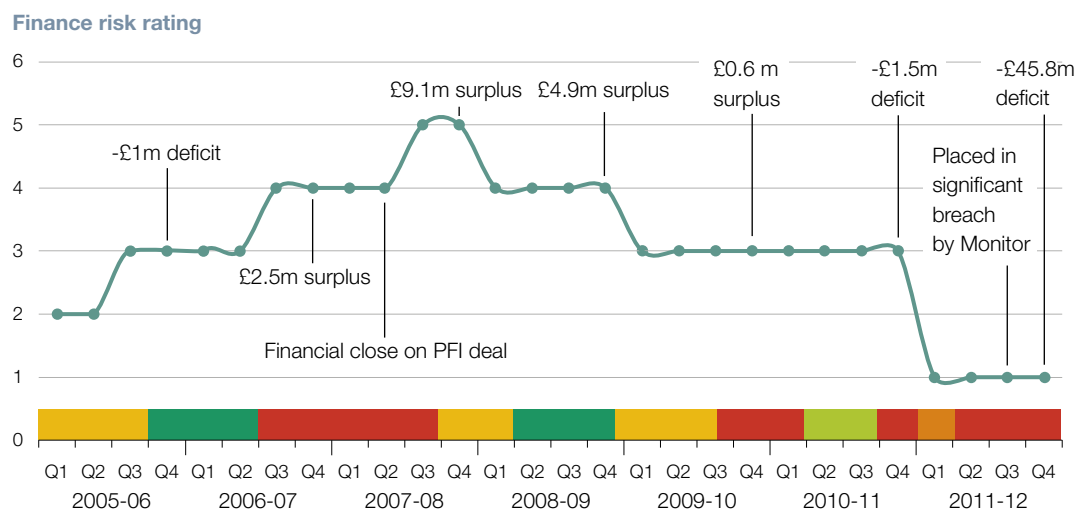
3.6 Ernst & Young's review of the risks and assumptions in the 2010-11 operating plan (see paragraph 2.9) reported several weaknesses in financial management. The executive team were being drawn into a 'fire-fighting' role and senior finance staff were heavily overworked and needed more support. Inefficient financial reporting processes within the Trust were also a contributory factor. Ernst & Young said that the lack of progress with the 2010-11 financial plan, including failing to prepare a downside case based on its current planning assumptions, made it impossible for the consultants "to form a view of the level of financial challenge facing the Trust at this time".

Shortcomings in Monitor's oversight

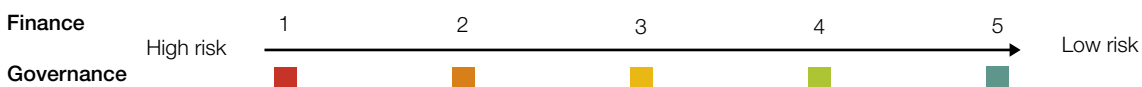
3.7 Although Monitor initially raised serious concerns about the affordability of the PFI scheme (see paragraph 1.8) its subsequent reporting on the financial health of the Trust did not reflect the regulator's own growing concerns about the ability of the Trust to cope with the financial implications of the PFI scheme as its operational date approached. Monitor assesses and reports the health of foundation trusts by allocating quarterly risk ratings for finance and overall governance. A financial risk rating below 3 would indicate that the Trust was no longer meeting the terms of its authorisation as a foundation trust. **Figure 14** shows that Monitor's calculated risk rating showed the Trust as low risk and did not reflect the future impact of the PFI development.

Figure 14

Monitor's risk ratings for Peterborough and Stamford Hospitals NHS Foundation Trust over the period covered in this report



Monitor risk ratings



NOTES

- 1 A financial risk rating of 1 reflects the highest level of financial risk and 5 the lowest risk.
- 2 A governance risk rating of red means likely or actual significant breach of terms of authorisation.

