



East of England

Hinchingbrooke Next Steps

Full Business Case (FBC)

Version 2.9

**(To reflect final form Intervention
Order and Treasury Requirements)**

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1 Introduction & executive summary

This document comprises the Full Business Case (FBC) for Hinchingsbrooke Health Care NHS Trust (HNS): 'Hinchingsbrooke Next Steps Project'. This business case follows on from the Outline Business Case (OBC).

The OBC was approved by the Hinchingsbrooke Project Board on 15 April 2008. It was also formally endorsed at the SHA Board Public Meeting held on 22 May 2008. The OBC:

- identified and developed the preferred procurement option for the Project;
- justified the need for the Project;
- prepared the foundation for the way forward;
- demonstrated a robust procurement strategy;
- showed that the Project is in response to a robust case for change; and
- demonstrated that key stakeholders have been involved in formulating, and are committed to the Project.

A copy of the OBC is available as Appendix 2.

This FBC is intended to form the basis of a recommendation to award the Franchise Agreement and;

- reconfirms the strategic case for the Project;
- demonstrates that the proposed Franchise Agreement delivers value for money (VfM);
- establishes that the Recommended Bidder is capable of meeting the requirement;
- sets out the commercial terms of the Franchise Agreement;
- summarises Project and risk management plans; and
- identifies how benefits will be realised and monitored.

1.1 Strategic case

HNS delivers the strategic aims and objectives as described in the strategic case of the OBC by utilising

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key policy drivers issued as those contained in the local and nationally published DH documents including amongst others (i) Health and Social Care Act 2003, (ii) NHS Operating Framework (iii) NHS Performance Standards, (iv) NHSC Strategic Plan and (v) Equity and excellence Liberating the NHS White Paper.

The Procurement provides:

- the means to reduce the debt which during the period 2000 to 2007 accumulated to £38.4m;
- the means to find a new partner via a franchise which is capable of providing a full range of modern hospital services at HHCT. HNS enables the delivery of services identified in the October 2007 Consultation, ensures the ownership structure for the Trust is fit for purpose, provides optimisation of value for the tax payer, ensures that the impact on staff and stakeholders is fully and properly considered and that VfM is provided;
- for services to be provided under an innovative Franchise Agreement transferring management responsibility together with risk and liability to the Franchisee but with the Trust retaining NHS staff and assets; and
- for changes to the OBC to include for (i) a Residual Trust Board so that the Trust can comply with its statutory obligations and (ii) an extension to the financial criteria to include both debt repayment and plans (described as “Initiatives”) to meet further deficits from NHSC Commissioning Strategy, QIPP and other economic factors.
- for progressive Benefit’s Realisation that shows the improvements gained by (i) Staff Satisfaction, (ii) Patient Satisfaction, (iii) Commissioner’s Satisfaction, (iv) Implementation and delivery of Initiatives and (v) Gateway review.
- for Project Risks that show the risk and mitigation measure, some examples are (i) non-performance of the franchisee, (ii) failure of the TUPE transfer, (iii) a severe reduction in the commissioning contract value and (iv) initiatives needing public consultation

Stakeholder support has been achieved from the outset by involving and engaging as broad a range of representation as possible including NHS EoE, NHSC, HHCT, Huntingdonshire District Council, Cambridgeshire Community Services NHS Trust, Cambridgeshire LINK and related trade unions. Engagement was also established with the Joint Health Overview and Scrutiny Committee. A communication plan

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was agreed to provide public engagement in parallel with the Procurement.

Specifically the process has been supported throughout by HHCT (signatory to the Franchise Agreement) and NHSC who have provided a support letter Attached as Appendix 3.

1.2 Economic case

At the time of preparing the OBC the Trust's historic deficit was projected to be £38.7m at 31 March 2008 (and was subsequently shown to be £38.9m in the final accounts). One of the key objectives of the project was the repayment of the Trust's historic deficit. At the time of finalising the OBC (April 2008), the macro economic assumptions and commissioning activity assumptions underpinning those projections were developed in a stronger economic climate. The result of the OBC analysis was that an '*Operating Franchise*' option was expected to make contributions of £19.6m (NPV) towards the repayment of historic deficit over a 10 year period compared to £5.9m (NPV) of contributions under a '*Do minimum*' option (i.e. Trust Comparator) solution. The other short-listed options ranked in between these two levels of contribution.

By the time the ITPD1 documentation was issued (December 2009), the economic downturn meant that the activity projections and macro economic assumptions required review. The ITPD1 documentation included Trust projections for a 7 year franchise term which indicated that even before the Trust could make contributions to the repayment of the historic deficit or before it could make a surplus, it would have to make cumulative savings of £102m over the 7 year term just to achieve break even.

ITPD2 documentation was issued (April 2010), by which time NHSC (the main commissioner of activity from the Trust) had published its 5 year commissioning strategy. Once these projections were built into the Trust's financial projections, the projected level of cumulative savings to achieve Trust breakeven had increased from £102m to £133m over a 7 year term. Bidders had identified during the first stage of dialogue that a 10 year term would allow them to invest in more initiatives as they would have a longer period to recover their investment. In ITPD2 bidders were also provided with 10 year Trust projections. The projected levels of cumulative savings to achieve Trust breakeven were £228m over a 10 year term (i.e. before

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franchisee fee or contributions to repayment of the historic deficit). These were identified as the Base Case projections.

The best and final offer received from the two bidders (Circle and Serco) in response to the Invitation to Tender were ranked against the Trust Comparator (see Appendix 7) to determine which solution offered best value for money.

Bidders were provided with Base Case, Upper 1 and Upper 2 scenarios for projected Trust Annual Surplus/(Deficit). Based on the level of savings associated with each bidder's proposed initiatives the projected Trust Annual Surplus/(Deficit) was updated to incorporate the savings. The sharing allocation of Trust Annual Surplus that was bid by each bidder under the Franchise Agreement was then applied to assess projected contributions to repayment of the Trust historic deficit (i.e. the share of Trust surplus allocated to the Trust). A similar approach was adopted for the Trust Comparator.

The ranking of bids and Trust Comparator was by highest projected Weighted Average Contribution to repayment of the Trust historic deficit calculated in NPV terms. The results are summarised below.

RANKING BY WEIGHTED AVERAGE CONTRIBUTION (IN NPV TERMS)

RANKING	Bid	WAC
1	[REDACTED]	[REDACTED]
2	[REDACTED]	[REDACTED]
3	[REDACTED]	[REDACTED]
4	[REDACTED]	[REDACTED]
5	[REDACTED]	[REDACTED]
6	[REDACTED]	[REDACTED]

[REDACTED]

It should be noted that these estimates include a double weighting against any guaranteed amounts. [REDACTED]

[REDACTED]

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[REDACTED]

Based on above ranking the 10 year franchise with Circle is expected to offer the greatest potential for contribution to repayment of the historic deficit and therefore the best value for money. [REDACTED]

[REDACTED]

The latest estimate of Trust historic deficit is £38.4m (as at 31 March 2010 based on audited accounts). Under the Base Case scenario, Circle's 10 year projections are showing a repayment of historic deficit of [REDACTED] by the seventh year but the amount not paid in full until the tenth year. However, it must be remembered that these are only projections based on an assumption that Circle's proposed initiatives deliver the projected savings to the projected timescales.

Bidders have incorporated their own risk assessment in arriving at their projected savings associated with initiatives and given that both parties are taking the same level of risk no further risk adjustments are made. With regard the Trust Comparator, the assessment of achievability of initiatives had built in an optimum bias element which resulted in a reduction of approximately [REDACTED] on the cumulative value of the initiatives proposed. Therefore no further adjustments are considered necessary.

The Upper 1 and Upper 2 scenarios provide an indication of the impact of the bid share allocation of Trust Annual Surplus between the Trust and Franchisee. Circle has benefitted from this because it has bid a higher allocation to the Trust than Serco for different bands of Trust Surplus and this is captured through the scenarios.

If downward sensitivities were applied then a point could be reached where Serco's 10 year bid offered better value for money (given the guaranteed amount). However given that the Base Case projections are already quite a downside scenario (with Trust revenues of £96m nominal in year 1 decreasing to £92.5m nominal in year 10) the likelihood of revenues falling lower than this are considered low. If downward sensitivities were applied to the 7 year term then Circle's bid would continue to offer better value for money than Serco's as there is not guaranteed contribution to the repayment of historic deficit.

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1.3 Commercial case

The Commercial Case substantiates the requirement to ensure that the Franchise Agreement provides a thorough understanding of the need to meet the Strategic aims and objectives.

It has considered:

- The need to appoint a Franchisee that can provide a full range of modern acute services whilst accepting risk and responsibility. That Franchisee should also be able to substantially contribute to the debt repayment having produced savings to meet the emerging commissioning strategy.
- The need to appoint a Franchisee for a Term that allows for the full benefits to be realised whilst producing value for money.
- The need to ensure that assets are retained by the NHS
- The need to ensure that staff are retained by the NHS using RoE (retention of Employment)
- HNS has managed these needs by using a detailed Invitation to Participate in Dialogue bid process in five stages
- Stage 1 – Expressions of Interest
- Stage 2 - Pre-Qualification Questionnaire and Memorandum of Understanding (PQQ)
- Stage 3 – Invitation to Participate in Dialogue 1 (ITPD1) testing Bidders' capability, capacity and requesting their views on cost savings
- Stage 4 – ITPD2 providing for dialogue with Bidders on their cost saving Initiatives
- Stage 5 – Invitation to Tender (ITT) detailing the final financial offer and agreeing to the Franchise Agreement.

Dealing with these five stages in more detail:

Nineteen organisations (both from the NHS and the independent sector) expressed interest and received PQQs.

Eleven PQQ responses were received and after evaluation and Project Board approval Cambridge University Hospital NHS Foundation Trust ("CUFHT"), Interhealth Canada (UK) Ltd, Partnership Health Group Ltd, Ramsay Health Care (UK) Ltd, Circle Health and Serco were

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selected to proceed to ITPD1. Serco confirmed that they would, if successful, appoint Peterborough and Stamford Hospitals NHS Foundation Trust as their clinical services sub-contractor.

ITPD1 tested Bidders' capability and capacity and requested appraisals on cost savings meeting the commissioning challenges and debt repayment. CUFHT withdrew during ITPD1 and therefore four submissions were received. After evaluation, Project Board approval three bidders were selected for ITPD2, these were Ramsay, Circle and Serco.

ITPD2 allowed for dialogue with Bidders on their cost saving Initiatives. Provided that they complied with a minimum £70m financial savings target (£70m) they would be selected for ITT. The evaluation of these savings allowed for comprehensive testing of: (i) clinical services delivery and governance; (ii) workforce and IM&T strategy and delivery; (iii) estates and ongoing maintenance strategy; and (iv) any other outside influences that might affect delivery. All Initiatives were evaluated legally and financially. Regrettably, Ramsay's submission did not comply with the requirements as they stated that they would only accept a contract that did not include the assumption of any risk liability on their part. After evaluation and approval, Circle and Serco were selected for ITT as both met the financial savings target.

After evaluation of the two Bidders' ITT submissions and approval by the Project Board, Circle were appointed the Recommended Bidder subject to approvals. In their ITT submission, Circle had confirmed agreement to the Franchise Agreement and provided an offer for debt repayment using a Weighted Average Comparison of [REDACTED] over a ten year term. Details are included in PWC Invitation to Tender (ITT) Financial Evaluation Report dated 25th November 2010 Report available in Appendix 5.

Circle's proposal includes Initiatives producing savings of [REDACTED] over a ten year term. Circle submitted 32 Initiatives dealing with: (i) improvement and rationalisation of service delivery; (ii) production of cost savings; and (iii) alteration to the hospital foot print as a result.

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Dealing with each in turn:

Service Delivery

- reduce patient length of stay [REDACTED]
- improve theatre productivity and utilisation [REDACTED]
- nurse to bed ratios [REDACTED]
- Treatment Centre consolidation [REDACTED]

[REDACTED] introduction of an Enhanced Recovery Programme [REDACTED]
[REDACTED];

- decrease “Do not Attends”;
- increase private patients use [REDACTED];
- streamline emergency admissions through A&E [REDACTED]

[REDACTED] CSSD outsourcing [REDACTED]

and in the longer term consider in conversation with Commissioners the possibility of:

- a maternity network [REDACTED]
- the introduction of an Integrated Care Organisation ([REDACTED])

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Cost Savings

Cost savings are proposed for:

- pathology;
- pharmacy;
- diagnostics – smarter use;
- administrative (non-clinical) staff reductions;
- using technology to streamline clinical correspondence;
- Finance Team; and
- procurement savings

The Commercial Case shows, via the evaluation of the submissions, how efficiencies are gained by the Initiatives and how they are effective to the sustainable delivery of services.

The outcome of these efficiencies and their effectiveness is demonstrated within the evaluation of ITPD(1) where the tests are overall capability and capacity, and in ITPD(2) where each Initiative was tested for clinical safety, delivery and governance, workforce strategy and plans, estates re-configuration and IM&T strategy and plans. Also in ITPD(2) the Initiatives were tested for implementation and delivery, including the need for Quality Impact Assessments and any third party influencers eg planning permissions. All of the tests within each Initiatives were evaluated on a pass/fail criteria and then, subject to having passed, were financially evaluated.

Details of Circle's clinical service delivery and governance, workforce strategy and planning, IM&T strategy and delivery and estates and maintenance strategies are included later in the Business Case.

1.4 Legal Case

1.4.1 Introduction

The Franchise is to be made pursuant to the provisions of section 67 of the NHS Act 2006 by the making of an Intervention Order by the Secretary of State. The legal effect of the Intervention Order is to: (i) alter the structure of the board of directors of the Trust; and (ii)

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delegate the statutory management functions of the Trust to the Franchisee. Certain statutory functions have been specifically reserved to the Residual Trust Board. The form of Intervention Order is brief and is made in accordance with the detailed terms of the Franchise Agreement which is attached to and forms part of the Intervention Order.

Following approvals the Intervention Order was made on 9th November 2011 and it gave authority to enter into a Franchise Agreement (dated 10th November 2011). However, the actual delegation of the Trust's functions to the Franchisee pursuant to the Intervention Order and in accordance with the terms of the Franchise Agreement does not become effective until the Services Commencement Date (to be 1 February)

1.4.2 Composition and functions of the Residual Trust Board

The purpose of the Franchise is to pass day to day management risk and responsibility to the Franchisee which is in accordance with the delegation of the Trust's functions to the Franchisee as mentioned in paragraph 5.1 above. Therefore the day to day operation of the Trust will be conducted by the Franchisee by an Executive Management Team. As a result of the delegation of the Trust's statutory functions to the Franchisee pursuant to the Intervention Order the roles and responsibilities of the Residual Trust Board are limited and consist of:

- approving the Trust's statutory accounts;
- fulfilling the Trust's public accountability obligations (eg representing the Trust at its AGM);
- performance managing the Franchise Agreement; and
- to give or withhold consent to the matters referred to in the Franchise Agreement as requiring its consent including the list of reserved matters. These reserved matters are set out in detail in Schedule 8 of the Franchise Agreement and summarised briefly in paragraph 5.3 below.

With effect from the Services Commencement Date the Residual Trust Board will consist of three members: a Chair, a financially qualified individual and a clinically qualified individual all of whom will hold non executive positions. The Residual Trust Board will meet at least four times per annum in public.

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1.4.3 Key Terms of the Franchise Agreement

The Franchise is a statutory procedure created by the Intervention Order itself. The form of Intervention Order has been discussed with the Department of Health and their solicitors who prepared the form of Intervention Order and approved its terms. The agreed form Franchise Agreement was appended to and formed part of the Intervention Order as the Franchise Agreement contains the detailed terms upon which the Franchise is to operate.

The Agreement contains an express provision that the Parties shall comply with the NHS Core principles and the NHS Constitution.

The parties to the Franchise Agreement are (1) Hinchingsbrooke Health Care NHS Trust (2) Circle Hinchingsbrooke Limited (3) Circle Holdings PLC and (4) East of England Strategic Health Authority. On conclusion of the approvals process, the Franchise Agreement was signed. After contract signature there is a Contract Transition Period during which the parties will implement the agreed form transition plan. On Services Commencement Date the delegation of the Trust's functions to the Franchisee pursuant to the Intervention Order will be effective.

Any termination of the Franchise Agreement or revocation by the Secretary of State of the Intervention Order prior to Service Commencement will only entitle the Franchisee to receive its mobilisation costs by way of compensation. This will not apply if the Franchisee is in breach of the Franchise Agreement.

The primary obligation of the Franchisee is performance of the Services that in essence amount to the operation of the hospital in accordance with all laws and NHS requirements, to implement its Initiatives in order to achieve the aims and objectives of the Intervention Order (repayment of historic deficit) and to generate a Trust annual surplus.

The day to day implementation, operation and co-operation between the Trust and the Franchisee is conducted by a representative of each party. The Residual Trust Board's representative is known as the Franchise Manager and the Franchisee representative is known as the Franchisee Representative. Within three months of contract signature and by 31 December in each year, the Franchise Manager and the Franchisee Representative need to review the Franchisee's progress

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in implementing its Initiatives, level of financial savings achieved and any variation the Franchisee wishes to make.

The total liability of the Franchisee is capped at £7 million. The latter is made up of £5 million working capital contributions (i.e. the Franchisee has to make a support payment to ensure the Trust breaks even) and £2 million termination costs.

To guarantee the termination costs Circle are obliged to place £2m into a security deposit account. PLC also act as guarantor for all Circle's obligations under the Franchise Agreement and is therefore a party for this reason.

There are a number of termination rights set out in the Franchise Contract. The Trust may terminate on 12 months notice and the Secretary of State may revoke the intervention order at any time. In these circumstances, provided the Franchisee is not in breach, it is entitled to receive compensation. This compensation will be mobilisation costs if termination occurs prior to Service Commencement and after Service Commencement the compensation will be loss of profits, mobilisation costs, demobilisation costs, and any Franchisee support payment made. The total liability of the Trust, in any event is capped at £10 million.

The Trust can terminate without paying compensation if the Franchisee commits a material breach, suffers the usual form of insolvency events, undergoing a change of control without the Trust and SHA's consent as well as if the Franchisee becomes obliged to pay a Franchisee support payment in excess of £5 million. The Franchisee can terminate for the SHA or Trust material breach such as where the Trust experiences failures in meeting the standard of quality and consistency expected by the Care Quality Commission (and compensation is at the full amount) and if it is required to pay more than £5 million by way of support payment (in which no compensation is payable). Either party can terminate if a force majeure event lasts for 3 months, and no compensation is payable. The Franchisee has to pay £2 million termination costs where it is at fault or in breach and that results in termination.

