HSJ LOCAL briefing

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PETERBOROUGH AND STAMFORD COPING WITH DEFICIT

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue Peterborough and Stamford Hospitals Foundation Trust is anticipating a £100m deficit accumulated in just two years.

Context In 2011-12 the trust made a loss of £46m; this year it expects that figure to widen to £54m. That's around 25 per cent of turnover - the trust's income in 2011-12 was £208m - and, were the trust a commercial organisation, would be likely to prompt bankruptcy.

Outcome Earlier this year the trust called on £41.2m in public dividend capital to keep it operating. Some form of additional support will be needed again this year.

The reasons for the trust's deficit

Part of the answer has to lie in the new Peterborough City Hospital, funded by the private finance initiative. This cost the trust £41.3m in 2011-12, with charges due to increase by the retail price index each year. A report to Monitor on "lessons learned" and its response revealed Monitor wrote to the trust board as long ago as 2006, raising concerns about affordability of the proposed hospital. It puts the amount of the deficit attributed to "structural/PFI related costs" as £22m.

Even without PFI, the trust would be facing a substantial deficit. Monitor's report puts part of this down to the trust not realising recurrent cost improvement plans - many CIPs were one-off savings and were not embedded in the way the trust works.

But there were also issues around income. The activity levels were insufficient to utilise the capacity of the new building, it says. And the old site the trust has vacated - Peterborough District Hospital - has not yet been sold and, when it is, is unlikely to realise the more optimistic valuations originally hoped for, That reflects the national position on building land.

Planning for financial viability

With the example of South London Healthcare Trust fresh in everyone's mind, it might seem to be only a matter of time before the failure regime is invoked and an administrator put in.

But Peterborough may have more time than most to sort out its problems. It was without a permanent chief executive for much of 2011 (Nik Patten was off sick for several months before he resigned in October) and it was only earlier this year that experienced chief executive Peter Reading was appointed to an interim role. While the predictions for 2012-13 are still dire, there must be a strong argument for giving the trust time to attempt to sort out its problems. Monitor is not planning to intervene in the short term.

Mr Reading says: "We are working closely with our regulator to bring us back to a sound financial footing. Although this cannot happen immediately, we believe we have a robust plan that spans the next five years.

"The delivery of our five-year plan will require the trust to drive through cost improvements; attract more business into the hospital to make best use of the facility; and to continue discussions with the Department of Health and the Treasury about how we get support for the cost of our PFI."

The trust's annual report for 2011-12 reveals the trust expects to have to make annual efficiency savings of 4-5 per cent beyond those encapsulated in the tariff: reducing pay costs is likely to be a part of this.

But it also wants an "increased financial contribution from the clinical services that we already have" and "the introduction of high quality and profitable new services". The trust's three-year business plan, which has been submitted to Monitor, covers "ways in which the organisation aspires to develop the business base to attract more patients". But government help with PFI costs will still be needed: the five-year plan submitted to Monitor predicts deficits each year unless government help is forthcoming.

The auditor's report in the annual report points out that the size and timing of this help is not known. It concludes that this, and other matters indicate "the existence of a material uncertainty which may cast significant doubt on the trust's ability to continue as a going concern".

Current performance

Health secretary Andrew Lansley last year laid down four tests for trusts which were looking for help with PFI prior to becoming foundation trusts. The DH has confirmed that the same tests will apply to Peterborough.

It would meet the first test easily - its problems are exceptional - but it will also need to demonstrate a clear plan to manage resources well, high levels of productivity savings and clinically viable high quality services which meet performance targets. The trust's last board papers show it breached the four-hour A&E wait and 18 weeks admission targets in May, It hopes to get the referral to treatment target back on track in the second quarter of the year but, like other trusts, is still struggling with emergency demand.

Attracting more patients

Peterborough has a lot going for it if it wants to attract more elective patients. The new hospital - with 50 per cent single ensuite rooms - would seem to be well placed to attract patients exercising choice, especially given the good road connections to a much wider area.

A new link road to Spalding (part of the A16) opened in October last year, reducing travel times to Peterborough from 45 minutes to 20-25 minutes. This has already had some impact on patient numbers especially in maternity and A&E and the trust is having discussions with commissioners about how this should affect the starting level for the 30 per cent A&E tariff.

Spalding is almost equidistant between Peterborough and Boston. This area may have looked towards the Pilgrim Hospital in Boston, part of United Lincolnshire Hospitals Trust. But last year the Nursing and Midwifery Council removed nursing students from the hospital - they returned earlier this year. The CQC has also raised concerns: its last inspection was still critical. This may be driving some patients to look towards Peterborough.

Capacity issues in some hospitals in the region may also mean that Peterborough would gain more patients. Orthopaedic surgery is a particular crunch point. Peterborough is in an envious position of having a top floor to the new hospital which could be reconfigured to provide extra wards at a fraction of the cost of a new block: this may make expansion both viable and attractive.