Source: Monitor

3.8 Monitor's criteria for assessing financial risk ratings for foundation trusts does not take into account concerns about the longer-term financial health of a trust beyond the current financial year. Within six months of the Trust signing the contract, Monitor allocated the lowest possible risk rating to the Trust which didn't reflect the future impact of the PFI development (Figure 14). This risk was defined as indicating 'no regulatory concerns'. Monitor did not assess the Trust's level of financial risk as unacceptable until the beginning of 2011-12.

3.9 The Trust board minutes recorded that Monitor reduced its level of monitoring of the Trust in May 2008, from a monthly to a quarterly basis, but Monitor have told us that they do not recognise this statement since their oversight of the Trust was consistently on a quarterly basis until the end of 2009-10. Monitor raised affordability concerns about the scheme with the Trust in October 2009, as it failed to make savings. On three occasions between February and October 2010, shortly before the new hospital became operational, Monitor discussed significant events involving the Trust's financial performance and on each occasion "concluded that an intervention would not necessarily improve or change the outcome positively". Nor did it change the Trust's financial risk rating, although this should involve a judgement about the Trust's likely financial performance over the next 12 to 18 months.

3.10 After Monitor became aware of the Trust's serious financial problems it commissioned a report by its internal auditors, KPMG, on the lessons to be learned from the PFI deal and subsequent actions.¹⁶ The review stated that Trust management failed to look ahead and manage the PFI deal from 2007 to early 2011, although it was the single biggest financial and service risk facing them. In the years running up to the opening of the new hospital, the board papers and the Trust's submissions to Monitor did not accurately reflect the size of the financial risk faced by the Trust. It also highlighted that the non-executive management failed to challenge the executive management sufficiently to be sure that the Trust was managing its financial position leading up to and through a major change.

3.11 The KPMG review also identified areas for Monitor to address in their internal procedures. Monitor could have required the Trust to recalculate numbers for the business case based on actual values each year. This would have enabled Trust management and Monitor to challenge the numbers and identify the growing gap between revenue and costs between 2007 and the end of 2010, providing an earlier warning of the impending deficit.

¹⁶ Learning and Implications from Peterborough & Stamford Hospitals NHS Foundation Trust, KPMG, June 2012. Available at: www.monitor-nhsft.gov.uk/sites/default/files/Peterborough%20Report%2026%20June%202012.pdf

3.12 KPMG set out three primary recommendations for Monitor in the future, which Monitor have accepted:

- When foundation trusts make significant long-term investments, management should update the assumptions and financial projections of the business case before the 'go live' date.
- Within the annual planning process, any foundation trust with an impending significant investment should show how the projections incorporate the impact of the investment, specifically focusing on the years after implementation.
- Where Monitor has concerns about accuracy or robustness of financial projections, it should require independent challenge.

Actions taken when the Trust's problems became clear

3.13 The Trust's external auditors first raised doubts about the Trust's ability to be viable for the next 12 months in June 2011 in their opinion on the Trust's 2010-11 accounts. KPMG were the Trust's external auditors from 2008-09 onwards but had not formally raised concerns until this point. They repeated their concerns in the 2011-12 accounts.

3.14 On 11 October 2011 Monitor wrote to the Trust to say that it had placed them in 'significant breach of their terms of authorisation' as a foundation trust because of:

- the Trust's financially unsustainable position and questions about the Trust as a going concern;
- failure to address its poor liquidity (cash) position;
- lack of a credible 'turnaround' plan;
- inaccurate financial forecasting; and
- poor board-level challenge and failure of the board to grasp the seriousness of the challenge.

3.15 The Trust has set out in its business plan steps to improve governance through:

- improving the quality of challenge by introducing a finance and investment committee and a governors' development and assurance committee;
- improving performance management of clinical business units;
- a new clinical directorate structure to promote service redesign; and
- a recruitment programme to the board.

3.16 The membership of the Trust board has largely changed since the financial problems became clear. Four of the Trust's six non-executive directors are new to the Trust in 2012. Post holders in the key executive board positions have also arrived since the Trust's financial issues emerged. The interim chief executive took up post in February 2012, the director of finance in June 2011 and the chief operating officer in April 2012.