1.5 Financial case

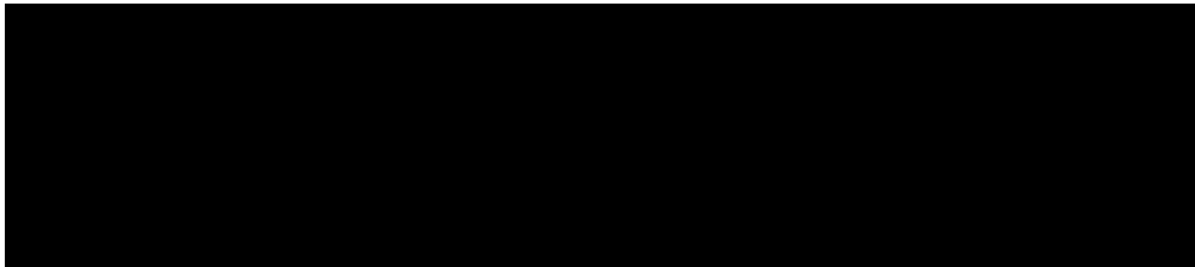
Under the proposed Franchise Agreement, the Franchisee will only receive payment when the Trust generates a surplus. The project is

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therefore considered affordable from a Trust and SHA perspective (parties to the Franchise Agreement).

The commissioners are not directly impacted by the Franchise Agreement. Under the Agreement, the Franchisee will act on behalf of the Trust in negotiating the annual commissioning contracts.

The projected financial impact on the Trust's I&E under the Base Case scenario based on the Preferred Bidder (Circle) proposals are summarised below.



Based on these indicative projections, if Circle delivers all of the projected levels of Trust surplus, then by the end of the tenth year all of the Trust historic deficit would be expected to be repaid. By the end of the seventh year the projections show that [REDACTED] of the Trust historic deficit would be expected to be repaid.

Given that the Franchisee shall be operating the hospital on behalf of the Trust and given that Circle has not identified any significant capital works associated with their initiatives (projecting an amount of less than [REDACTED] which may be funded through the Trust's discretionary capital), the Franchisee is not expected to have an implication for the Trust balance sheet.

1.6 Management case

The Management Case substantiates the requirement to ensure that the Franchisee has a robust understanding of the Franchise Management at both Mobilisation and during the Term Contract provides a thorough understanding of the need to meet and comply the Strategic aims and objectives.

The Franchisee must comply with the same regulatory framework and standards as the Trust applicable to the provision of clinical services as specified by the NHS from time to time. It specifically demonstrates:

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Governance

- The franchise management arrangements for this Project are designed to encapsulate a clear commitment to partnership working, where the Franchisee operating as the Trust integrates and regularly consults with the local Health Service Bodies.
- In support of this, and following appointment by the SHA, the Franchise Manager (FM) will work with the Trust Board, the NHS and the Franchisee to ensure collaborative, robust governance during mobilisation and throughout the term of the Franchise Agreement.
- The FM appointment is confirmed by the Trust Board to provide consultancy to the NHS and guidance to the Franchisee within the Franchise Agreement and will have access to subject matter experts in the areas of commercial, legal, clinical governance, franchise management, performance management and dispute resolution and supports the Trust Board by advising on contractual obligations and liabilities.

Management Structures during Mobilisation and Service Delivery

- The Franchise Agreement covers two specific phases - Mobilisation and Service Delivery. These two phases require different management structures. The Franchisee will be expected to ensure that the appropriate skill sets are applied to each phase. For example the composition of teams will require an understanding of project management during mobilisation in order to ensure that deliverables and milestones are met, whilst Service Delivery will require an operating knowledge of patient focus, franchise management and commercial skills.
- Circle have noted the NHSC Commissioning Strategy and Intentions for future management of demand shifting from the PCT to the GP Clusters which will require Circle to consult, where required, with bodies during mobilisation and throughout the term of the Franchise Agreement.

Milestones

Circle has provided the following Milestones relating to the Mobilisation Period from February to June 2010:



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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- Circle have provided as part of their Bid an outline description of their proposed exit strategy detailing the steps envisaged to successfully disengage from the NHS at the end of the term of the Franchise Agreement or earlier termination pursuant to the Franchise Agreement.

Project Timelines

The Project Timelines are agreed as:

Preferred Franchisee appointed	25/11/10
FBC/Approvals	30/11/10-09/11/11
Contract Award & Signature	09/11/11
Contract Mobilisation	10/11/11- 31/01/12
Statement of Readiness Sign Off	17/01/12
Service Commencement	01/02/12
Staff and Public involvement	Ongoing

1.7 Conclusions

In conclusion, this FBC confirms:

- That the Strategic Case for the Project is still applicable ie a requirement to re-pay the historic debt and to provide continuing sustainable services in accordance with the Public Consultation
- That a planned strategy to Stakeholder, Staff and Public support has been adopted alongside the HNS Procurement
- That the Procurement provides VfM and demonstrates financial advantages to the Trust Comparator

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- That the Invitation to Dialogue process demonstrates that Circle have the capability and capacity to deliver the Project and to repay the debt completely over a 10 year term whilst being able to Implement cost savings (Initiatives) meeting the emerging commissioning challenges
- That Circle accept the Franchise Agreement
- That there are robust plans for Franchise Management and Mobilisation
- That there are robust plans for risk management and benefits realisation
- Key to becoming a Foundation Trust is being able to demonstrate that a Trust is providing high quality services, that meet or surpass national standards and targets, are delivered within the financial envelope available and that an applicant can demonstrate good governance processes and that they have a strong Board. The franchise focuses on strengthening these fundamentals and if delivered should put the Trust in a good position to mount a credible FT application.

1.8 Recommendations

Based on this FBC, it is noted that following the issue of the approved Intervention Order that:

- this FBC is approved; and
- the Franchise Agreement has been awarded to Circle on a 10 year term.

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2 Strategic case

2.1 Introduction

This section explains the significance of the Project and the appointment of a Franchisee to operate the Trust. The appointed Franchisee will operate the Trust and will provide a full range of modern acute hospital services. Under the Franchise Agreement the Franchisee accepts management responsibility together with risk and liability. All NHS assets and staff remain with the Trust.

The Trust's major income comes from commissioning contracts with seven primary care trusts. These are:

- NHS Bedfordshire;
- NHS Cambridgeshire;
- NHS Lincolnshire;
- NHS Norfolk;
- NHS Northamptonshire;
- NHS Peterborough; and
- NHS Suffolk.

NHS Cambridgeshire acts as the co-ordinating commissioner under the Commissioning Contract with the Trust.

2.2 National service context and objectives

The Procurement is intended to support both local and national government's policies and aims for health services.

These policies and aims are contained in local and nationally published DH documents including:

- Health and Social Care Act 2003;
- NHS Operating Framework as published annually;
- NHS Performance Standards, e.g. 2 week cancer wait; and
- NHS Cambridgeshire Strategic Plan 2010 to 2015.
- 'Equity and excellence: Liberating the NHS' White Paper July 2010

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A distillation of the content of these (and other) documents identifies the following Government policies and aims:

- all NHS provider organisations should become NHS Foundation Trusts;
- clearance of HHCT's historical debt;
- establish effective and strong management control and processes;
- promoting health and preventing disease;
- older people's health and care;
- patient experience and customer care;
- safe and effective health services; and
- total expenditure through public sources, including NHS commissioning organisations, such as NHS Cambridgeshire, should be within budget and represent excellent VfM.

The Coalition agreement commits 'to the continuous improvement of the quality of services to patients, and to achieving this through much greater involvement of the independent sector and voluntary providers'.

The NHS White Paper titled '*Equity and excellence: Liberating the NHS*' issued on the 12th July 2010 stated that:

'...Within three years, we will support all NHS trusts to become foundation trusts. It will not be an option for organisations to decide to remain as an NHS trust rather than become or be part of a foundation trust. "in due course, we will repeal the NHS trust legislative model."

Clarification was sought from the D H which confirmed that that any decision on the Project does not preclude this commitment. Departmental solicitors have advised that it will be possible to make provision in the Health Bill to repeal the NHS Trust legislation, subject to a commencement order. This approach avoids having to set a precise date for the repeal within the Health Bill itself and provides flexibility to determine the timing in due course. Departmental solicitors have advised that there would be scope to make exceptions in such a commencement order to allow the Project to continue as a franchised NHS Trust pending its establishment as a Foundation Trust, if necessary.

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Being debt free and having a sustainable five year financial model (10 years for PFI Trusts) is a pre-requisite of any NHS Foundation Trust application. During the period 2000-2007 the Trust made successive losses leading to an accumulated debt of £38.4m (see section 2.3 for further information). Insofar as possible this debt needs to be repaid.

A public consultation on the future of the Trust in 2007 affirmed the need to continue to provide the full range of modern acute hospital services at the Hospital. It also concluded that a franchise agreement would be the best option for repayment of the debt.

It is necessary to secure a sustainable future for hospital services and staff at the Hospital and to start the repayment process of the historic deficit while improving service quality for patients and securing VfM for tax payers.

The Trust continues to perform poorly, with the worst risk rating of any NHS trust in the east of England for August 2010 (see RQQ on below table). This situation has been consistent in previous months.

Risk Rating Summary -

Aug-10



Strategic leadership for your local NHS

Trust	FRR			GRR		CRR		Freq.	FY Surplus (£m)	
	Plan	YTD	FOT	Plan	Period	Plan	Period		Plan M5	FOT M5
Bedford Hospitals NHS Trust								Monthly	0.0	1.6
East & North Hertfordshire NHS Trust								Monthly	3.3	3.3
East of England Ambulance Service NHS Trust								Monthly	0.1	2.0
Hinchingbrooke Healthcare NHS Trust								Weekly	0.0	0.0
Ipswich Hospital NHS Trust								Monthly	3.5	3.6
Mid Essex Hospitals NHS Trust								Monthly	11.4	1.0
Queen Elizabeth Hospital King's Lynn NHS Trust								Quarterly	2.7	2.7
Suffolk Mental Health Partnership NHS Trust								Monthly	0.8	0.8
The Princess Alexandra Hospital NHS Trust								Monthly	2.7	0.5
West Hertfordshire Hospitals NHS Trust								Monthly	8.6	8.1
West Suffolk Hospitals NHS Trust								Monthly	3.6	1.2
									36.7	24.8

Local service context and targets

This Project demonstrates a commitment from the NHS East of England to look to deal with difficult situations innovatively within its health community. The financial situation faced by the Trust was seen as unenviable and would require complex and challenging solutions to secure a financially sustainable future for the people of Huntingdon.

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In February 2007, the PCT, in partnership with the SHA and Trust, started a consultation regarding a major reconfiguration of services in Huntingdon.

The consultation considered 4 options:

Option 1: minimum change – provision of broadly the same range of services on the site but at lower volumes;

Option 2: remodelled services – provision of broadly the same range of services at lower volumes through a major redesign of how services are provided across the Hospital and community setting;

Option 3: transferring significant elements of patient services to other hospitals and significantly reducing activity on the Hospital site; and

Option 4: closing all services on the Hospital site with the exception of inpatient surgery and outpatient services in the Treatment Centre.

The consultation suggested that Option 1 was “high risk” as the full savings identified (£10.37m recurrent savings) may be difficult to deliver as the Trust was facing further financial pressure in the months and years to come. This Option was therefore considered non-viable.

Option 3 was not considered viable as it would place the long term future of provision of medical services at the Trust in jeopardy (with clinical risks associated would be higher because of the lack of emergency surgery). It was also considered less financially viable – recurrent savings of £10.3m and would be unpopular with the local community as it would greatly reduce the services provided at the Trust.

Option 4, producing only a £4m recurrent saving, after the loss of income of £50.3m following the closure of the majority of patient services, was considered to be insufficient to gain long term financial stability.

Option 2 was considered to be the preferred solution as it would allow the Trust to move to a recurrent break-even position, and maintain the same range of services, including emergency and maternity. The move of certain services to the community would be enabled via a PCT investment of £2.5m and would bring services closer to people's homes, where clinically safe and appropriate.

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The lower volumes projected under Option 2 would aim to “*bring activity levels at the Hospital closer to England averages*”. This information was based on information produced by the SHA, which had identified that the number of Huntingdonshire residents that visited the Hospital for treatment is well above the England average for similar populations (41% above for the number of inpatient stays and 34% above for new outpatient appointments. The PCT noted that the local health system was not funded at a level that could sustain this referral level.

It is within the context of delivering Option 2 that the existing Trust Board indicated a willingness to allow services to be transferred to another NHS provider, as a contribution to the required financial savings, with effect from April 2009.

2.3 The case for change

The Trust initiated its own turnaround process in the summer of 2006 and the baseline assessment confirmed that there was an underlying deficit. The Trust’s financial recovery plan (“**FRP**”) required £9.6m of savings to be delivered by 31 March 2007. However, following review by external consultants, the cost improvement target was revised to £4.2m. The revised cost improvements were achieved in 2006/07. However the turnaround process clarified that the cost improvements identified, including a significant number of redundancies, would not provide sufficient savings to enable the Trust to breakeven in 2006/07.

The Trust established a Finance Committee in November 2006 whose purpose includes carrying out detailed scrutiny of the Trust’s cost budgets and assisting the Director of Finance and the Board in financial recovery planning.

The Trust produced an updated FRP, which was presented to the Board in January 2007. However, this document did not include a plan that resulted in the Trust achieving its cumulative breakeven duty over a five year period ending March 2009. The Trust’s priority in developing this FRP was to stop any further deterioration in its in-year financial position rather than to address the cumulative deficit.

The Trust’s focus was on achieving and then maintaining in-year operational financial balance. The budget for 2007/08 agreed by the Board in March 2007 planned for a £2.5m operational deficit after a £15.1m reduction to income in respect of the Payment by Results

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(“**PbR**”) transitional arrangements, i.e. a planned £17.6m deficit for the year. The plan for 2007/08 required savings totalling £2.0m in order to achieve the planned deficit. The plan forecast a cumulative deficit at the end of 2007/08 of £40.5m.

Together with the outcome of public consultation during 2007, and with the support of the DH, the SHA ran an open and transparent competitive tendering process to find the best partner to operate a franchise for the Hospital. To conclude it was agreed that the public consultation produced solution on the delivery of services but the repayment of deficit required the tendering process.

2.3.1 Existing Strategy

Brief Overview of Huntingdonshire

Huntingdonshire is a relatively affluent area and is in the least deprived 15% of local authorities based on the IMD score 2007. The Office of National Statistics (“**ONS**”) estimates the 2008 population to be 168,900, which is higher than the Cambs County Council Research Group estimate of 163,100. The ONS project the population to grow by 14% over the next decade. The fertility rate is lower than the national average. The population structure is similar to the England average, although there are proportionally less people in their 20s and early 30s and of retirement age. Huntingdonshire is less ethnically diverse than the England average.

The health of people in Huntingdonshire is generally significantly better than the England average. However, road injuries and deaths appear worse than the England average, despite the fact that the rate is decreasing and Cambridgeshire is currently likely to meet related improvement targets.

There are inequalities within Huntingdonshire. Men from the least deprived areas can expect to live about 5 years longer than those from the most deprived areas; in women this difference is 1 year.

Over the past ten years, rates of death from all causes and early death rates from heart disease and stroke have tracked the improving England averages. Early death rates from cancer have improved and are better than the England average.

The rate of alcohol related hospital admissions in Huntingdonshire is similar to the England average. Huntingdonshire has significantly fewer

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children in Reception Year who are classified as obese compared with the average for England.

2.3.2 Current Trust Activity

The Trust is a small district general hospital that provides a range of health care services for the people of Huntingdonshire and the surrounding areas. Its traditional catchment area is approximately 160,000 people.

NB: The graphic above is for information only and does not contain a comprehensive list of NHS and private sector health care provision for the area.

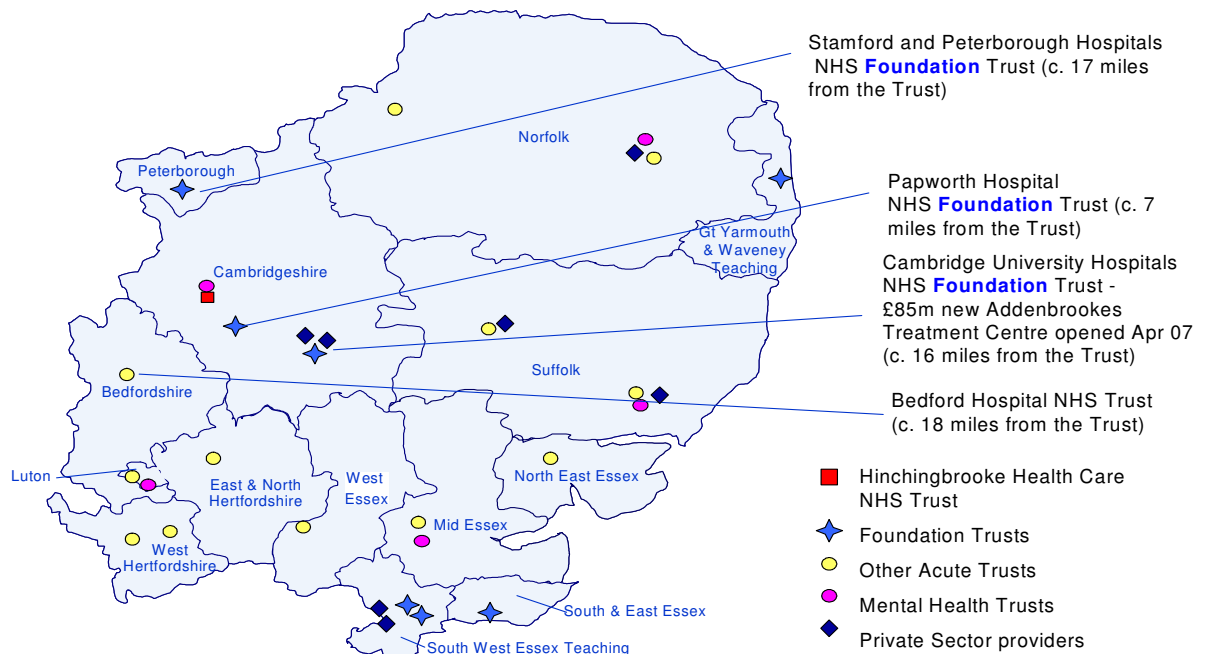
The Trust has a long history of providing excellent patient care. It works closely with its local community and actively engages with local GPs. The Trust provides a wide range of outpatient, day case and inpatient services, a 24/7 Accident & Emergency Department and Maternity service.