But a strategic use of Peterborough to provide additional capacity would take wider agreement. NHS Norfolk has already flagged up its desire to see more elective work repatriated to its local acute trusts from other providers. Other hospitals are likely to want to

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grow elective work - Hinchingbrooke, for example, has already been taking some patients from Cambridge University Hospitals Trust's Addenbrooke's Hospital to help with waiting time management.

Stamford and Rutland Hospital

The future of Stamford and Rutland Hospital - situated 14 miles north-west of Peterborough - has often seemed uncertain. Although it serves a distinct community, it would be easy for a cash-strapped trust to draw in its horns and reduce services.

The inpatient section of the hospital was closed for refurbishment in the summer of 2011 and was only reopened in response to winter pressures, speaking fears over its long-term future. But some new clinics have been developed. Outpatient numbers have increased steadily since 2008-9 - especially for follow ups - and one area of growth has been therapies where first appointments grew from 364 in 2008-9 to 1,270 in the last financial year and follow ups from 794 to 2,458.

Overall, the trust draws 30 per cent of its patients from South Lincolnshire - Stamford, Bourne and the Deepings are key areas - and the hospital is a conduit for many of them. They may attend an outpatients appointment there, come into Peterborough for a procedure and then return to Stamford for follow up care.

"Stamford is a vital part of the trust. It is our foothold in South Lincolnshire," says John Randall, the trust's medical director. "If the facility closed a lot of those patients may go elsewhere."

A new vision for the hospital has now been produced between the trust and the South Lincolnshire CCG which was outlined at the trust's June board meeting. Drawing patients into Stamford for initial appointments and investigations appears to be a major part of this. The trust wants a wider range of outpatients being seen there, the return of an endoscopy service, and further development of imaging services, including ones taking GP referrals.

The older patients unit will be remodelled as a nurse and therapist led intermediate care unit. A nurse-led minor injuries unit seeing 30-35 patients a day will replace the doctor-led service which has been based there: it is currently largely staffed by locums. Whether or not the site will retain an operating theatre is to be reviewed. Chemotherapy and haematology clinics will be increased.

The trust says what it wants is a long-term sustainable future for the hospital, which has seen several previous attempts to define and refine its future.

It wants to find a partner to redevelop the site: two thirds of the site is not used for clinical purposes and the trust would like to concentrate services in modern buildings at one end of the site, opening the way for the rest of the site to be used by other healthcare providers, such as GPs (there are covenants limiting the use of the land). It is advertising in the Official Journal of the European Union for a partner in this.

The impact on services in Lincolnshire

Enhanced services in Stamford could also attract patients who currently travel to other hospitals - notably those in Rutland and the small town of Oakham who tend to make the longer journey to Leicester. Other parts of Lincolnshire - such as South Holland - could also look south rather than north and some patients on the Northamptonshire boundary could also be attracted. Discussions with CCGs and GPs are ongoing.

But if Peterborough is going to attract more work, one potential loser is United Lincolnshire Hospitals Trust, which will already be affected by the increasing number of patients from South Lincolnshire looking to Peterborough City Hospital and could be impacted by any improvements in service or new provision at Stamford and Rutland. While patient choice prevails, there is relatively little it can do about this other than to improve its offering and try to influence GPs whose advice to patients may be critical.

However, NHS Lincolnshire is already warning about the potential for overspend on acute services across its patch. Its July finance report included mention of a "significant year end overspend" and there is potential for a £16m overspend on PbR services alone. Costs attributed to South Lincolnshire CCG are included within this and could amount to a £5m overspend in 2012-13.

This is likely to lead to a crackdown on costs - and potentially more focus on reducing referrals and procedures. This could impact on Peterborough.

And even if the trust did manage to extend its catchment area that could only be part of the solution. "I am not under any illusions that we will be able to grow our way out of the problem," says Dr Randall, pointing to the financial constraints on commissioners.

The trust may grow "organically", he says, but it does not want to destablise other trusts and hopes to provide complementary services (for example, the chemotherapy and haematology services being grown at Stamford are not available at the United Lincolnshire's Pilgrim Hospital).

Cost improvement is the key

In both the short and long term cost improvement has to be a key part of any strategy to dig the trust out of the mire. This year's target is £13.2m of savings and the trust is broadly on track for this - even a little ahead at the end of month two. Cost control will be important if extra income is not to mean significant extra costs.

But the losses are still staggering: £8.6m at the end of month two, for example (and that was less than plan at £9.2m).

In the short term, the trust is likely to confirm the plans for Stamford and have a costed business plan prepared for the end of the year. Stakeholder engagement is under way and NHS Lincolnshire will determine whether a full consultation is needed.

The timing and extent of DH support is still uncertain: the DH says it is dealing with trusts on a case-by-case basis and has not revealed any timescale. With commissioners praising the work it has done so far, the trust may weather the storm. Mr Reading believes that it could be substantially turned round in two to three years if the plans for government support, cost control and increased business succeed.