Consultancy work for the Trust

3.17 The Trust has increasingly used consultants to support management and generate plans and analysis to help turn around its financial fortunes. Major pieces of work the Trust commissioned from consultants include:

- an Ernst & Young analysis of the Trust's operational and financial plans on behalf of the board. They were engaged by the Trust for a large part of 2010;
- work by Deloitte to help the development of the Trust's five-year business plan in mid-2012; and
- work by McKinsey & Co to analyse the Trust's financial performance against a peer group of hospitals and identify the scope for savings, in connection with the Trust's five-year business plan.

3.18 Consultancy costs connected with the implementation of the PFI development have decreased but they have been more than offset by the costs of consultants brought in to analyse and diagnose the Trust's increasing financial problems (**Figure 15**). Minutes of the Trust board indicate varying levels of satisfaction with the results of this work.

Figure 15
Increases in consultancy costs

Consultancy type (£m)	2007-08	2008-09	2009-10	2010-11	2011-12
PFI implementation	0.72	0.32	2.05	1.00	0.62
Management support/turnaround	0.01	0.05		3.09	3.40
Other			0.30	0.04	0.70
Total	0.73	0.37	2.35	4.13	4.72

NOTE

1 Before 2009-10 the Trust has estimated figures by reviewing purchase invoices.

Source: Peterborough and Stamford Hospitals NHS Foundation Trust

Actions to stabilise Trust finances

3.19 As part of its response to being placed in 'significant breach', the Trust produced a five-year 'turnaround' plan in May 2012. After further amendment, the board approved the turnaround plan and submitted it to Monitor in July alongside the standard three-year forward plan produced annually.

3.20 The projections in the plan leave an underlying deficit of £49 million by 2016-17, even assuming the Trust makes cumulative efficiency savings of nearly £64 million. These projections do not assume any additional support from the Department of Health (the Department). Of the savings, £26 million will rely on the Trust achieving a level of efficiencies that would bring it level with the best of its peers. The Trust will be required to better its 2011-12 savings performance in each of the following three years to maintain the deficit at current levels. In the meantime, the Trust's annual payments to the PFI contractor will continue to increase in line with the Retail Prices Index, as specified in the contract. The Trust is forecasting to Monitor savings of £13.2 million for 2012-13.

3.21 To reduce the deficit the Trust has to increase income. The Trust sees two main sources of additional income, which could return it to financial balance:

- additional ongoing support for the 'unaffordable' aspects of the scheme, as discussed in Part One; and
- developing new business opportunities with commissioners to exploit capacity created by efficiencies.

3.22 The Department announced in February 2012 that the Trust would be eligible for central support for its PFI-related costs, joining six other previously announced trusts with 'unaffordable' PFI schemes. Before granting support the Department will consider whether the Trust has met its four conditions:

- Financial problems are exceptional.
- Financial problems are historic and the Trust has a clear plan to manage resources.
- The Trust is making high levels of annual productivity savings.
- The Trust must provide clinically viable, high-quality services, including low waiting times and other performance measures.

3.23 New business opportunities will be harder to develop when the NHS is financially challenged and the lead commissioner is under pressure to stay within its funding limits. There is, however, scope to develop spare capacity in the hospital if the local health economy can reduce the level of short-term emergency admissions. The Trust sees potential business development in the future in three areas, which would be assisted by plans to improve how existing facilities are used and by releasing bed and theatre capacity through efficiency savings:

- Maintaining market share with their existing core catchment area, for example in the face of potential entrepreneurial activity by Hinchingbrooke Health Care NHS Trust, while expanding market share beyond the East of England Strategic Health Authority area at the expense of other NHS providers.
- Developing specialist services in areas such as cancer and elective activity, and especially orthopaedics.
- Developing private patient facilities.