Overall the Trust directly employs over 1600 staff, including 69 consultants.

The Trust currently has a number of trial off-site clinics, e.g. Gynaecology, and it is exploring further options which will improve patient access in line with the previous public consultation.

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Hinchingbrooke Health Care NHS Trust



Sources: East of England Strategic Health Authority Intranet, BUPA and Nuffield Hospitals websites, Finance Team at SHA

2.3.3 Provider of choice for local community

The local community looks to the Trust to provide virtually all their major health care needs from maternity care and accident and emergency cover to major surgical intervention. The results of the 2007 consultation have shown significant support from the local community to keep their services.

The Trust works well with other local providers and agencies, and has well established links with GP networks.

Where the Trust is not able to provide full time cover itself, it has arranged some innovative relationships with other Trusts, including Addenbrookes, to share consultant care. The Trust is therefore able to provide a wider and more specialist level of care than would at first be expected for a hospital of its size.

2.3.4 Commissioning Perspective

NHS Cambridgeshire (“**NHSC**”) is the Lead Commissioner for Hinchingbrooke and is responsible for ensuring that clinical services

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are commissioned each year in line with national and local policy frameworks. The lead commissioning role extends to oversight of Associate PCTs' commissioning priorities and investment in the Trust's clinical services.

In January 2010, NHSC published a new strategic plan in response to the anticipated impacts of the economic downturn and set out the six major strategic change programmes which are intended to ensure that financial balance is achieved by the end of the current strategic period. An overview of the NHSC Strategic Plan was included in the tender documentation.

In the NHSC Strategic Plan (Section 3.2.5), NHSC in conjunction with Hunts Health, the major GP Commissioning Cluster for Huntingdonshire, set out the range of clinical commissioning priorities which will be discussed and negotiated with the Trust in conjunction with the Franchisee prior to service commencement on 1st June 2011. Agreements reached will be incorporated into the Commissioning Contract for 2011/12. The priorities identified in the tender documentation were an integral part of the formal dialogue stage with Bidders. The key priorities were explored formally in interview with Bidders by Huntingdonshire GPs in September 2010 and evaluated according to a set of agreed clinical evaluation criteria consistent with the Trust's evaluation plan.

Looking ahead to 2013/14, and subject to the outcomes of the consultation on the Government's White Paper (Liberating the NHS), commissioning will be largely undertaken by GP Commissioning Clusters with some responsibilities borne by the new NHS Commissioning Board. NHSC as a commissioning organisation will cease to exist from 1st April 2013.

Huntingdonshire primary care has benefitted greatly by the work undertaken in previous years by Hunts Comm, which was the local practice based commissioning consortium prior to the creation of GP Commissioning Clusters in 2010/11. Hunts Health and any new clusters which emerge in the next couple of years will build on this work.

Huntingdonshire GPs value their local hospital and the strength of the working relationships forged over the years. Their intention is to work closely and constructively with the Franchisee to develop together over the term of the Franchise Agreement a new culture which dissolves the

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traditional boundaries between primary, secondary and community care.

In essence, their long term plan is to achieve a 'hospital without walls' with the prime focus on clinical quality and outcomes.

GPs want to work with the Franchisee to maintain and build further the Trust's reputation as a provider of high quality, safe and sustainable clinical services with innovation and continuous improvement at its heart. They recognise that the Trust cannot and should not try to do everything. Instead, the Trust should focus on what it does well and use the benefits of robust clinical networks with other providers to undertake the work that they do best.

2.3.5 NHS Cambridgeshire Support

Attached as Appendix 3 is a copy of NHS Cambridgeshire's letter of support, dated October 2010, confirming their support for the Franchise and their intention to maintain a Commissioning Contract between NHSC in its capacity as Co-ordinating Commissioner and the Trust in its capacity as Service Provider.

2.3.6 Current Trust Performance

The Hospital is (and remains at time of writing) currently on weekly reporting to the Director of Strategy under the NHS EoE Provider Management Regime. The Trust was escalated in January 2010 due to:

- red financial risk ratings and large negative variance against in-year financial plan at month four;
- red governance risk ratings for 8 out of the last 11 months, several of the red ratings reflect late and/or incomplete submissions;
- self-certifying non compliance with the cancer two week waiting time target for the past 15 months; and
- reaching the annual ceiling for MRSA cases in month four.

The Provider Development Board, a formal subcommittee of the SHA Board, in November 2009 had agreed to escalate the Trust due to their red financial risk rating and red governance risk rating, which was driven by failure to achieve key service performance targets. The Trust's service and financial performance has since been closely

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monitored through self-certifications and discussed in detail at monthly Provider Management Regime meetings.

The Trust can be considered for returning to monthly monitoring if they can demonstrate sustained improvements in service and financial performance.

The table below shows the Trust's service performance for the last 16 months to August 2010 and its Governance Risk Rating.

HINCHINGBROOKE SERVICE & GOVERNANCE RISK RATING

Score	DoH Metrics	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	August
1	Clostridium difficile	x		x	x		x	x	x				
	MRSA			x	x	x	x	x		x	x		
	Cancer – 31 days subsequent treatment	x											
	Cancer – 62 days from referral to start of treatment										x	x	x
	HSMR 100 >										x	x	x
0.5	A&E 4hr target		x	x	x	x	x						
	Thrombolysis within 60 minutes	Not applicable											
	Urgent GP cancer referral – max. 2 week wait	x	x	x	x	x	x	x	x	x	x	x	x
	Cancer – 31 days from diagnosis to treatment										x	x	
	MRSA elective screening	x	x	x	x	x	x	x	x	x	x	x	x
0.4	National core standards compliance	x	x	x	x	x	x	x	n/a	n/a	n/a	n/a	n/a
	Total	3.4	1.9	3.9	3.9	2.9	3.9	3.4	2.0	2.0	4.5	4.0	3.0

HCAI's remain extremely challenging for the Trust in 2009/10. The Trust had reached its in year ceiling of two cases, in month four.

The Trust has not had an MRSA bacteraemia since, and remains at its ceiling at month six.

The Trust is currently below its year to date ceiling for C-difficile cases (August).

The Trust has continually struggled to achieve cancer targets, specifically the Urgent two week GP cancer referral target.

The Trust is generally failing to achieve this target in three specialities: Dermatology, Urology and Head & Neck. Most breaches in these areas relate to capacity.

In early 2010/11, the Trust gave notice to NHS Cambridgeshire to cease provision of Dermatology services week commencing 4 October 2010. The Trust will now continue to provide the service until early November, as the commissioner has yet to confirm an alternative arrangement for patients.

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The Trust has taken a number of actions to improve capacity in Urology, including opening a third endoscopy suite in September 2010 and recruiting an additional part time consultant.

The Trust is also currently not achieving the MRSA elective screening target, however have made considerable improvements in performance over the last few months. The Trust's most recent performance (August) was 99.3%, 3 elective patients were not screened.

The Trust achieved registration with the CQC in April 2010 with no conditions.

The Hospital was rated as 'challenged' under the DH Performance Framework for four consecutive quarters in 2009/10. The DH has adjusted this to an improved rating of 'underperforming' based on the assurance derived from the Project.

2.4 Procurement objectives

The objective of the Project was to find a new partner who is capable of providing a full range of modern acute hospital services at the Hospital.

The objectives of the Project are:

- to ensure that the range of services identified in the preferred option in the public consultation documentation dated February 2007, continue to be made available to patients locally. Any proposals which reduce the portfolio of services offered on the site to local people or increase volumes, other than by substitution with other providers will not be accepted. Any such proposals would need the agreement of the PCT and may be subject to further public consultation depending on the scale of the change being proposed;
- to ensure the ownership structure for the Trust is fit for purpose;
- to optimise the value to the taxpayer, making the operations of the Trust financially sustainable and in so doing and where possible to maximise the early repayment of the temporary loans and/or PDC provided to the Trust;
- to develop health services following best practice whilst maintaining a robust local health economy;

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- to ensure that the impact on staff is fully and properly considered and that all appropriate employment policies and protocols are followed; and
- to ensure the achievement of VfM from expenditure related to the correct choice of ownership structure.

The tender process was open to organisations within the NHS, from the independent sector or the third sectors or a combination of them, in order to secure a sustainable future for the Hospital services and staff and to start the repayment process of the historic deficit while improving service quality for patients and securing VfM for tax payers.

2.5 Scope of the scheme

Services are to be provided under an innovative Franchise Agreement whereby full management responsibility together with risk and liability will pass to the Franchisee whilst NHS assets and staff will be retained by the Trust.

The delegation of the Trust's statutory management functions to the Franchisee and the entry into the Franchise Agreement by the Trust and the Franchisee will require authorisation by the Secretary of State using an Intervention Order under Section 67 of the NHS Act 2006.

2.6 Outline business case

The OBC considered the options available and recommended that:

- a franchise partner be appointed by the Trust accepting full operational risk and operating as if it were the Trust within NHS rules;
- Trust assets and staff be retained by the Trust with the Franchisee operating as the operator;
- the appointment of the Franchisee provide for a contract of an agreed term that repaid the debt in whole or in part;
- the appointment of the Franchisee ensured the continued delivery of safe and sustainable services within the parameters of Option 2 Consultation; and
- there be no transfer of staff and that staff be made available to the Franchisee using the Retention of Employment ("RoE") model.

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Since agreement to the OBC, and during the Procurement, it became apparent that there was a need to reflect two changes to the approved criteria:

- in consultation with the DH, it was deemed necessary that the Trust in order to comply with its statutory obligations should retain a Board. This Board now known as the “Residual Trust Board” will have three Directors and is deemed “light touch”; and
- following issue of NHSC five year Strategic Commissioning Plan and economic constraints eg QIPP imposed by the DH, there was potential further deficit in the projected Trust’s financial plan. The result is that the Procurement criteria were altered to include both a requirement to meet the projected deficit and repayment of the debt in whole or in part. It also considered the possibility that payment support may be needed by the appointed Franchisee.

Dealing with each in turn:

- The Residual Trust Board – the Board will consist of three members: a Chair, a financially qualified individual and a clinically qualified individual all of whom will hold non executive positions. The Residual Trust Board will meet at least four times per annum in public
- the effect is to increase the cost of the Franchise Agreement by circa £300,000 over a 10 year term due to salaries not previously allowed; and
- the effects of the alteration in Commissioning Strategy - the Procurement included a requirement for Bidders to show that they had plans (described as Initiatives) to meet the expected financial deficit. Both Bidders included at ITT achieved these savings.

As part of the approval process the DH required a change to the Intervention Order to stipulate that the Trust’s statutory management functions only will be delegated to the Franchisee

2.7 Stakeholder support

Strenuous steps have been taken, from the outset, to involve and engage as broad a range of stakeholders as possible in the Project, and encourage its positive media coverage.

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2.7.1 Co-ordinated approach

Following completion of the project Memorandum of Agreement between NHS EoE, NHSC and HHCT, a communications alliance was established with representatives from the three organisations, along with colleagues from HDC and CCS. An initial meeting was held on 13 October 2009, leading to a series of regular face to face or telephone meetings to agree engagement and communication strategies. The alliance ensured a co-ordinated approach whereby all parties had the opportunity for editorial input, and 'sign off', prior to release to internal and external audiences. This ensured 'buy in' and consistency of message.

2.7.2 Three phases of public engagement

It was established that ongoing stakeholder involvement in the Project, "rather than leaving it until a preferred bidder is selected" was the preferred route. This ensured 'genuine' involvement of stakeholders from the earliest possible point, and then throughout the Project. Consequently, the Project Board agreed that a comprehensive and wide ranging engagement plan be introduced.

Three waves of engagement were implemented to mirror the key stages of tender process. These spanned the following dates, each launched with a new edition of the bespoke newsletter, Hinchingsbrooke Next Steps News:

- 4 November – 2 December (four weeks)
- 6 January – 31 March (12 weeks)
- 9 May – 11 August (12 weeks)

Through each edition of Next Steps News, a questionnaire sought suggestions and feedback from stakeholders on a range of issues. People could either post in their responses, using a freepost address, or complete the questions online. Responses were collated and fed back to the Project Board, forwarded to bidding organisations, and used to shape the content of subsequent involvement materials.

Copies of Next Steps News are attached as Appendix 4, along with an additional article summarising responses to the question in Next Steps News edition 3. Responses have been fed back to respondents via Next Steps News, the SPT's website

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(www.eoe.nhs.uk/strategicprojects) and at public and stakeholder meetings.

The extent of the engagement has been widely acknowledged. Cllr Heathcock, Chairman of Cambridgeshire County Council's Joint Health Overview and Scrutiny Committee ("**HOSC**"), for example, said that he:

"is pleased to highlight that the Strategic Health Authority is running an extensive public and stakeholder engagement programme throughout the Hinchingbrooke franchise process".

2.7.3 Joint Health Overview and Scrutiny Committee (HOSC)

The HOSC was engaged early in the Project, with Dr Stephen Dunn (Director of Strategy, NHS EoE) giving a presentation to the HOSC on 12 May 2008, followed by a second on 2 November 2008 by Dr Dunn and Mark Millar (then CEO at HHCT).

The HOSC set up a subcommittee with a remit of providing dedicated scrutiny on the Project. The SPT gave a dedicated series of private briefings, attended by at least two senior members of the team, where councillors received confidential presentations around the key stages and the opportunity to ask questions. While members did not receive commercially sensitive papers, they were given detailed presentations on the content of ITPD1 and ITPD2. The dates for these meetings were 23 November 2009, 17 March, 3 June, 12 July and 30 September 2010.

2.7.4 HNS stakeholder panel

Members of the HOSC were also actively engaged via the Trust stakeholder panel meetings, established to encourage the participation of key influential stakeholders. There were 32 members of the panel, representing HHCT, NHSC, NHS EoE, LINK, unions, local authorities and others. It was independently chaired by David Monks, Chief Executive of HDC.

Eight meetings were held, in public, timed to coincide with key stages of the Project, and were attended by between 40 and 60 people each time. In response to requests from the public that they would like to know more about the Bidders, representatives from Circle, Ramsay Health Care UK and Serco Health gave a presentation to the 26 May 2010 stakeholder meeting. While the rules of the tender process

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precluded them from explaining their proposed Initiatives for the Hospital, they gave presentations on their organisations' experience and ethos, and stakeholders and the wider public had the chance to ask questions directly. The meeting was very well attended and was key in helping stakeholders build a profile of the organisations interested in taking on the Franchise. Mirroring articles featured in Next Steps News, and the exchange was carried extensively in the media.

The stakeholder panel nominated a sub-group which interviewed the Bidders on 8 September 2010, as part a deliberate inclusion in the bid evaluation process. The sub group comprised:

- Dr Catherine Hubbard, Consultant Radiologist, Hinchingsbrooke Health Care NHS Trust;
- Ruth Clapham, Chair, LINK Hinchingsbrooke Task Group;
- Cllr Steve Criswell, Chair of Scrutiny Committee, Huntingdonshire District Council;
- Tony Durcan, RCN Officer, Hinchingsbrooke Health Care NHS Trust;
- Julie Farrow, Chief Executive, Hunts Forum of Voluntary Organisations;
- Patrick Kadewere, Community Officer, Huntingdon Community Group;
- Phil Green, Regional Organiser, Unison;
- June Griffin, Chair, Friends of Hinchingsbrooke hospital; and
- Rod Craig, Executive Director, Community and Adult Services, Cambridgeshire County Council.

Cllr Steve Criswell chaired that meeting and afterwards said: "This was a valuable opportunity to challenge both bidders on the issues that concern patients, staff, volunteers and the wider community. The answers to our questions and the sub group's resulting evaluation will be considered by the Project Board to help inform their decision".

2.7.5 Public and other meetings

In addition to the stakeholder meetings, to which the public was invited, there were five public meetings, independently chaired by David Monks. These were designed to outreach the Trust engagement, and took place on the fringes of the Hospital's catchment

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in Cambourne (4 March 2010), March (7 July 2010), St Neots (19 July 2010) and St Ives (23 September 2010). The latter two venues were added in direct response to requests from the public. A fifth took place in Huntingdon (27 October 2010).

Representatives from the SPT repeatedly offered to give presentations at other meetings and, in response to invitations from the public, spoke at Huntingdonshire Patients Congress (20 May 10), Doddington Patient Participation Group (6 May 2010), Cambridgeshire LINK (11 March 2010) and Kimbolton & Stonely Annual Parish Meeting (18 March 2010). Regular presentations were also given to Hinchingsbrooke's Medical Advisory Committee and Staff Trust Council.

2.7.6 Engaging and informing staff

The process for engaging and informing staff at the Hospital was managed included:

- open meetings, chaired by the Chief Executive;
- formal monthly team briefings, with HNS as a standing item;
- fortnightly internal newsletter;
- trust staff council, meeting on a bi-monthly basis;
- local negotiating committee;
- medical advisory committee;
- representation on stakeholder panel;
- engaging staff side representatives at local, regional and national level; and
- all staff emails and intranet.

A log containing a sample of these activities is included in Appendix 4.

2.7.7 Information dissemination

As well as meetings, there were numerous other routes through which the broader public was invited to take part and stay informed of the Project. An e-newsletter, Next Steps Now, was circulated between issues of Next Steps News magazine, giving updates on intermediate stages of the Project. Eight editions were produced, emailed to all contacts and posted onto the Hinchingsbrooke microsite on the SPT's website (www.eoe.nhs.uk/strategicprojects).

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The SPT's website was a key source of information on the Project, and in the website's Information Centre, the public was able to access:

- stakeholder agendas and minutes;
- reports and publications;
- press releases and statements;
- frequently asked questions;
- background information and useful links; and
- interactive forms replicating the questions posed in Next Steps News, as well as a general 'get in touch' mechanism.

Visitor numbers demonstrate that the website was well used. In the period 4 November 2009 to 21 October 2010 the SPT's website had received 8,949 visits from 4,997 visitors. The most visited Hinchingsbrooke pages were:

PAGE	NUMBER OF VISITS	NUMBER OF VISITORS
Trust presentations, minutes and agendas	1,685	807
Media releases	1,075	742
Trust reports and magazines	1,061	627

Other routes through which engagement was encouraged included the SPT monthly SPT Update, twitter postings, Q&A stalls at the Hospital and media activity.

2.7.8 Engaging with the media

Proactive, positive press releases were issued at key stages of the Procurement process. Nine have been released to date (21 October), covering issues such as the launch of public engagement campaigns to the shortlisting of bidders. The press releases were detailed and usually included quotes from NHS Cambridgeshire, Hinchingsbrooke Health Care NHS Trust and NHS East of England, to demonstrate a consistency of message and a co-ordinated approach.

Press statements were promptly issued to Trust related stories generated elsewhere.

