



National Audit Office

**REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL**

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Peterborough and Stamford Hospitals
NHS Foundation Trust

Peterborough and Stamford Hospitals NHS Foundation Trust

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.