3.24 Although in theory the Trust expects to run out of cash in January 2013, once advance payments from commissioners for 2012-13 activity run out, the Department told us that it will continue to fund the Trust's day-to-day operations. The Trust's commercial facility, which would normally help the Trust through a short-term cash shortage, is unusable since the Trust cannot make use of the facility where there is uncertainty that the Trust will be able to repay any advances received. In any case the facility was withdrawn once Monitor assessed the Trust as facing an unacceptable level of financial risk. In our report *Securing the future financial sustainability of the NHS*,¹⁷ we recommended that the Department should introduce a working capital fund. The fund would be for foundation trusts to access capital, as an alternative to commercial facilities.

¹⁷ Comptroller and Auditor General, *Securing the future financial sustainability of the NHS*, Session 2012-13, HC 191, National Audit Office, July 2012. Available at: www.nao.org.uk/publications/1213/nhs_financial_sustainability.aspx

Appendix One

Our audit approach

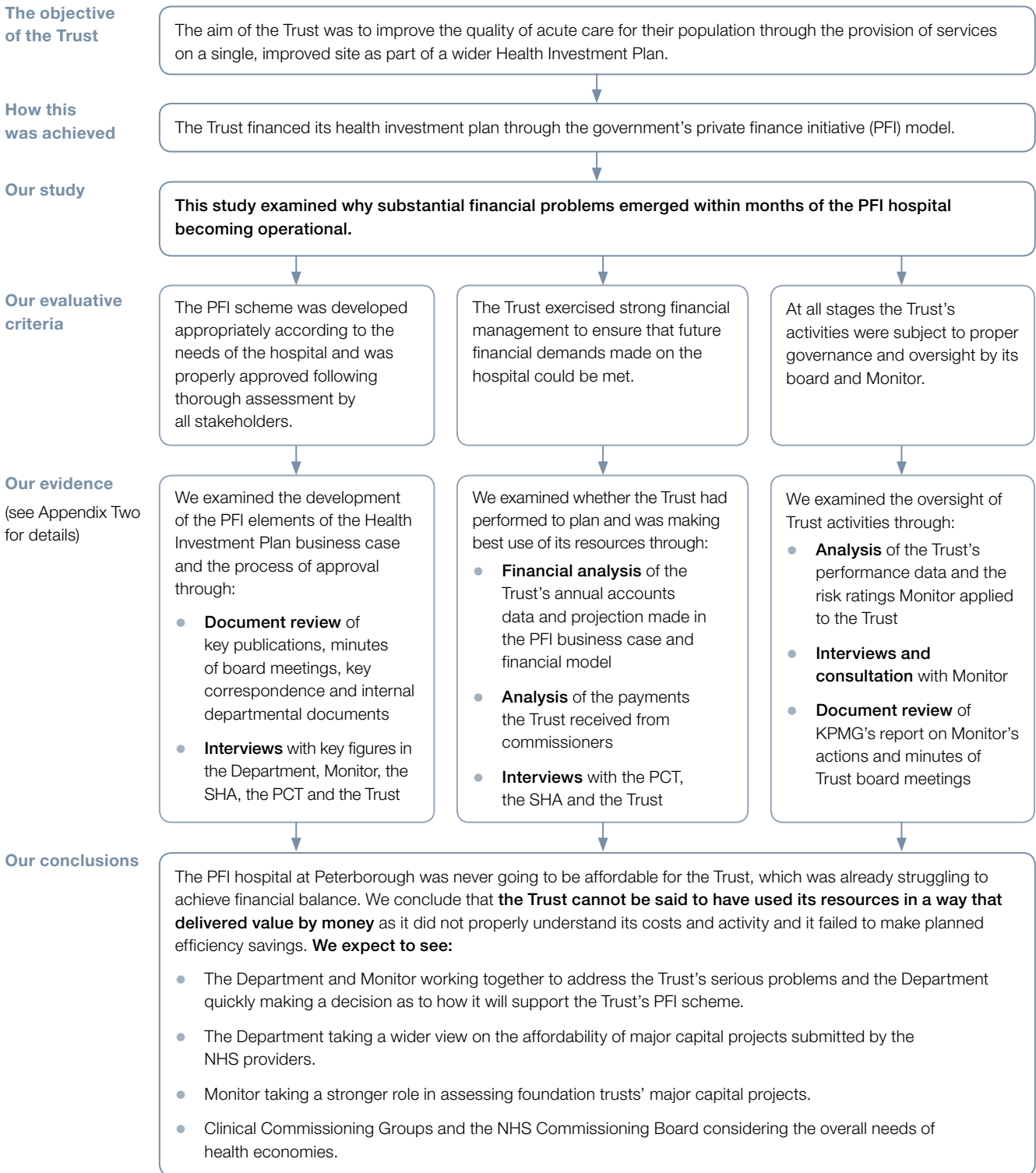
1 This study examined further risks identified in our report *Securing the financial sustainability of the NHS (2012-13, HC 191)* in order to understand specific problems faced by Peterborough and Stamford Hospital NHS Foundation Trust (the Trust), which the report had identified as being [faced by] particular challenges due to a Private Finance Initiative (PFI) scheme which was becoming unaffordable for the Trust. We reviewed:

- the Department of Health's (the Department) approval of the Trust's PFI scheme;
- the serious financial problems that the Trust has faced in the years since the deal; and
- why the Trust's finances deteriorated so substantially and what is being done to put things right.

2 We developed our own analytical framework to assess value for money, supported by evaluative criteria based on good practice. Our assessment of value for money was restricted by a short time frame in which we had to reach our conclusions. However, we assessed whether the Trust's business case for its health improvement plan was a robust assessment, enabling the key stakeholders approving the scheme to make well-informed decisions. We then looked at the financial management exercised by the Trust and finally if, at all stages, the activities of the Trust were subject to proper governance and oversight by the board and Monitor.

3 Our audit approach is summarised in **Figure 16** overleaf. Our evidence base is described in Appendix Two.

Figure 16
Our audit approach



Appendix Two

Our evidence base

1 We formed our independent conclusions on whether the actions and decisions of Peterborough and Stamford Hospitals NHS Foundation Trust (the Trust) demonstrated value for money. Our conclusions were based on interviews with key stakeholders and the documents, financial data and performance data we collected. Our fieldwork took place between August and September 2012.

2 We applied an evaluative framework to obtain a better understanding of the current financial situation of the Trust and the actions and decisions underlying it. Our audit approach is outlined in Appendix One.

3 We reviewed the development of the business plan for the PFI hospital and the robustness of the approval process it went through:

- We reviewed board papers to determine the level of challenge the proposals had received from the Trust board and what risks had been identified by the Trust before key decisions were made.
- We reviewed correspondence between key stakeholders and key departmental documents. We looked at concerns about the affordability of the scheme that had been raised by Monitor and how these concerns had affected the approval process.
- We also interviewed key stakeholders to provide context to the documents that we were reviewing and to understand which key decisions were made by whom and at what time.

4 We analysed the Trust's financial data:

- We compared the financial projections with actual data in the Trust's annual accounts. We looked at whether estimates of future cost and income had been accurate and if assumptions made in the business case had been fair and rational. We used projections from the June 2007 version of the business case (at the point of contract sign-off). These figures varied slightly, but non-materially, from earlier versions used by the Department and Monitor during assessment of the scheme.

- We **analysed annual accounts** data in order to determine when the Trust started experiencing financial difficulties and what factors contributed to its poor performance against plan and its recorded deficit in 2010-11.
- We **spoke to the Trust's current financial director** to discuss the context behind the Trust's financial data and its key elements, and to understand how key decisions made by the Trust had affected its financial position.

5 We reviewed the governance and oversight of the Trust's activities:

- We **interviewed board members of the Trust and its SHA and lead PCT to understand how the Trust's activity had changed over time** and the impact of the wider health economy on the Trust's ability to increase its income.
- We **analysed performance data** to understand if the Trust had met national targets in the years since the outline business case of the PFI scheme was submitted.
- We **spoke to Monitor and analysed the data it produces on foundation trust performance** to understand what oversight Monitor had of the performance of the Trust.



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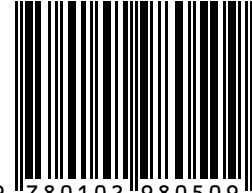
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