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To ensure a consistency of message, a series of 'lines to take' were developed in response to frequently asked questions, so all within the communications alliance and their managers could be confident in responding to journalists' queries. These 'lines to take' were developed in conjunction with the DH and NHS EoE's communications team. To further reinforce the key messages, and in response to requests from the public, 'ten key facts' about the Project were developed, and included in materials. These facts included, for example, that 'staff will continue to be employed by the NHS, retaining their NHS terms and conditions' and 'the successful franchisee will not be making a profit at the expense of patient care'.

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3 Economic case

3.1 Introduction

This section of the FBC documents evidence to show that we have selected the most economically advantageous offer, which best meets our service needs and optimises value for money.

3.2 The long-listed options

A summarised version of the long list of options evaluated within the OBC were as follows:

OPTION		DESCRIPTION
1	Do Minimum	Continue with current management structure and improvement plans. This represents the baseline case.
2	Merger between HHCT and PCT Provider Arm	Under the proposed option the Trust would merge with the provider arm of the PCT, building on the existing community based care infrastructure and its expansion planned for 2008/09, releasing financial as well as service benefits.
3	Split out assets from operations (AssetCo/OpCo)	<p>This an asset based solution, with HHCT remaining in place, and which would separate staff and assets in the business:</p> <p>The assets would be sold under a competitive procurement to a third party (under a sale and leaseback arrangement), thereby generating an upfront capital receipt to repay/contribute to repayment of the historic debt subject to NHS accounting rules.</p> <p>NHS staff would continue to provide services, not being distracted by having to manage the estate</p>
4	New Service Model (Local integration with Community based care)	<p>This represents an integrated service provider option for Hunts. It requires a joining together of current Hinchingsbrooke and current local Hunts community services, in turn increasing the scope of the proposal. Ownership could be in either the public or private sector.</p> <p>A competitive process would seek to develop new</p>

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OPTION		DESCRIPTION
		models of care that would co-locate and integrate community-based care at Hinchingsbrooke. One option could be the adoption of a 'polyclinic' type facility to provide a full range of primary and community services. Hinchingsbrooke hospital would continue to provide non-complex inpatient and day case care in the local setting in the DGH model.
5	New Organisational Model (Kaiser)	<p>This option is a further development of Option 4 providing additional incentive for local innovation in service delivery through the integration of primary care as well as community services and secondary care.</p> <p>A 'supplier' would be given a per-capita budget (which could be determined through a competitive process) and would be expected to deliver integrated primary, community and secondary care services for the Hinchingsbrooke area population. The 'supplier' would be expected to align incentives to focus on prevention.</p> <p>For example, a 'supplier' at Hinchingsbrooke hospital could experiment with an organisational model which would help it align incentives to manage its aging population with Long Term Conditions (LTCs) in a more sustainable way.</p>
6	Management Franchise	<p>A franchise is an agreement by which the right to own and/or supply a service is awarded to a provider for a defined period of time.</p> <p>In the past the franchise concept was used to deal with failing NHS Trusts such as the franchise for the management of Goodhope Hospital that was won initially by a private sector organisation. This form of franchising is in essence contracting for skilled management talent through a partnering organisation. The partnering organisation would operate in the same way as a traditional Chief Executive.</p> <p>Under this option:</p> <p>A competitive tendering process would be used to select a third party to manage the Hinchingsbrooke hospital under a Management Franchise Agreement, for a</p>

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OPTION		DESCRIPTION
		<p>specified contract period. The aim would be to transfer skills and expertise to the staff and organisation so that at the end of the contract period, the Trust could be 'handed back' in a stronger, more successful position</p> <p>Feedback from third party discussion meetings indicate a term of 2-3 years would be suitable for this option</p> <p>Competition should be open to: NHS Foundation Trusts, NHS Trusts, current management and the Independent Sector</p> <p>HHCT remains in place and remains the provider of services.</p>
7	Operating Franchise	<p>For the purposes of franchising the activities of a 'failing' NHS trust, an Operating Franchise can be summarised as the grant of a right to provide all of the services (including clinical services) currently being provided by an NHS trust using some or all of the assets and employees.</p> <p>Under this option:</p> <p>A competitive tendering process would be used to select a third party to take on the provision of services as set out in option 2 of the Cambridgeshire PCT consultation document which are broadly the same range as those currently provided at Hinchingsbrooke Hospital</p> <p>Feedback from third party discussion meetings indicate a term of 10 years would be appropriate for this option (minimum of 7). A break clause after 5 years could be incorporated</p> <p>Competition should be open to: NHS Foundation Trusts, NHS Trusts, current management and the Independent Sector</p> <p>HHCT remains in place to hold the assets and staff contracts and has a contract with the operator for their use</p>
8	Sale (competition open to NHS organisations and	<p>Under this option:</p> <p>Hinchingsbrooke Hospital would be acquired by another</p>

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OPTION		DESCRIPTION
	IS)	<p>organisation under a competitive tendering process</p> <p>Competition would be open to NHS Foundation Trusts, NHS Trusts and the Independent Sector</p> <p>The assets of the Trust are transferred to the acquirer and the staff are transferred under a TUPE transfer.</p>
9	Sale (competition only open to NHS organisations)	<p>Under this option:</p> <p>Hinchingbrooke Hospital would be acquired by another organisation under a competitive tendering process</p> <p>Competition would be open to NHS Foundation Trusts and NHS Trusts.</p> <p>The assets of the Trust are transferred to the NHS acquirer and the staff are transferred under a TUPE transfer</p>

3.3 Short-listed options

The short listed options shown within the OBC were as follows:

OPTION
Operating Franchise
Sale (open to IS, NHS FTs and NHS Trusts)
Sale (open to NHS FTs and NHS Trusts)
Acquisition of PCT provider arm
Management Franchise
Do Minimum

The preferred and agreed option at OBC stage was Option 7, the Operating Franchise. This was the solution that was taken through procurement.

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3.4 The procurement process

The competitive dialogue procurement route was followed. The procurement process and results are presented in detail in Section 4.4 of the Commercial Case.

Following the end of the dialogue period, two shortlisted bidders were invited to submit their best and final financial offers in response to issued Invitation to Tender documentation: Circle Health Limited (“Circle”) and Serco Health Limited (“Serco”). A Trust Comparator developed by the Trust is used for determining VfM.

3.5 Economic Appraisal

3.5.1 Introduction

The purpose of the economic appraisal is to compare the relative costs or benefits of the options by ranking them in terms of Net Present Value (NPV), appropriately adjusted for the risks inherent to each and make a recommendation of the preferred option.

As identified in the OBC, this Project is highly unusual, which makes the economic appraisal unusual. In the OBC options were ranked on the basis of the expected levels of contribution to the repayment of the Trust’s accumulated deficit. In the FBC the same approach is adopted with bids and the Trust Comparator ranked on the basis of projected levels of contribution to repayment of the historic deficit.

At the time of preparing the OBC the Trust’s historic deficit was projected to be £38.7m at 31 March 2008 (and was subsequently shown to be £38.9m in the final accounts). One of the key objectives of the project was the repayment of the Trust’s historic deficit. At the time of finalising the OBC (April 2008), the macro economic assumptions and commissioning activity assumptions underpinning those projections were developed in a stronger economic climate. The result of the OBC analysis was that an ‘*Operating Franchise*’ option was expected to make contributions of £19.6m (NPV) towards the repayment of historic deficit over a 10 year period compared to £5.9m (NPV) of contributions under a ‘*Do minimum*’ option (i.e. Trust Comparator) solution. The other short-listed options ranked in between these two levels of contribution.

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3.5.2 Impact of economic downturn on projections

By the time the procurement had reached its first stage of dialogue, the economic downturn meant that the activity projections and macro economic assumptions had to be revisited. The ITPD1 documentation included Trust projections for a 7 year franchise term which indicated that even before the Trust could make contributions to the repayment of Trust historic deficit it or before it could take a fee, it would have to make cumulative savings of £102m over the 7 year term just for the Trust to achieve break even.

By the time ITPD2 documentation was issued (April 2010), NHSC (the main commissioner of activity from the Trust) had published its 5 year commissioning strategy. Once these projections were built into the Trust's financial projections, the projected level of cumulative savings to achieve Trust breakeven had increased from £102m to £133m over a 7 year term. Bidders had identified during the first stage of dialogue that a 10 year term would allow them to invest in more initiatives as they would have longer period to recover their investment. In ITPD2 bidders were also provided with 10 year Trust projections. The projected levels of cumulative savings to achieve Trust breakeven were £228m over a 10 year term (i.e. before franchisee fee or contributions to repayment of the historic deficit. These were identified as the Base Case projections and are included in the Economic Appraisal.

Given the enormity of the changes, the 'Do Minimum' projections adopted in the OBC had to be revised in order to provide a like for like comparison for bids received. At each stage of the procurement process, the Trust Comparator was updated to align with the projections being provided to bidders. Details of the methodology of the Trust Comparator are included in Appendix 7.

3.5.3 Economic appraisal during the procurement

In their bid submissions (at ITPD1, ITPD2 and ITT) bidders were required to submit details of initiatives they expected to implement at the Trust and to project the 'savings' associated with each initiative.

At ITPD2 these initiatives were assessed across workstreams (clinical and service, workforce, estates, IM&T, legal and financial) and where these passed the evaluation the savings were allowed to be incorporated in the bidders' Base Case financial models.

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A similar approach was adopted for the Trust Comparator where initiatives developed by the Trust were assessed by a designated SHA team (completely separable from the procurement team). The review of initiatives incorporated an optimum bias element and therefore no separate optimum bias adjustments were deemed necessary. Details of the evaluation of the Trust Comparator are included in Appendix 7.

At ITPD2 bidders were required to achieve cumulative savings associated with their initiatives of over £70m in order to proceed to the ITT stage.

At ITT bidders were required to submit two bids each – one based on an assumed 7 year term and one based on an assumed 10 year term. All bids were assessed in terms of their projected contribution to repayment of the Trust's historic deficit under three defined revenue scenarios. A weighted average was then calculated for each bid in NPV terms (the "Weighted Average Contribution"). The financial evaluation identified the Most Economically Advantageous Tender ("MEAT") by ranking the bids in order of their Weighted Average Contribution.

The financial evaluation methodology and criteria were included in the ITT documentation issued to bidders on the 6th October 2010. The Evaluation Report is included in Appendix 5.

3.5.4 Methodology for economic appraisal of final bid submissions and Trust Comparator

Defined Revenue Scenarios and associated Weightings. The Base case scenario defined at ITPD2 remained unchanged at ITT. The Base Case scenario was based on activity and revenue projections provided by NHSC up to 2013/14 to align with their 5 year commissioning strategy and for subsequent years based on assumptions agreed by the Project Team

The purpose of identifying alternative revenue scenarios was to highlight the differences between Bidders' proposed sharing allocations of the Trust Annual Surplus between the Franchisee and Trust across different bands of surplus (as bid in Schedule 3 (Charges and Payments) in the Franchise Agreement which could then be taken into consideration in the financial evaluation. For example, where one Bidder bids a 50:50 share of Trust Annual Surplus between the Franchisee and Trust at a higher Trust Annual Surplus band and a second Bidder bids a 30:70 share of Trust Annual Surplus between the

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Franchisee and Trust within a similar band, then the financial evaluation was designed to take account of the additional financial benefit to the Trust under the second Bidder. It was therefore anticipated that by including upper scenarios in the evaluation, this would incentivise bidders to bid competitively at higher Trust Annual Surplus bands which would mitigate the risk of the Franchisee benefitting from super profits. It should be noted that the sharing allocations used by bidders were included in Schedule 3 of the Franchise Agreement and thus are binding over the course of the Franchise.

The specific scenarios identified were chosen as a 'simple' revenue pricing mechanisms for triggering increases to Trust Annual Surplus. It was recognised that under a real scenario were NHS tariff to increase, then it is likely that there would be pressure on the cost line as well. However, as we were trying to identify the impact of an increase in Trust Annual Surplus across different bids, we purposefully selected scenarios linked to movements in price that would have a direct impact on the revenue line, an equivalent direct impact on the Trust Annual Surplus and no impact on the cost line.

Therefore in addition to the Base Case Scenario, two upside scenarios were identified as summarised in the table below. The table shows the projected cumulative Trust 'shortfall' associated with each scenario and the proposed weighting to be used in calculating the Weighted Average Contribution for each bid.

Why downside scenarios have not been incorporated in the evaluation

The Upper Scenario 1 and Upper Scenario 2 revenue projections provide an indication of upside macro economic assumptions on each bids projected contribution to repayment of Trust historic deficit. As stated above, the main purpose of incorporating these scenarios in the financial evaluation was to incentivise bidders to bid higher % share allocations to the Trust for higher bands of Trust Annual Surplus and to mitigate the risk of the Franchisee benefitting from super profits. Although bidders could have been asked to provide projections for macroeconomic downside scenarios this was intentionally not requested because:

- Although the Base Case scenario reflected the PCTs projections as at June 2010, the outputs were similar to downside Monitor efficiency projections published in April 2010 and therefore were already considered challenging;

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- If downside scenarios were incorporated then given the high level of savings required to be met even under the base case (circa £227m over 10 years), and particularly the fact that at ITPD2 bidders had not projected even achieving these level of savings, it was expected that the £5m Franchisee Support Payment threshold would be reached relatively quickly which would allow the Trust or Franchisee to trigger termination for Franchisee default under the Agreement; and
- Given that during ITPD2 dialogue all bidders were raising the potential need for NHS support payments, it was feared that if further downside scenarios were presented this could encourage further discussions with bidders wanting to build into the Franchise Agreement specific circumstances that would trigger an obligation to pay such NHS support payments.

SCENARIO	PROJECTED CUMULATIVE TRUST 'SHORTFALL'	WEIGHTING
Base Case	As per ITPD2 Base Case with projected cumulative Trust shortfalls of £132.5m (over 7 years) and £227.6m (over 10 years) as shown in Appendix 5 (Economic Appraisal).	70%
Upper Scenario 1	Instead of assuming that activity prices decrease at '-2%' per annum below 2010/11 tariff levels for the first 3 years of the franchise (as per the Base Case), assume that prices stay level in nominal terms (i.e. cash terms) for the first 3 years. Therefore the revenue is projected to be flat in cash terms without any increasing activity. This would reduce the projected cumulative Trust shortfalls to £103.5m (over 7 years) and £184.2m (over 10 years) as shown in Appendix 5 (Economic Appraisal).	20%
Upper Scenario 2	Instead of assuming that activity prices decrease at '-2%' per annum below 2010/11 tariff levels for the first 3 years of the franchise and stay level in nominal terms thereafter (as per the Base Case), assume that prices increase by 1.5% level in nominal terms (i.e. cash terms) for the duration of the franchise.	10%

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SCENARIO	PROJECTED CUMULATIVE TRUST 'SHORTFALL'	WEIGHTING
	Therefore the revenue is projected to b without any increasing activity. This would reduce the projected cumulative Trust shortfalls to £68.5m (over 7 years) and £114.7m (over 10 years) as shown in Appendix 5 (Economic Appraisal).	

Completed ITT Proforma Templates

In response to the ITT Bidders were required to complete a Proforma Template excel spreadsheet which comprised 6 separate proforma:

- Proforma 1 – Base Case (7 years)
- Proforma 2 – Upper Scenario 1 (7 years)
- Proforma 3 – Upper Scenario 2 (7 years)
- Proforma 4 – Base Case (10 years)
- Proforma 5 – Upper Scenario 1 (10 years)
- Proforma 6 – Upper Scenario 2 (10 years)

In completing the Proforma Template, Bidders were required to complete the shaded cells in each Proforma to reflect:

- the net impact on **'savings' from their combined initiatives** (to include the combination of 'Option 2' and the 'Possible Future Revisions to Sustainable Services' ('PFRSS') initiatives) or from their Option 2 only initiatives where this results in higher projected savings than the combined initiatives;
- the timing and amounts of **Franchisee Support Payments** if required (to ensure the Trust does not post a deficit) together with timing and amounts of repayments; and
- the aggregate sum of **Contribution to repayment of historic deficit** aligned with the sharing arrangements identified in Annex C of Schedule 3 (Charges and Payment), i.e. the aggregate of Trust Annual Surplus within define bands multiplied by the % allocation to the Trust within the same bands); and
- the **Guaranteed component of Trust Historic Deficit Repayment** (as bid in Annex B of Schedule 3 (Charges and Payment).

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The ITT set out guidelines for bidders in completing the ITT Proforma Template:

- Bidders should not identify additional savings from new initiatives;
- Where additional savings were identified against ITPD2 initiatives then additional back-up needed to be provided to support the changes so that these could be evaluated and appropriate adjustments made to the Bidders projections of savings from initiatives;
- Bidders were required to apply their own risk assessment in arriving at the projected level of 'savings' to be included in the Proforma for evaluation purposes;
- Given that Bidders were taking public consultation risk, any savings identified from the possible future revisions to Sustainable Services initiatives would be given the same weighting (on a £ for £ basis) as those identified from Option 2 initiatives (i.e. there would be no discounting of savings identified);
- Bidders were required to show any requirement for injections of Franchisee Support Payments (payments to be made by the Franchisee to the Trust) in completing the Proforma. The level of Franchisee Support Payment should be determined as the amount that would ensure that the Trust Annual Surplus did not fall below zero in any year (for all scenarios). These injections could be assumed to be repaid in subsequent years provided that level of repayment was set so that any subsequent Trust Annual Surplus did not fall below zero (in accordance with Schedule 3 (Charges and Payment));
- Where a Bidder identified transformation costs that related to fees which were expected to be incurred by the Franchisee or its subcontractors in implementing its initiatives ("Franchisee Transformation Costs"), these costs were to be at the Franchisee's risk and were therefore only to be recoverable through the Franchisee Fee (in accordance with Schedule 3 (Charges and Payment)); and
- Where a Bidder proposed making guaranteed contributions to repayment of the historic deficit then they were required to complete Annex B of Schedule 3 (Charges and Payment) of the Franchise Agreement, clearly setting out the timing and amount of guaranteed payments. In the evaluation such guaranteed amounts would be awarded double weighting in financial terms

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(i.e. £2 for every £1 guaranteed). However, it should be noted that any amount guaranteed would have to be supported by an acceptable financial guarantee over and above the £5m Franchisee Support Payment already required under the Franchise Agreement.

The Proforma Templates were also completed for the Trust Comparator based on the level of savings from initiatives projected.

Selection of Most Economically Advantageous Tender (“MEAT”)

Subject to having passed the legal and commercial evaluation, bids were required to be ranked on the basis of the highest Weighted Average Contribution. If a Bidder’s 10 year bid projected a higher WAC than its 7 year bid, then the 10 year bid would be ranked higher than the 7 year bid. The Trust Comparator would also be included in the ranking on a similar basis.

3.5.5 Application of methodology in determining the net present value of contributions to repayment of Trust historic deficit

The financial evaluation considered a weighted average of contributions to repayment of historic deficit in Net Present Value (NPV) terms.

The Net Present Value was calculated assuming a real discount rate of 3.5% (and an assumed nominal discount rate of approximately 6.1% ($1.025 \times 1.035 = 1.061$)).

The contributions to repayment of historic deficit were based on projected contributions. However, any guaranteed element of contribution (bid as a Guaranteed component of Trust Historic Deficit Repayment in Annex B of Schedule 3 (Charges and Payment) of the Franchise Agreement), were awarded double weighting in financial terms (i.e. £2 for every £1 guaranteed).

For a 7 year bid the Weighted Average Contribution for a bid was calculated as:

$$WAC_{(7yrs)} = 0.7NPVC_{(P1 \text{ Base Case})} + 0.2NPVC_{(P2 \text{ Upper Scenario 1})} + 0.1NPVC_{(P3 \text{ Upper Scenario 2})}$$

Where:

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- $NPVC_{(P1 \text{ Base Case})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Base Case scenario over 7 years as calculated in Proforma 1
- $NPVC_{(P2 \text{ Upper Scenario 1})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Upper Scenario 1 over 7 years as calculated in Proforma 2;
- $NPVC_{(P3 \text{ Upper Scenario 2})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Upper Scenario 2 over 7 years as calculated in Proforma 3.

For a 10 year bid the Weighted Average Contribution for a bid was calculated as:

$$WAC_{(10\text{yrs})} = 0.7NPVC_{(P4 \text{ Base Case})} + 0.2NPVC_{(P5 \text{ Upper Scenario 1})} + 0.1NPVC_{(P6 \text{ Upper Scenario 2})}$$

Where:

- $NPVC_{(P4 \text{ Base Case})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Base Case scenario over 10 years as calculated in Proforma 4
- $NPVC_{(P5 \text{ Upper Scenario 1})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Upper Scenario 1 over 10 years as calculated in Proforma 5
- $NPVC_{(P6 \text{ Upper Scenario 2})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Upper Scenario 2 over 10 years as calculated in Proforma 6

The Proforma Templates showing the calculated contributions in NPV terms (for Circle, Serco and the Trust Comparator) are included in Appendix 5 (Economic Appraisal). The results are summarised in the table below together with the Weighted Average Contribution amount calculated in accordance with the above formulas.

WEIGHTED AVERAGE CONTRIBUTION (7 YEARS)

NPV (£'m)	CIRCLE	SERCO	TRUST COMPARATOR
$NPVC_{(P1 \text{ Base Case})}$			

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NPV (£'m)	CIRCLE	SERCO	TRUST COMPARATOR
NPVC _(P2 Upper Scenario 1)			
NPVC _(P3 Upper Scenario 2)			
WAC _(7yrs)			

WEIGHTED AVERAGE CONTRIBUTION (10 YEARS)

NPV (£'m)	CIRCLE	SERCO	TRUST COMPARATOR
NPVC _(P4 Base Case)			
NPVC _(P5 Upper Scenario 1)			
NPVC _(P6 Upper Scenario 2)			
WAC _(10yrs)			

3.5.6 Option ranking

The ranking of bids and Trust Comparator by highest Weighted Average Contribution are summarised below. It should be noted that these estimates include a double weighting against any guaranteed amounts:

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RANKING BY WEIGHTED AVERAGE CONTRIBUTION (IN NPV TERMS)

RANKING	Bid	WAC
1	[REDACTED]	[REDACTED]
2	[REDACTED]	[REDACTED]
3	[REDACTED]	[REDACTED]
4	[REDACTED]	[REDACTED]
5	[REDACTED]	[REDACTED]
6	[REDACTED]	[REDACTED]

[REDACTED]

[REDACTED]

3.6 Risk Appraisal

Bidders have built in their own risk assessment in presenting the results of their initiatives. With regard the Trust Comparator, the assessment of initiatives also built in an optimum bias risk adjustment. As a result the assessment the cumulative savings associated with proposed Trust initiatives were reduced by approximately [REDACTED].

3.7 Sensitivity Analysis

3.7.1 Upside Scenarios

The upper scenarios provide an assessment of the impact on contributions to repayment of Trust historic deficit based on upside projections of the Trust Annual Surplus.

3.7.2 Comparator Scenario (ten year model only)

The projected contribution to repayment of Trust historic deficit is summarised in the tables below (in nominal terms). Under the Serco Base Case scenario, [REDACTED]

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██████████. Under the Circle Base Case scenario, a cumulative contribution of ██████████ is projected. However, in the case of Circle, based on their projected savings profile, a cumulative contribution repayment of ██████████ would not be cumulatively made until the █ year of the franchise.

Projected cumulative contribution to repaying Trust historic deficit (10 yrs)

Nominal (£'m)	CIRCLE	SERCO
Base Case	██████████	██████████

From sensitivity analysis it can be seen that if Circle's projected savings were reduced by circa ██████████ over the last four years of the franchise, then it would still project a repayment of historic deficit of ██████████ by year █ and breakeven for the Trust thereafter. However, it should be noted that in NPV terms Serco would be a preferable option given the time value of the repayment.

Projected cumulative contribution to repaying Trust historic deficit (10 yrs) based on running a sensitivity of reduced Circle savings

Nominal (£'m)	CIRCLE	SERCO
Base Case	██████████	██████████

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4 Commercial case

This section of the FBC sets out the agreed arrangements.

4.1 Franchise Overview

The Franchisee will provide a full range of modern acute hospital services. Full management risk and responsibility will pass to the Franchisee whilst NHS assets and staff will remain with the Trust.

4.2 Proposed contract length

The Business Case recommends a franchise term over 10 years as it demonstrates

- A greater debt repayment - £40m rather than £24m over years
- A partner that is able to undertake initiatives that produce the required cost savings to meet the commissioning deficit.

4.3 Personnel implications

4.3.1 ROE

Whilst TUPE is not expected to apply at the start of services commencement under the Franchise Agreement this cannot be said to be the case categorically. As a result, and to ensure NHS employees stay within the NHS (and retain their NHS pension scheme), the decision was made, to use a form of RoE model. Under the RoE model to be used under the Franchise Agreement, the employees of HHCT (via their employee representatives) will be consulted with about the Franchise Agreement and its consequences.

All HHCT employees will then be invited to opt out of any possible TUPE transfer by exercising their statutory right to do so. Under TUPE, the HHCT employees' employment would automatically cease following an opt out and so, instead, HHCT will immediately offer re-employment with HHCT on the same terms and conditions. In this way, HHCT employees' employment will remain with HHCT.

During the dialogue process the Bidders (Serco and Circle) indicated that they wanted protection against any employment liabilities that might transfer to them under TUPE in the form of an indemnity. Such

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liabilities could transfer to the Franchisee in a number of cases (all of which are subject to the start of the services provision constituting a TUPE transfer in any event):

- where employees do not opt out - either because they make the conscious decision that they wish to transfer to the Franchisee or because they have been missed in the consultation process;
- where there is a successful challenge to the validity of the RoE model to prevent employment transferring under TUPE in these circumstances; and
- where SoS withdraws approval to use RoE in this case.

If employees' employment should transfer, it would mean that liabilities associated with the employees would also transfer - such as the liability for any discriminatory conduct of HHCT before the transfer and any breaches of contract that might have occurred before the transfer.

A mechanism has therefore been developed as follows:

- HHCT employees will be consulted with about the Franchise Agreement and its consequences;
- HHCT employees will be invited to opt out of any potential TUPE transfer;
- if, during the consultation process, the indications are that large numbers of employees will not opt out of the transfer, HHCT (with the agreement of SHA) has the right to bring the Franchise Agreement to an end so that the services do not commence at all. Otherwise, the amount of money HHCT would have to pay out on the indemnity (described below) would be too onerous; and
- if, during the consultation process there are no/very few employees who wish to opt out of the transfer (so that HHCT need not bring the agreement to an end), but if some employees do claim to transfer to the Franchisee, the Franchisee must, subject to below, terminate such employee's employment and HHCT will indemnify the Franchisee for the costs of termination (including salary and benefits up to the date of termination) and any other liabilities arising from HHCT's acts/omissions prior to the transfer. However, before the Franchisee can terminate such employees' employment, HHCT will be given the opportunity to offer to redeploy those employees so as to avoid the Franchisee having to dismiss their employment.

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Existing staff will continue to remain employees of the Trust as long as they continue to be employed there. No transfers of staff would be required by the proposed agreement

4.4 Procurement route

4.4.1 Background

EoE, on behalf of the Trust and in collaboration NHS Cambridgeshire, are responsible for procuring the Franchise.

The Outline Business Case approved by the Project Board on 15 April 2008 and reviewed by the SHA Board on 24 April 2008 recommended that the Procurement be adopted to appoint an operating franchise partner to operate the Trust delivering services as if it were the Trust. The procurement approach to be adopted was an open competition using an Invitation to Participate in Dialogue in the following five stages:

- Stage 1 – Expressions of Interest;
- Stage 2 - Pre-Qualification Questionnaire and Memorandum of Understanding;
- Stage 3 – Invitation to Participate in Dialogue Stage 1 (ITPD1) testing Bidders' capability, capacity and requesting their views on cost savings;
- Stage 4 – Invitation to Participate in Dialogue Stage 2 (ITPD2) providing for dialogue with Bidders on their cost saving Initiatives; and
- Stage 5 – Invitation to Tender (ITT) detailing the final financial offer and agreeing to the Franchise Agreement.

The OBC confirmed that the drivers for the Procurement should be: (i) the repayment of the historic debt (£38.4m); and (ii) the delivery of sustainable services without recourse to Public Consultation. Subsequently at ITPD1 and recognising the change in Commissioners Strategy, particularly the Strategic Plan produced by NHS Cambridgeshire a requirement was included to test the projected cost savings against the anticipated commissioning deficit (circa £150m). This was confirmed by the Project Board on 18 December 2009.

The letter of approval from the Department of Health further confirmed that at franchise commencement staff should undertake a RoE model.

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The delegation of the Trust's functions to the Franchisee required authorisation by the Secretary of State using an Intervention Order under section 67 of the NHS Act 2006.

4.4.2 Pre Qualification Questionnaire (PQQ)

A total of 19 organisations (including NHS and Independent Sector providers) expressed an interest in the Hinchingsbrooke Next Steps Procurement. The MOI and PQQ documentation was issued to all 19 Bidders.

11 PQQ bid responses were received by the PQQ submission deadline on 16th November from the following Bidders:

- Cambridge University Hospitals NHS Foundation Trust (CUHFT);
- Circle Health;
- Coral Health;
- Guy's & St. Thomas' NHS Foundation Trust;
- Health Care Projects Ltd (HCP);
- Interhealth Canada (UK) Ltd;
- Netcare Healthcare U.K (Netcare U.K);
- Partnership Health Group Limited (PHG);
- Ramsay Health Care UK;
- Serco Health; and
- UK Specialist Hospitals Ltd.

Potential Bidders were evaluated on submissions made for Clinical, Workforce, Legal and Financial:

- 7 Bidders passed the PQQ evaluation; and
- 6 Bidders prequalified and were eligible to participate in ITPD1.

This is on the basis that Guy's & St Thomas' and Serco Health submitted individual PQQ bids. However both organisations stated their intention to pursue the Procurement as a joint venture arrangement with one another. During the clarification process Guys & St Thomas' and Serco confirmed a joint venture arrangement whereby Guys & St Thomas' would act as the lead Bidder. On this basis Guys & St Thomas' evaluation scores were taken forward for short-listing purposes.

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- 4 Bidders failed the evaluation

The results of the PQQ Evaluation are shown in below:

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SUMMARY OF PQQ EVALUATION

Bidder:	(1) CUH	(2) Circle	(3) Coral	(4) G&StT	(5) HCP	(6) IntCan	(7) Netcare	(8) PHG	(9) Ramsay	(10) Serco	(11) UKSH
For information											
A Details of potential Bidder	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Workstream											
B Legal	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
C Financial	Pass	Pass	Fail	Pass	Fail	Pass	Pass	Pass	Pass	Pass	Pass
F Declaration	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
G Confidentiality Undertaking	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Scored											
D Clinical requirements	Pass	Pass	Pass	Pass	Fail	Pass	Fail	Pass	Pass	Pass	Fail
E Workforce requirements	Pass	Pass	Pass	Pass	Fail	Pass	Pass	Pass	Pass	Pass	Fail
Total	91%	63%	48%	86%*	12%	59%	35%	62%	60%	94%*	50%
Overall Outcome:	Pass	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Pass	Pass	Fail
Rank:	1	3		2*		6		4	5	*	

Important note :

During the clarification process Guys & St Thomas' and Serco confirmed a joint venture arrangement.

Guys & St Thomas' is the lead Bidder; therefore Guys & St Thomas scores will be taken forward for Shortlisting purposes.

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Six Bidders passed all workstream evaluation requirements and qualified at PQQ Stage as follows:

- Cambridge Universities Hospital NHS Foundation Trust (ranked 1st);
- Guy's & St Thomas' and Serco (ranked 2nd). (Guys and St Thomas scores (and not Serco's) were taken forward for short listing purposes. This is on the basis that Guys and St Thomas' were acting as lead organisation in their joint venture with Serco);
- Circle (ranked 3rd);
- Partnerships in Health Group Ltd (PHG) (ranked 4th);
- Ramsay (ranked 5th); and
- Interhealth Canada (ranked 6th). (Interhealth Canada's total score of 59% fell just below the overall 60% pass threshold. The Moderation Panel agreed to allow Interhealth Canada to qualify on the basis that it passed all workstream level evaluations and it was only a percentage point below the 60% pass threshold, which was within an acceptable 5% margin).

The evaluation of PQQ noted that the passed Bidders scored well as they:

- directly answered questions in such a way as to integrate their responses into a clear and robust submission which demonstrated the Bidders' capacity and capability for effective delivery of services; and
- responded to questions clearly and comprehensively with sufficient detail which demonstrated a good understanding of the Project requirements and met the requirements of the evaluation criteria set out in the PQQ evaluation plan; and
- supplied all the information that was requested in a particular question (either within the response or via reference to annexes etc).

The four Bidders who failed at PQQ stage were as follows:

- Health Care Projects ("HCP") failed on finance, workforce and clinical.

On finance, HCP failed to provide adequate information on terminations costs and working capital. On workforce, HCP provided a generally poor response and failed the employment check question.

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On clinical, HCP provided a generally non-compliant response as they failed to provide any details about a clinical service provider as part of their arrangements.

- UKSH failed on workforce and clinical.

UKSH failed to satisfactorily answer the workforce 'pass fail' question on staff turnover and recruitment and on clinical there were minor concerns regarding their A&E, maternity and diagnostics experience.

- Netcare failed as they provided a generally poor response across all workstreams. It was noted that little effort had been put into developing their PQQ response.
- Coral failed to meet the financial evaluation criteria and failed to demonstrate sufficient funding to support the organisation through the bid process. Coral also fell below the required 50% pass mark threshold.

The PQQ Evaluation Report is attached in Appendix 5.

4.4.3 Invitation to Participate in Dialogue 1 (ITPD1)

The ITPD1 documentation was issued on 21 December 2009 to all Bidders that qualified at PQQ stage. The six Bidders recommended at PQQ were selected and confirmed by the Project Board on 18 December 2009:

- Cambridge Universities Hospital NHS Foundation Trust;
- Guy's & St Thomas' and Serco;
- Circle;
- Partnerships in Health Group Ltd (PHG);
- Ramsay; and
- Interhealth Canada.

Guy's & St Thomas' and Serco originally submitted individual PQQ responses with each of them acting as lead Bidder in their respective submissions and with the other of them acting as their partner. Both passed the PQQ Evaluation. On the basis that both Bidders named the other as their partner provider Guy's & St Thomas' and Serco Health confirmed they would form a joint venture, with Guy's and St Thomas' acting as the lead. The detailed background information with regards to this arrangement is set out in Annex 1 of the HNS PQQ Evaluation Report Addendum.

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However, following issue of ITPD1 Guys and St Thomas's confirmed their intention to withdraw from the Procurement process. Serco requested they be allowed to continue to participate in the Procurement on the basis that their original response submitted with them as the lead Bidder had passed the original PQQ evaluation and it was only to avoid duplication of Bids from Guys & St Thomas' and Serco Health that the original selection to proceed with Guys & St Thomas' as the lead Bidder had been made. The Project Director asked Serco Health to submit a revised PQQ response (confirming details of any new clinical services supplier to replace Guys & St Thomas') subject to Project Board approval of Serco's participation in the Procurement process. Following Project Board approval, Serco requested and were allowed to continue in the Procurement process, they were issued an ITPD1 it was agreed as a condition precedent that it would be evaluated provided that Serco submitted a revised PQQ submission providing details of their new clinical services supplier and that the PQQ successfully met the Authority's evaluation criteria as outlined in the PQQ Evaluation Plan. Serco's revised PQQ submission was received by the agreed deadline and successfully met the Authority's evaluation criteria. It was noted that their proposed clinical services supplier was named as Peterborough and Stamford NHS Foundation Trust

ITPD1 was intended to assess the Bidders' capability and capacity which was tested and evaluated around five workstreams: (i) clinical services; (ii) workforce; (iii) IM&T; (iv) estates; and (v) finance. Information was also requested on the contracts and Bidders were asked to confirm their acceptance of legal terms, this was evaluated on a Pass/Fail basis.

So as to provide evidence that Bidders could comply with the anticipated commissioning deficit, they were asked to provide for evaluation an outline of initiatives that would produce the savings required over the term of the Franchise. This workstream was headed "Key Commercial Considerations".

The following five Bidders submitted an ITPD1 bid response by the deadline of 15 February 2010:

- Circle Health;
- Interhealth Canada (UK) Ltd;
- Partnership Health Group Ltd (PHG);
- Ramsay Health Care UK; and

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- Serco Health.

Cambridge Hospitals Foundation Trust (CUHFT) decided not to proceed with their bid submission and therefore formally withdrew from the Procurement on 10 February 2009. CUHFT stated that their Board had made the decision to withdraw primarily so that they can focus their attention on the implications of the operating framework and as a consequence they did not believe the Procurement to be within their strategic plan.

A two-stage evaluation commenced, as per the agreed Evaluation Plan. Stage 1 evaluation of the written bid responses was completed inclusive of individual workstream moderations. A cross workstream moderation meeting was held to agree and consolidate the pre-dialogue meetings scores and agree agenda items for the Bidder clarification meetings

Stage 2 of the evaluation began with Bidder clarification meetings following which formal clarification questions were sent to Bidders for a formal written response. This was followed by a Stage 2 evaluation process involving evaluation of the written responses to the clarification questions (and an adjustment to scores where relevant) and a second moderation meeting was held.

Below is a resume of the ITPD1 evaluation:

At Stage 1 the workstream level results (pre stage 2 Bidder clarification meeting) were as follows:

Workstream Level Weighted Scores (at section level)

Section	Section Weight	Circle Health	Interhealth	Partnership Health	Ramsay Health Care	Serco Health	Threshold Score
ITPD1	(blank)	42.50%	43.75%	14.78%	57.95%	76.92%	
Clinical	45 %	55.00%	28.75%	16.88%	43.75%	63.13%	60%
Workforce	20 %	58.75%	41.25%	35.00%	82.50%	91.25%	60%
Estates and Facilities	5 %	50.00%	82.50%	15.00%	50.00%	82.50%	50%
IM&T	5 %	32.50%	50.00%	62.50%	62.50%	45.00%	50%
Key Commercial Considerations	25 %	50.00%	57.50%	0.00%	72.50%	72.50%	50%
Financial	100 %	0.00%	50.00%	0.00%	50.00%	100.00%	50%

Colour Key:

Score above Threshold

Score below Threshold

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Overall Weighted Scores (Overall Test 1 and Test 2 combined total of 100%)

Section	Section Impact	Circle Health	Interhealth	Partnership Health	Ramsay Health Care	Serco Health
ITPD1	100%	42.50%	43.75%	14.78%	57.95%	76.92%
Clinical	36%	19.80%	10.35%	6.08%	15.75%	22.73%
Workforce	16%	9.40%	6.60%	5.60%	13.20%	14.60%
Estates and Facilities	4%	2.00%	3.30%	0.60%	2.00%	3.30%
IM&T	4%	1.30%	2.00%	2.50%	2.50%	1.80%
Key Commercial Considerations	20%	10.00%	11.50%	0.00%	14.50%	14.50%
Financial	20%	0.00%	10.00%	0.00%	10.00%	20.00%

Clinical: At workstream level only Serco met the minimum 60% threshold for the clinical workstream. In ranking Circle came second scoring slightly lower at 55%. Interhealth, Partnership Health and Ramsay scored significantly lower.

Workforce: Serco and Ramsay met the minimum 60% threshold. Circle scored marginally lower at 58.7%. Interhealth and Partnership Health scored significantly lower.

Estates: All Bidders (except Partnership Health) met the minimum 50% threshold for the Estates workstream. However, Circle scored exactly 50% compared to the highest scores of 82.5% from Interhealth and Serco. Partnership Health scored 15%.

IM&T: Interhealth, Partnership Health and Ramsay met the minimum threshold of 50%. Serco scored only slightly lower at 45%.

Key Commercial Considerations: All Bidders (except Partnership Health) met the minimum 50% threshold for the Key Commercial Considerations workstream. Ramsay and Serco scored the highest at 72.5%.

Legal: All Bidders passed the stage 1 legal evaluation which was pass/fail although Ramsay and Interhealth were passed conditional upon receipt of clear responses to clarification questions.

Finance: The minimum threshold for finance was 50%. Circle and Partnership Health scored 0% and therefore did not meet the minimum criteria. Interhealth and Ramsay both scored 50% and Serco scored highest at 100%.

Circle completed the financial model template incorrectly as they appeared to misunderstand the requirements. Clarification was raised with the Bidder on this issue. Fuller details can be found below.

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All workstreams identified a number of questions for all Bidders to be raised at the stage 2 clarification meetings.

The above results were subject to stage 2 clarification meetings and therefore the scores were subject to further change.

Stage 2 evaluation was intended so that submissions could be re-evaluated following clarifications.

The Bidder clarification meetings were not evaluated however the outcome of these meetings were used to re-review the stage one evaluation scores. The intended questions to be asked at the meetings were shared with Bidders prior to the meetings taking place. All Bidders were asked to submit written confirmation of their responses the clarification questions within 48 hours of the meeting. Bidders clarification responses were reviewed by the evaluation leads (and their evaluation teams where applicable) and the original stage 1 evaluation scores were reconsidered where necessary.

Following conclusion of the clarification meetings and receipt of Bidders' written clarification responses (within the stipulated deadlines) the clinical, workforce, IM&T, key commercial consideration and financial workstreams revisited the stage 1 scores to update their scores accordingly.

In summary changes were made to the clinical, IM&T and financial scores as follows:

- the stage 2 clinical evaluation resulted in two score changes for Ramsay response to Question 4 on collaborative working for healthcare organisation and question 11 ENT case study. The scores improved from 1 (minor concerns) to 2 (good confidence) however this was not a sufficient enough increase for Ramsay to pass the overall clinical threshold.
- Circle confirmed that they had misunderstood the target Trust savings required under the financial template provided to Bidders at ITPD1. They had assumed a [REDACTED] target instead of a [REDACTED] target. In response to clarification they submitted an updated financial template which showed proposed 'savings' from initiatives of [REDACTED]
[REDACTED] The clinical evaluation confirmed the feasibility of initiatives and therefore the additional identified savings were incorporated in the analysis and

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scores adjusted accordingly. On this basis Circle's score increased from '0' to '2'.

SUMMARY STAGE 2 EVALUATION

Section	Section Weight	Circle Health	Inter-health	Partner-ship Health	Ramsay Health Care	Serco Health
ITPD1	(blank)	53.20%	45.15%	14.78%	59.07%	77.63 %
Clinical	45 %	55.00%	28.75%	16.88%	46.88%	63.13 %
Workforce	20 %	58.75%	50.00%	35.00%	82.50%	91.25 %
Estates and Facilities	5 %	50.00%	82.50%	15.00%	50.00%	82.50 %
IM&T	5 %	50.00%	50.00%	62.50%	62.50%	62.50 %
Key Commercial Considerations	25 %	50.00%	57.50%	0.00%	72.50%	72.50 %
Financial	100 %	50.00%	50.00%	0.00%	50.00%	100.00 %

Colour Key:

Score above Threshold

Score below Threshold

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STAGE 2 SCORE SUMMARY

Overall and Section Results - Total Weighted Scores

Section	Section Impact	Circle Health	Interhealth	Partnership Health	Ramsay Health Care	Serco Health
ITPD1	100%	53.20%	45.15%	14.78 %	59.07%	77.63%
Clinical	36%	19.80%	10.35%	6.08%	16.88%	22.73%
Workforce	16%	9.40%	8.00%	5.60%	13.20%	14.60%
Estates and Facilities	4%	2.00%	3.30%	0.60%	2.00%	3.30%
IM&T	4%	2.00%	2.00%	2.50%	2.50%	2.50%
Key Commercial Considerations	20%	10.00%	11.50%	0.00%	14.50%	14.50%
Financial	20%	10.00%	10.00%	0.00%	10.00%	20.00%

The ranking of Bidders based on the final consolidated scores across all workstreams were as follows:

- Serco Health – 77.63% - PASS
- Ramsay Health Care UK – 59.07% - Below 60% Pass Threshold
- Circle Health – 53.20% - Below 60% Pass Threshold
- Interhealth Canada (UK) Ltd – 45.15% - Below 60% Pass Threshold
- Partnership Health Group Ltd - 14.78% – Below 60% Pass Threshold

These results were discussed during the stage 2 moderation meeting on the 15 March 2010. The moderation meeting was represented by members of NHS EoE, the Trust, NHS Cambridgeshire and the legal and financial advisors to the Procurement.

Based on the final scores Serco was the only organisation to achieve over the 60% aggregate threshold for Tests 1 and 2 required in the

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ITPD2 Evaluation Plan. Based on the final stage 2 results the Procurement Lead presented the following four options for those present at the meeting to consider:

Scenario One

No change to the evaluation criteria resulting in Serco being the only Bidder to pass ITPD1 and proceed to ITPD2.

Scenario Two

Exercise the Commercial Lead's discretion (as set out in the Evaluation Plan) to reduce both the overall threshold i.e. the aggregate threshold for Tests 1 and 2 and the clinical workstream. Circle's clinical score of 55% would pass the reduced threshold level and Serco and Circle would then pass ITPD1 and proceed to ITPD2.

Scenario Three

Reduce the clinical work stream threshold to 50% and then exercise the Commercial Lead's discretion to accept a clinical score within 10% of the reduced threshold. Ramsay's clinical score of 46.88% would then pass the reduced threshold. Serco and Ramsay would then pass ITPD1 and proceed to ITPD2

Scenario Four

Combine scenarios two and three. Serco, Circle and Ramsay would then pass ITPD1 and proceed to ITPD2.

It was agreed by all Evaluation Leads and attending representatives from, EoE, NHS Cambridgeshire and the Trust that scenario one was not acceptable as it did not allow any competition to remain within the process and all attendees confirmed that the purpose of the procurement was to achieve the best solution driven from a competitive process. Scenarios three and four were not acceptable as the reduction of the clinical threshold was too great. In particular it should be noted that Ramsay had been given every opportunity to improve their clinical scores through the clarification process. It was therefore unanimously agreed that scenario two was the best option, as this allowed for competition and did not compromise on the overriding importance of the clinical aspects of the evaluation.

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At conclusion of stage 1 and stage 2 evaluations and based on:

- the recommendation to pursue scenario two; and
- the outcomes of the stage 2 moderation to lower the overall and clinical threshold from 60% to 50%.

The final outcomes of the stage 1 and stage 2 evaluation across all work streams were:

- Serco Heath – 77.63% overall - PASS
- Circle Health – 53.20% overall - PASS
- Ramsay Health Care UK – 59.07% overall - fail
- Interhealth Canada (UK) Ltd – 45.15% overall - fail
- Partnership Health Group – 14.78% overall - fail

This recommendation was made to the Project Board who discussed in detail the outcomes put forward and the evaluation of ITPD1. After due consideration the Project Board agreed that Ramsay be included in addition to Serco and Circle. The Project Board Minutes of the 24 March 2010 state:

“The Board recognised this risk but confirmed their agreement to the appointment of Serco, Circle and Ramsay to ITPD2.”

Copies of the ITPD1 Evaluation Report and The Project Board Minutes dated 24 March 2010 are attached as Appendix 5.

4.4.4 ITPD2

The selection of these Bidders was confirmed by the Project Board on 24 March 2010 and the ITPD2 Documents were issued to the three Bidders on 12 April 2010. The three Bidders were:

- Circle Health;
- Ramsay Health Care UK; and
- Serco Health.

The purpose of ITPD2 was to allow Bidders in discussion with EoE to refine and provide further and better details of the proposals they submitted at ITPD1 stage and to enable them to focus on their Initiatives from a respective clinical and non-clinical perspective.

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To enable Bidders to refine and develop their proposals they were provided with additional information (i.e. within the ITPD2 document itself and further due diligence information contained in the Dataroom) and invited to attend a series of competitive dialogue meetings.

Bidders were required to submit their written ITPD2 submission in the form of: (i) an executive summary setting out in overview what their proposal for operating the Franchise will entail and indicating as an overview their vision for the Trust in years 1 to 3, 3 to 5 and 5 to 7 of the Franchise term (Bidders specifically relating this overview to NHSC's Commissioning Strategy); and (ii) a document setting out in detail their fully developed Initiatives and the estimated financial savings those Initiatives will create for the Trust during the term of the Franchise.

Bidders were asked to consider either a 7 and 10 year Franchise term.

The written ITPD2 bid submissions were evaluated on an Initiative by Initiative basis in accordance with detailed evaluation criteria. Initiatives either passed or failed the evaluation criteria set out in the ITPD2 Evaluation Plan.

Once Bidders' Initiatives had been evaluated, the financial savings attributable to those Initiatives that had passed the evaluation were totalled and Bidders were ranked by the Authority based on the total amount of savings achieved (with the highest ranking Bidder being the Bidder with the most financial savings).

In addition to their ITPD2 written proposal, Bidders were invited to a series of interviews and meetings, the details of which were set out in the ITPD2 documentation.

Bidders were informed that it was the Authority's intention to allow each of the Bidders to proceed to ITT provided Bidders achieve, in their ITPD2 bid submission, at least £70 million of the financial savings previously identified by them in their ITPD1 submission.

Bidders were also informed that their ITPD2 bid submissions must be compliant with the recommendations set out in Option 2 of the 2007 consultation (i.e. to maintain broadly the same current range of Services) subject to the Milestone to be achieved by 13 May 2010.

This requirement was caused by a clarification supplement issued on the 27 April 2010 which provided a common set of assumptions for

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Bidders to use in developing their financial models over a 7 and 10 year Franchise term (NHSC activity projections, other income projections and macro economic assumptions). NHSC worked back from the financial envelope identified in their five year strategic plan in order to establish a common set of activity projections that could be used for comparing bids and assessing affordability.

The Milestone dealt only with the 7 year effect.

The financial impact of the common assumptions showed a cumulative deficit of £150m over a 7 year Franchise term. This deficit was over and above the Trust's historic deficit. NHSC activity revenues were £81.5m in 2009/10 and have been agreed at £82.8m for 2010/11. However NHSC has projected that their revenues will drop by over 6% to £77.7 by the first year of the Franchise (2011/12) and further reduce to £72m over the 7 years.

The information submitted was considered and as a consequence a clarification was issued to Bidders on the 23 June 2010 confirming the outcome of the milestone and requested that as part of their Initiatives to be submitted at (ITPD2) they consider Possible Future Revisions to Sustainable Services (“**PFRSS**”). The reason for the issue of this clarification was that the Authority was concerned about Bidder's ability to meet the target of £70m financial savings.

All three Bidders submitted proposals on 26 July 2010.

On initial examination Circle and Serco's submissions complied with the requirements of ITPD2, however Ramsay's submission was based on a management franchise not accepting operating risk and therefore would not meet the criteria.

Ramsay were asked, via clarification dated 27 July 2010, to confirm the nature of their submission. They replied:

“During the course of the ITPD2 stage, it became clear to Ramsay that the operating environment and the original requirements of the bid as set out by the SHA and the process being followed were significantly and rapidly changing.

As a result, we have submitted a proposal that takes these changes into account and that we believe will ensure a long term future for Hinchingbrooke.”

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After discussions with representatives of the Project Board it was agreed that Ramsay's submission did not meet the ITPD2 requirements and that they would not be invited to the ITT Stage, a letter was sent to them on 28 July 2010 informing them of this decision.

The remaining Bids submitted by Circle and Serco were evaluated. This section describes the Bidders' submissions prior to and during Evaluation.

The Evaluation was in two parts:

- Interviews with GPs, Stakeholders and the Project Board. Bidders were ranked.
- The written ITPD2 bid submissions were evaluated on an Initiative by Initiative basis in accordance with detailed evaluation criteria set out in the Evaluation Plan. Initiatives either passed or failed the evaluation criteria.

Each Initiative was evaluated to ensure that it was:

- clinically viable and deliverable;
- operationally robust;
- not wholly dependent on a third party or event outside a Bidder's control; and
- financially viable in terms of savings achieved.

For each Initiative that passed the evaluation, the financial savings presented in the financial model as attributable to those Initiatives were aggregated.

If an Initiative failed the evaluation the financial savings attributed to that Initiative were not aggregated with that Bidder's other financial savings and the Initiative itself will not be taken forward to ITT stage for further discussion. In order to proceed to ITT stage Bidders were required to achieve £70 million of the financial savings previously identified by them in their ITPD1 submission.

Bidders were ranked by the Authority based on their total amount of savings estimated (with the highest ranking Bidder being the Bidder with the most financial savings). This ranking is based on the aggregated savings achieved from: (i) Option 2 Initiatives; and (ii)

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Initiatives which deal with possible future revisions to sustainable services.

An overview of each submission and its evaluation shows:

Circle

Circle submitted 32 Initiatives dealing with: (i) improvement and rationalisation of service delivery; (ii) production of cost savings; and (iii) alteration to the hospital foot print as a result.

Firstly Service Delivery included :

- reduce patient length of stay [REDACTED]
- improve theatre productivity and utilisation [REDACTED];
- nurse to bed ratios [REDACTED];
- Treatment Centre consolidation [REDACTED];
- introduction of an Enhanced Recovery Programme ("ERP") [REDACTED].
- decrease "Do not Attends";
- increase private patients [REDACTED];
- streamline emergency admissions through A&E [REDACTED]
- CSSD Outsourcing [REDACTED].

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and in the longer term consider in conversation with Commissioners the possibility of:

- a maternity network [REDACTED];
- the introduction of an Integrated Care Organisation [REDACTED].

Secondly Cost Savings are proposed for

- pathology;
- pharmacy;
- diagnostics – smarter use;
- administrative (non-clinical) staff reductions;
- using technology to streamline clinical correspondence;
- finance team; and
- procurement savings.

Those Initiatives produced savings of [REDACTED] over 7 years and [REDACTED] over 10 years. All Initiatives passed the evaluation criteria and achieved the necessary savings of £70m to proceed to ITT.

Circle attended the stage 1 interviews and passed the relevant evaluation criteria. Details of these results are summarised later in the FBC.

Serco

Serco submitted 29 Initiatives that: (i) improve and rationalise service delivery; and (ii) produce cost savings.

Dealing with each in turn:

Firstly Service Delivery included :

- greater share of GP referrals [REDACTED];

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- change in mix [REDACTED]
[REDACTED];
- service improvement and development [REDACTED]
[REDACTED];
- integrated care [REDACTED]
[REDACTED]
- multi-site clinical network model [REDACTED]
[REDACTED]
- reduced length of stay and pre-operative bed days [REDACTED]
[REDACTED],

and in the longer term consider in conversation with Commissioners the possibility of:

- sustainable hospital [REDACTED]
[REDACTED].

Secondly Cost Savings are proposed for:

- pathology;
- back office IM&T;
- procurement;
- continuous improvement; and
- demand led capacity review – including HSDU, radiology, pharmacy and theatres.

Those Initiatives passed the evaluation criteria with the exception of one relating to theatre usage producing savings of [REDACTED] over 7 years and [REDACTED] over 10 years. The Initiatives that passed the evaluation criteria achieved the necessary savings of £70m to proceed to ITT.

Serco attended the stage 1 interviews and passed the relevant evaluation criteria. Details of these results are summarised below.

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Scoring for the Interviews are shown in the below Table:

STAGE 1 SCORES





	CIRCLE	SERCO
Overall Score	87.78%	63.33%
Stakeholder Interview Score	94.44%	66.67%
GP Interview Score	88.89%	83.33%
Board to Board Interview Score	83.33%	41.67%

Bidders were ranked 1st Circle and 2nd Serco.

Scoring for the written submissions and financial results show:

- Circle's submission passed all evaluation criteria for all Initiatives and therefore passed the written submission;
- Serco's submission passed all but two of the Initiatives, both relating to theatres, and all other initiatives passed the written submission;
- both Serco and Circle passed the £70m target financial savings threshold; and
- Bidders were ranked on the basis of the highest adjusted projected financial savings associated with combined Option 2 and PFRSS Initiatives. Details can be found in the table below:

OVERALL BIDDER PROJECTED SAVINGS

7 YEARS	10 YEARS
	
	

In financial terms, Bidders were ranked 1st Circle and 2nd Serco.

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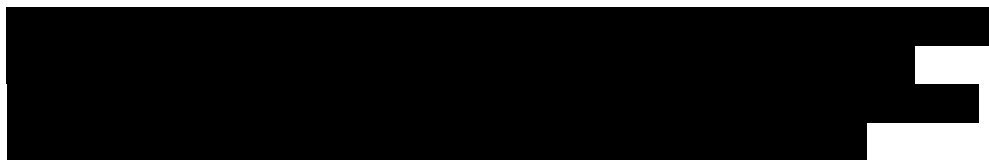
The evaluation of ITPD2 recommended:

- both Bidders met the ITPD2 for selection to proceed to ITT i.e. achieving £70m of ITPD1 savings over the seven year term;
- that both Bidders be selected to proceed to ITT.

A copy of the ITPD2 Evaluation Report is attached as Appendix 5.

4.4.5 ITT

Both Bidders submitted ITTs on 20th October 2010.



The Bids were evaluated using the following criteria:

Initiatives

Please reconfirm your agreement to each initiative listed above. You should identify in your response the initiatives (if any) which you do not intend to take through to the ITT stage.

Please confirm the value associated with each initiative (noting that any changes to value associated with initiatives will be evaluated as part of the financial evaluation).

(Pass/Fail on an initiative by initiative basis)

Franchise Agreement

Please confirm that you accept the Franchise Agreement in the form attached at the Appendix to the ITT. **(Pass/Fail)**

Please confirm that you do not intend to use any material sub-contractors to provide any of the Services other than those already identified by you in your ITPD2 submission. **(Pass/Fail)**

Commercial Requirements

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Corporate Structure/Financial Robustness

Please confirm your proposed corporate structure. Please submit the latest set of audited accounts for Serco's/Circle's proposed contracting entity. In addition Circle were asked for their latest management accounts

Funding Requirements

Please identify any funding requirements to support your financial proposal (including those identified in response to initiatives). Please summarise:

- the level and timing of investments;
- source of funding to support your proposed investments; and
- impact of investment on Trust in terms of accounting treatment.

Working Capital and Termination Costs

Please confirm that you accept the terms relating to working capital liabilities included in the Franchise Agreement (£5m).

Please confirm that you accept the terms relating to termination cost liabilities included in the Franchise Agreement (£2m).

(All Pass/Fail)

Financial Requirements

Each Bidder is required to submit two bids - one based on an assumed 7 year term and one based on an assumed 10 year term.

Each bid will be assessed in terms of its projected contribution to repayment of the Trust's historic deficit under three defined revenue scenarios. A weighted average will then be calculated (the "Weighted Average Contribution").

The financial evaluation will identify the Most Economically Advantageous Tender by ranking the bids in order of their Weighted Average Contribution.

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4.5 Evaluation Results

Dealing with each Bidder separately:

Serco

Initiatives

At ITPD(2) Serco submitted 29 accepted Initiatives that (i) improve and rationalise service delivery and (ii) produce cost savings.

Firstly service delivery included:

- greater share of GP referrals [REDACTED];
- change in Mix [REDACTED];
- service Improvement and Development [REDACTED];
- integrated Care [REDACTED];
- multi-Site Clinical Network model [REDACTED];
- reduced length of stay and pre-operative bed days [REDACTED];
- and in the longer term consider in conversation with Commissioners the possibility of;
- sustainable Hospital [REDACTED].

Secondly cost savings are proposed for:

- Pathology

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- Back office IM&T
- Procurement
- Continuous improvement
- Demand led capacity review – including HSDU, Radiology, Pharmacy and Theatres.

Serco's savings at ITPD(2) were [REDACTED] over 7 years and [REDACTED] over 10 years.

At ITT Serco confirmed that all Initiatives were still applicable but that there level of savings had increased from the above to [REDACTED] over 7 years and [REDACTED] over 10 years.

The Evaluation considered the content of the Initiatives and accepted that there had been no change with the exception of an initiative relating to Depreciation which was not accepted.

Full details of the rationale to disallow this Initiative are contained in the PWC "Invitation to Tender (ITT) Financial Evaluation Report" dated 25th November 2010 attached in Appendix 5 (the Financial Report).

After the omission of the Initiative for Depreciation Serco's savings were reduced to [REDACTED] over 7 years and [REDACTED] over 10 years

Franchise Agreement

Bidders were issued with a Franchise Agreement, the evaluation criteria for which was a Pass/Fail. During the clarification process after issue of the ITT version of the Franchise Agreement both Bidders asked whether the Authority would be willing to accept amendments to the Franchise Agreement. The Authority informed both bidders that minor drafting amendments (such as correcting typographical errors, cross referencing to correct clause numbers) which improved and clarified the drafting would almost certainly be acceptable. However the Authority explained that if either bidder wanted to make material changes to the drafting (eg that changed the risk profile of the franchise) whilst they were free to suggest such amendments in their ITT submission they ran the risk that those proposed amendments would not be acceptable to the Authority and their submission would be evaluated on that basis.

In their ITT submission Serco accepted the form of Franchise Agreement issued at ITT without proposing any amendments.

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Accordingly Serco's ITT submission passed the legal evaluation criteria.

Commercial

Please refer to the detailed Financial Report

To summarise – Serco have provided acceptable evidence on:

- confirmation of their proposed corporate structure and the latest set of audited accounts;
- confirmation of Funding Requirements;
- confirmation of Working Capital;
- confirmation of Termination Costs;
- Financial Requirements.

Financial

The Financial Outcome of the Evaluation is described later in this Report for both Bidders.

Circle

Initiatives

At ITPD(2) Circle submitted 32 accepted Initiatives dealing with (i) improvement and rationalisation of service delivery, (ii) production of cost savings and (iii) alteration to the hospital foot print as a result.

Firstly Service Delivery included:

- reduce patients length of stay [REDACTED];
- improve theatre productivity and utilisation – [REDACTED];
- nurse to bed ratios [REDACTED];
- Treatment Centre Consolidation [REDACTED];

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- introduction of an Enhanced Recovery Programme [REDACTED]
[REDACTED]
[REDACTED];
- decrease “ Do not Attends “;
- increase Private Patients use [REDACTED];
- streamline emergency admissions through A&E [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]; and
- CSSD Outsourcing – [REDACTED]
[REDACTED];
- and in the longer term consider in conversation with Commissioners the possibility of;
- a Maternity Network [REDACTED]
[REDACTED];
- the introduction of an Integrated Care Organisation [REDACTED]
[REDACTED]
[REDACTED].

Secondly Cost Savings are proposed for:

- Pathology;
- Pharmacy;
- Diagnostics – smarter use;
- Administrative (non-clinical) staff reductions;
- Using technology to streamline clinical correspondence;
- Finance Team;
- Procurement Savings.

Circle’s savings at ITPD(2) were [REDACTED] over 7 years and [REDACTED] over 10 years.

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At ITT Circle confirmed that all Initiatives were still applicable but that there level of savings had in increased from the above to [REDACTED] over 7 years and [REDACTED] over 10 years.

The Evaluation considered the content of the Initiatives and accepted that there had been no overall change. However the Evaluation team noted that Circle had increased their Continuous Improvement efficiencies from year 4 onwards from [REDACTED] to “reflect consistency with Monitor’s forecasts

of target CIP efficiency across all Foundation Trusts” A Clarification Question was asked for supporting information to reflect this greater level of savings. Circle confirmed as an outcome of that question:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

The Evaluation considered this approach and concluded that it complied with the evaluation criteria.

Therefore there was no alteration to the anticipated ITT savings.

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Franchise Agreement

Bidders were issued with a Franchise Agreement, the evaluation criteria for which was a Pass/Fail. During the clarification process after issue of the ITT version of the Franchise Agreement both Bidders asked whether the Authority would be willing to accept amendments to the Franchise Agreement. The Authority informed both bidders that minor drafting amendments (such as correcting typographical errors, cross referencing to correct clause numbers) which improved and clarified the drafting would almost certainly be acceptable. However the Authority explained that if either bidder wanted to make material changes to the drafting (eg that changed the risk profile of the franchise) whilst they were free to suggest such amendments in their ITT submission they ran the risk that those proposed amendments would not be acceptable to the Authority and their submission would be evaluated on that basis.

Circle submitted an amended version of their Franchise Agreement and stated that they had made a number of drafting amendments. On review of their amended contract the Authority issued a clarification to Circle confirming that in the Authority's view 5 amendments did not amount to minor drafting changes and if they insisted that they were still required then their submission would be evaluated on that basis. Circle issued a clarification response confirming that they were withdrawing those 5 previously proposed amendments.

Accordingly Circle's ITT submission passed the legal evaluation criteria.

Commercial

Please refer to the detailed Financial Report

To summarise – Circle, after clarification, have provided confirmation of their proposed corporate structure and the latest set of audited accounts.

Circle have identified in their ITT response that Circle Health Limited (“Circle”) would create a Newco, which would be the proposed contracting entity and Franchisee under the Franchise Agreement. Newco would be a private limited liability company organised under the laws of England and Wales and would be a wholly-owned subsidiary of Circle. Health Investment Holdings Ltd (“HIHL”) will be a signatory to

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the Franchise Agreement providing a parent company guarantee to the new created Newco.

It was agreed that this passed the financial evaluation criteria

Confirmation of Funding Requirements

Since submission of the ITT and appointment of the preferred bidder PLC have been admitted to the Alternative Investment Market of the London Stock Exchange (AIM). Please refer to Annex E [?] which considers the security.

To guarantee the termination costs Circle are obliged to place £2m into a security deposit account.

Financial

The Financial Outcome of the Evaluation is described later in this report for both Bidders (see below).

Financial Report

Please refer to the detailed Financial Report. This Report considers the Evaluation under the following headings:

- Financial evaluation methodology and criteria
- Review of additional savings identified in response to the ITT
- Review of guaranteed contributions to repayment of Trust historic deficit as bid at ITT
- Review of share allocation of Trust Annual Surpluses as bid at ITT
- Review of projected contributions to repayment of Trust historic deficit based on share allocation bid at ITT
- Financial evaluation calculations
- Selection of Most Economically Advantageous Tender ("MEAT")

Extracted from this Report are the conclusions of The Financial evaluation

Review of guaranteed contributions to repayment of Trust historic deficit as bid at ITT

Both bidders were invited to indicate how much they were willing to guarantee in terms of contribution to repayment of Trust historic deficit

Guaranteed cumulative contribution to repayment of Trust historic deficit

NOMINAL (£'M)	CIRCLE	SERCO
7 years	■	■
10 years	■	■

Review of share allocation of Trust Annual Surpluses as bid at ITT

It should be noted that the Franchisee Fee as defined in Schedule 3 also includes a performance related payment which could be up to +/- 10% of Franchisee Share of Trust Annual Surplus. In practice this should impact on the amount of contribution to repayment of Trust historic deficit as if the Franchisee performs well and earns an additional 10% then this will have to be funded from the Trust share of the surplus. If the Franchise performs badly with deductions applied then this should increase the contribution to repayment of Trust historic deficit. We have assumed for the purposes of evaluation that the Franchisee performs within the targets set and that the performance related element is zero.

Based on this assumption the share allocation to the Trust that would contribute to the repayment of historic deficit is as summarised below (i.e. 100% less the amounts shown in Annex C of Schedule 3):

Allocation of Trust Annual Surplus to be shared with Trust for the purposes of repaying historic deficit

BANDS OF TRUST ANNUAL SURPLUS*	CIRCLE	SERCO
£0 - £2,000,000	■	■

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BANDS OF TRUST ANNUAL SURPLUS*	CIRCLE	SERCO
£2,000,001 - £6,000,000	■	■
£6,000,001 - £7,000,000	■	■
£7,000,001 - £10,000,000	■	■■■■■■■■■■ ■■■■■■■■■■
£10,000,001 - £12,000,000	■	■■■■■■■■■■ ■■■■■■■■■■
£12,000,000 - £16,000,000	■	■■■■■■■■■■ ■■■■■■■■■■
£16,000,001 - £22,000,000	■	■■■■■■■■■■ ■■■■■■■■■■
>£22,000,000	■	■■■■■■■■■■

*Note Trust Annual Surplus is as defined under the contract (and therefore excludes impact of arrears, disposals and charity income and expenditure)

From the above, it can be seen that until Trust Annual Surplus Projections are above ■■■■, Serco does not propose sharing any of that surplus with the Trust for the purposes of making contributions towards repaying the Trust historic deficit (over and above the guaranteed amount in year 1). This compares to Circle's proposal to contribute between ■■■■■■■■■■ of Trust Annual Surplus over and above surpluses of ■■■■. Even between ■■■■■■■■■■ projected Trust Annual Surpluses Serco is only proposing to contribute ■■■■ towards historic deficit repayment and only then from the fourth year onwards. It is not until the Trust is generating Trust Annual Surpluses of more than ■■■■ that there is a significant share made towards deficit repayment (■■■■ from the fourth year onwards).

It should also be noted that the Franchisee is required to take the risk on its projected transformation costs generating future savings. There is also a need to protect the Trust from the Franchisee taking a fee through its transformation costs (e.g. invoicing the Trust separately for

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support it provides the Trust in implementing initiatives). Therefore bidders have been advised that they must recover their Transformation costs through the Franchisee Fee which is the Trust's share of Trust Annual Surplus and will therefore only be paid when a surplus is generated. This is one of the main reasons for both bidders proposing the Franchisee allocation of [REDACTED] share of Trust Annual Surplus for the lower bands of surplus so that they can recover their incurred Transformation Costs. Schedule 3 (Charges and Payment) identifies an option for on account Transformation Costs to be paid under specified conditions to assist with cashflow; however, these would have to be repaid to the Trust in the event that insufficient Trust Annual Surpluses were generated.

Review of projected contributions to repayment of Trust historic deficit based on share allocation bid at ITT

Bidders were provided with three scenarios of Trust revenues and expenditure (as described in the financial evaluation methodology set out in Section 2:

Base Case

Upper Scenario 1

Upper Scenario 2

The 6 evaluation Proforma Templates (to cover the three scenarios over 7 year and 10 year franchise periods) have been completed to reflect:

- the projected value of initiative savings post evaluation as identified in Section 3.10;
- the proposed share of Trust Annual Surplus to be allocated to the Trust for the purposes of contributing to the repayment of the Trust historic deficit (extracted from completed Annex C of Schedule 3 of the Franchise Agreement and as identified in Section 5.3; and
- any guaranteed element of contribution to repayment of the Trust historic deficit (extracted from completed Annex B of Schedule 3 of the Franchise Agreement as identified in Section 4.1.

The completed Proforma Templates are included in Annex A for Circle and Annex B for Serco. The resulting projected contribution to repayment of Trust historic deficit are calculated in the Performa and

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summarised in the tables below in terms of projected cumulative contribution to repayment of Trust historic deficit (in nominal terms).

Projected cumulative contribution to repaying Trust historic deficit (7 yrs)

NOMINAL (£'M)	CIRCLE	SERCO
Base Case		
Upper Scenario 1		
Upper Scenario 2		

Projected cumulative contribution to repaying Trust historic deficit (10 yrs)

NOMINAL (£'M)	CIRCLE	SERCO
Base Case		
Upper Scenario 1		
Upper Scenario 2		

Financial evaluation calculations

The financial evaluation considers a weighted average of contributions to repayment of historic deficit in Net Present Value (NPV) terms.

The Net Present Value is calculated assuming a real discount rate of 3.5% (and an assumed nominal discount rate of approximately 6.1% ($1.025 \times 1.035 = 1.061$)).

The contributions to repayment of historic deficit are based on projected contributions. However, any guaranteed element of contribution (bid as a Guaranteed component of Trust Historic Deficit Repayment in Annex B of Schedule 3 (Charges and Payment) of the Franchise Agreement), are awarded double weighting in financial terms (i.e. £2 for every £1 guaranteed).

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For a 7 year bid the Weighted Average Contribution for a bid is calculated as:

$$WAC_{(7yrs)} = 0.7NPVC_{(P1 \text{ Base Case})} + 0.2NPVC_{(P2 \text{ Upper Scenario 1})} + 0.1NPVC_{(P3 \text{ Upper Scenario 2})}$$

Where:

- $NPVC_{(P1 \text{ Base Case})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Base Case scenario over 7 years as calculated in Proforma 1
- $NPVC_{(P2 \text{ Upper Scenario 1})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Upper Scenario 1 over 7 years as calculated in Proforma 2
- $NPVC_{(P3 \text{ Upper Scenario 2})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Upper Scenario 2 over 7 years as calculated in Proforma 3

For a 10 year bid the Weighted Average Contribution for a bid is calculated as:

$$WAC_{(10yrs)} = 0.7NPVC_{(P4 \text{ Base Case})} + 0.2NPVC_{(P5 \text{ Upper Scenario 1})} + 0.1NPVC_{(P6 \text{ Upper Scenario 2})}$$

Where:

- $NPVC_{(P4 \text{ Base Case})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Base Case scenario over 10 years as calculated in Proforma 4
- $NPVC_{(P5 \text{ Upper Scenario 1})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Upper Scenario 1 over 10 years as calculated in Proforma 5
- $NPVC_{(P6 \text{ Upper Scenario 2})}$ is the NPV of the projected contribution to repayment of historic deficit projected under the Upper Scenario 2 over 10 years as calculated in Proforma 6

The NPV of projected contributions to repayment of historic deficit are calculated in the Proforma Templates included in Annex A (Circle) and

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Annex B (Serco). The results are summarised in the table below together with Weighted Average Contribution amount calculated in accordance with the formulas shown in Sections 7.4 and 7.5.

WEIGHTED AVERAGE CONTRIBUTION (7 YEARS)

NOMINAL (£'M)	CIRCLE	SERCO
NPVC _(P4 Base Case)		
NPVC _(P2 Upper Scenario 1)		
NPVC _(P3 Upper Scenario 2)		
WAC _(7yrs)		

WEIGHTED AVERAGE CONTRIBUTION (10 YEARS)

NOMINAL (£'M)	CIRCLE	SERCO
NPVC _(P4 Base Case)		
NPVC _(P5 Upper Scenario 1)		
NPVC _(P6 Upper Scenario 2)		
WAC _(10yrs)		

* includes double weighting for guaranteed amount

Selection of Most Economically Advantageous Tender ("MEAT")

The evaluation criteria states that "Subject to having passed the legal and commercial evaluation, bids will be ranked on the basis of the highest Weighted Average Contribution. Where a Bidder's 10 year bid projects a higher WAC than its 7 year bid, then the 10 year bid would be ranked higher than the 7 year bid."

Therefore if bids pass the legal and commercial evaluation, then the ranking of bids according to the highest Weighted Average Contribution would be as follows:

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RANKING BY WEIGHTED AVERAGE CONTRIBUTION (NPV)

RANKING	BID	WAC
1		
2		
3		
4		

It should be noted that the projections of contribution to repayment of historic deficit in the case of the Serco's 10 year projection incorporates double weighting for the guaranteed element, in accordance with the financial evaluation criteria.

4.6 Cross Workstream Moderation Meeting

At a Moderation Meeting on 2nd November the Evaluation was considered by section:

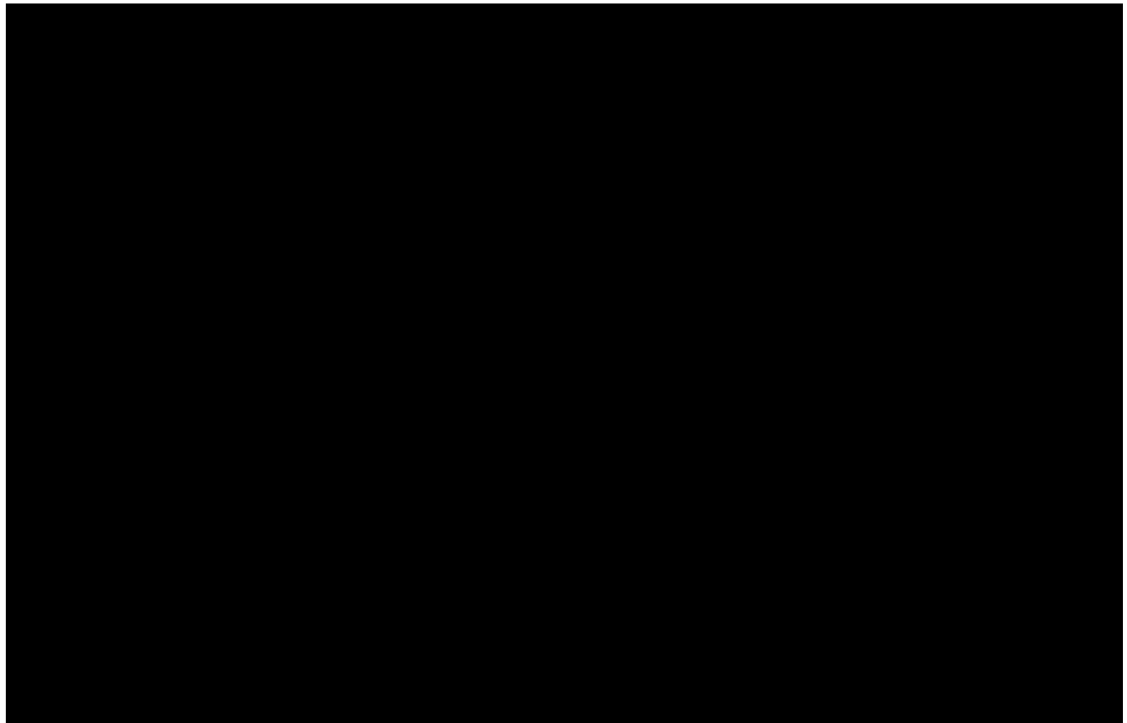
Initiatives – The conclusions reached were accepted, therefore the anticipated savings are assessed below:

SUMMARY OF PROJECTED SAVINGS FROM INITIATIVES – POST EVALUATION

NOMINAL £'M	ITT (7 YEARS)	ITT (10 YEARS)

The projected savings from initiatives post evaluation are shown schematically below, on an annual basis and on a cumulative basis. [The steeper curve for Circle's annual profile reflects the impact of their Continuous Improvement efficiency projections from year 4 onwards.]

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Legal - Both Serco and Circle passed the Legal Evaluation

Commercial – Both Serco and Circle passed the Commercial Evaluation

Financial - The Conclusions reached were accepted, therefore the anticipated levels of debt repayment are assessed (using the Weighted Average Contribution) as :

RANKING BY WEIGHTED AVERAGE CONTRIBUTION (NPV)

RANKING	BID	WAC
1	[REDACTED]	[REDACTED]
2	[REDACTED]	[REDACTED]
3	[REDACTED]	[REDACTED]
4	[REDACTED]	[REDACTED]



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4.7 Conclusion:

Reference to previous Evaluation Reports at ITPD(1) and (2) conclude that both Bidders met the criteria set for Capability and Capacity (ITPD(1)) and a Plan to produce Initiative Cost Savings meeting the evaluation criteria (ITPD(2))

The ITT Evaluation shows

- Circle have substantive initiative cost savings producing [REDACTED] over 7 years and [REDACTED] over 10;
- Circle accept the Franchise Agreement;
- Circle pass the Commercial Assessment. The Contract allows for a Financial Review to confirm funding every six months over the Term;
- Circle produce the best debt repayment although there is no guaranteed element. This repayment expressed as a Weighted Average Contribution is [REDACTED] over 7 years and [REDACTED] over 10.

The Evaluation therefore recommends that the Project Board accept, subject to approval of the Full Business Case, Circle as the Preferred Franchisee for a 10 year term offering [REDACTED] debt repayment which represents 100%.

This was approved by the Project Board on 15th November 2010

4.7.1 Key dates

The timetable for the procurement was/is summarised below:

KEY MILESTONE DATES

KEY PROGRAMME MILESTONES	DATE
Phase 1- MOI/PQQ	
Issue MOI and PQQ to interested parties (identified through expressions of interest)	26/10/09

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KEY PROGRAMME MILESTONES	DATE
PQQ Bidder responses	26/10/09 – 16/11/09
Phase 2 – PQQ	
PQQ submission deadline	16/11/09
PQQ Evaluation including report and submission to Project Board	17/11/09 – 11/12/09
PQQ Successful Bidders Shortlist approved	21/12/09
Phase 3 – ITPD 1	
ITPD1 Issued	21/12/09
ITPD1 dialogue	04/01/10 – 15/01/10
ITPD1 Submission deadline	15/02/10
ITPD1 Evaluation	16/02/10 – 29/03/10
Confirmation of Bidders recommended to proceed to ITPD 2	08/04/10
Phase 4 – ITPD2	
ITPD2 Issued	12/04/10
ITPD2 Submission deadline	26/07/10
ITPD2 Evaluation	27/07/10 – 29/09/10
Confirmation of Bidders recommended to proceed to ITT	29/09/10
Phase 5 – ITT	
ITT Issued	11/10/10
ITT Submission deadline	20/10/10
ITT Evaluation	20/10/10-04/11/10
Preferred Franchisee appointed	25/11/10

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KEY PROGRAMME MILESTONES	DATE
Phase 6 - - Approvals – subject to confirmation of approval & consultation process	
FBC/Approvals	30/11/10-09/11/11
Contract Award & Signature	09/11/11
Service Commencement	01/02/12
Staff and Public involvement	Ongoing

4.7.2 Clinical Services

Circle submitted 32 Initiatives which included 14 Initiatives that directly relate to clinical service delivery. This section provides an overview of these Initiatives and a summary of the Recommended Bidder's approach to clinical leadership, clinical governance and risk management, clinical quality and patient experience. The Initiatives that relate primarily to clinical service delivery are:

- reduce patient length of stay [REDACTED];
- improve theatre productivity and utilisation [REDACTED];
- nurse to bed ratios [REDACTED];
- Treatment Centre consolidation [REDACTED];
- Rationalisation of pathology services, in particular haematology and biochemistry services, [REDACTED];
- introduction of an Enhanced Recovery Programme ("ERP") [REDACTED];

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- better use of diagnostics [REDACTED];
- decrease “do not attends” [REDACTED];
- increase private patients [REDACTED];
- streamline emergency admissions through A&E [REDACTED];

Circle was also requested to submit proposals on their approach to improve service delivery for the following services within the Trust:

- Front of house;
- Cardiology;
- Gastroenterology; and
- Urology.

All of the Initiatives passed the clinical evaluation.

In addition, Circle was requested to submit eight further proposals which included their approach to improve clinical leadership, clinical governance and risk management, clinical quality and patient experience. Their approach to these important clinical aspects passed without clarification during the evaluation process and is summarised below:

Clinical Leadership

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

Clinical Governance & Clinical Risk Management

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

Clinical Quality

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

Patient Experience

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

Summary

Circle submitted 32 Initiatives which all passed the clinical evaluation. [REDACTED] Initiatives related directly to the delivery of clinical services and a further [REDACTED] Initiatives focused on important clinical aspects to improve patient safety, clinical effectiveness and patient experience.

Circle has a robust clinically-led model for service delivery which is based on the formation of clinical units which, together with proposals to improve clinical leadership, clinical governance, clinical risk management, clinical quality and patient experience, will facilitate the safe delivery of Initiatives to ensure that the integrity and effectiveness of clinical services is maintained during transition and full service commencement.

4.7.3 Workforce Proposals

This section provides an overview of the Recommended Bidder's approach to workforce strategy and planning.

Workforce Strategy

[REDACTED]

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[REDACTED]

[REDACTED]

Employee Relations

[REDACTED]

Workforce Reconfiguration

[REDACTED]

[REDACTED]

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[REDACTED]

Managing Pay Costs

[REDACTED]

Training and Development

[REDACTED]

Engagement

[REDACTED]

Governance and Accountability

[REDACTED]

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[REDACTED]

Liability and Indemnity

[REDACTED]

Retention of Employment

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[illegible]

Circle has identified through its initiatives a workforce model closely aligned to the new services as they evolve, supported through engagement and training at all levels. Circle believes that the proposed resizing can be achieved over the time line given in a way which will

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support service delivery going forward and create a sustainable future for HHCT.

4.7.4 Information Management and Technology (IM&T) Proposals

This section provides an overview of the Recommended Bidder's approach to IM&T.

Summary of Requirement

The requirement is that each proposed Initiative must be demonstrably supported by appropriate IM&T. The areas covered are:

- infrastructure (hardware, network communications, application software);
- support (people and processes in support of users of the above);
- information Governance (safeguards on data and security of systems); and
- strategy (fit with internal and external strategic requirements).

Key Aspects of Bidder's Proposals

The Bidder asserts that IM&T will provide real benefits to patients and clinicians by improving the quality of care through the provision of relevant and accurate information to inform the different decisions that are made throughout the various care pathways. The Bidder further asserts that patient-centred care services will be well supported by their patient-centred IM&T approach. The Bidder demonstrates a generally incremental and partnership approach to IM&T in support of their proposed initiatives.

IM&T Infrastructure

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

IM&T Support

[REDACTED]

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Information Governance



At Start of Service Delivery

There are a number of high priority projects for year 1 and year 2.
These are:

Infrastructure

- [Redacted]

Patient Administrative System

- [Redacted];
- [Redacted];
- [Redacted]; and
- [Redacted].

Financial Management

- [Redacted].

Stock Management

- [Redacted]; and
- [Redacted].

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Web site

- [REDACTED].

Management and Clinical information

- [REDACTED];
- [REDACTED];
- [REDACTED];
and
- [REDACTED].

Clinical Information systems

- [REDACTED].

PACS

- [REDACTED];
- [REDACTED].; and
- [REDACTED].

Clinical support services

- [REDACTED];
- [REDACTED];
- [REDACTED]; and
- [REDACTED].

Communications with other stakeholders

- [REDACTED];

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- [REDACTED]; and
- [REDACTED].

Coding, Data quality and Information Management

- [REDACTED].

Information Governance

- [REDACTED].

Other Tasks

- [REDACTED]; and
- [REDACTED].

Strategic Considerations

- [REDACTED].

4.7.5 Estates - Management and development

This section provides an overview of the Recommended Bidder's approach to the management and development of the estate.

The Trust, like all NHS institutions, is responsible for managing its

[REDACTED]

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[REDACTED]

[REDACTED]

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5 Legal Case

5.1 Introduction

The Franchise is to be made pursuant to the provisions of section 67 of the NHS Act 2006 by the making of an Intervention Order by the Secretary of State. The legal effect of the Intervention Order is to: (i) alter the structure of the board of directors of the Trust; and (ii) delegate the statutory management functions of the Trust to the Franchisee. Certain statutory functions have been reserved to the Residual Trust Board. The form of Intervention Order is brief and is made in accordance with the detailed terms of the Franchise Agreement which is attached to and forms part of the Intervention Order.

Following approvals the Intervention Order was made on the 9th November 2011 and it gave the authority to enter into a Franchise Agreement (dated 10th November 2011) However, the actual delegation of the Trust's functions to the Franchisee pursuant to the Intervention Order and in accordance with the terms of the Franchise Agreement does not become effective until the Services Commencement Date (to be 1 February 2012).

5.2 Composition and functions of the Residual Trust Board

The overarching principle of the Franchise is that the Franchisee takes full demand risk and therefore must have full freedom and flexibility to manage the Trust as it sees fit, within the terms of the Franchise Agreement. This is in accordance with the delegation of the Trust's functions to the Franchisee as mentioned in paragraph 5.1 above. Therefore the day to day management of the Trust will be conducted by the Franchisee by an Executive Management Team which is expected to comprise the executive directors and any other persons they deem appropriate. As a result of the delegation of the Trust's statutory functions to the Franchisee pursuant to the Intervention Order the roles and responsibilities of the Residual Trust Board are limited and consist of:

- approving the Trust's statutory accounts;
- fulfilling the Trust's public accountability obligations (eg representing the Trust at its AGM);

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- performance managing the Franchise Agreement; and
- to give or withhold consent to the matters referred to in the Franchise Agreement as requiring its consent including the list of reserved matters. These reserved matters are set out in detail in Schedule 8 of the Franchise Agreement and summarised briefly in paragraph 5.3 below.

With effect from the Services Commencement Date the Residual Trust Board will consist of three members: a Chair, a financially qualified individual and a clinically qualified individual all of whom will hold non executive positions. The Residual Trust Board will meet monthly in the first contractual year and at least four times per thereafter .

The current Executive Directors, who are existing Trust Board Directors, cannot be members of the Residual Trust Board by virtue of the impossible conflict of interest that would create. On the one hand they would be involved in the performance management of the Franchisee and on the other hand they would have an integral role in the day to day operation of the Trust and provision of the services as directed by the Franchisee. This has been agreed in principle with the Executive team who will need to resign as Trust Board Directors with effect from Services Commencement.

5.3 Key terms of Franchise Agreement

The Franchise is a statutory procedure created by the Intervention Order itself. The form of Intervention Order has been discussed with the Department of Health and their solicitors who prepared the form of Intervention Order and approved its terms. The agreed from Franchise Agreement was appended to and formed part of the Intervention Order as the Franchise Agreement contains the detailed terms upon which the Franchise is to operate.

The Agreement contains an express provision that the Parties shall comply with the NHS Core principles and the NHS Constitution.

The parties to the Franchise Agreement are 1) Hinchingsbrooke Health Care NHS Trust (2) Circle Hinchingsbrooke Limited (3) Circle Holdings PLC and (4) East of England Strategic Health Authority. The duration of the Franchise Agreement will be 10 years to be confirmed as part of the approvals process.

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Subject to the conclusion of the approvals process, the Franchise Agreement was signed on 10 November 2011. After contract signature there is a Contract Transition Period during which the parties will implement the agreed form transition plan (which is set out in Schedule 9 of the Franchise Agreement. It is anticipated that the Services Commencement Date will be 1 February 2012 whereupon the delegation of the Trust's functions to the Franchisee pursuant to the Intervention Order will be effective.

During the Contract Transition Period the Trust (in conjunction with the Franchisee) will undertake a formal TUPE consultation with all staff and request that they opt out of the potential TUPE transfer that may be triggered by virtue of Service Commencement. If one or more staff fail to opt out the Trust will calculate its potential liability should such staff transfer to the employment of the Franchisee. If that liability exceeds £500,000, the Trust may terminate the Franchise Agreement prior to Services Commencement. The Trust is also able to terminate the Franchise Agreement prior to Services Commencement if the Secretary of State revokes approval to use the RoE model or a court or tribunal decision or challenge calls into question the validity of its use. The Franchisee can terminate the Franchise Agreement prior to Service Commencement if the Secretary of State revokes approval to use the RoE model.

If the Transition Plan is not fully implemented by the planned Services Commencement Date of 1 February 2012 it can be postponed to a longstop date on or before 1 May 2012 and subsequently the Secretary of State has the ability to postpone Services Commencement to a second longstop date. Failure to reach Services Commencement by the second longstop date will amount to a breach of contract by the party at fault.

If there is a judicial review claim prior to Services Commencement, the Secretary of State may postpone Services Commencement and/or suspend any of the arrangements in the Franchise Agreement. If the Secretary of State has postponed Services Commencement beyond 1 August 2012 then on that date (and every three months afterwards) the parties will review the impact of such postponement and any additional attributable mobilisation costs will be recoverable by the Franchisee.

Any termination of the Franchise Agreement or revocation by the Secretary of State of the Intervention Order prior to Services

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Commencement will only entitle the Franchisee to receive its mobilisation costs by way of compensation. This will not apply if the Franchisee is in breach of the Franchise Agreement.

During the Contract Transition Period the Trust will carry on the operation of the Hospital in the ordinary course of business and will consult with the SHA and the Franchisee before taking any action which could materially affect the Hospital, its assets or staff.

The primary obligation of the Franchisee is to performance the Services (as defined in Schedule 2 of the Franchise Agreement). In essence that amounts to the operation of the Hospital in accordance with all laws and NHS requirements, to implement its Initiatives in order to achieve the aims and objectives of the Intervention Order (repayment of historic deficit) and to generate a Trust annual surplus. The Franchisee is also obliged to perform all Trust contracts and is therefore obliged to perform all activities commissioned by NHSC under the annual commissioning contract.

The day to day implementation, operation and co-operation between the Trust and the Franchisee is conducted by a representative of each party. The Residual Trust Board's representative is known as the Franchise Manager and the Franchisee representative is known as the Franchisee Representative. Within three months of contract signature and by 31 December in each year, the Franchise Manager and the Franchisee Representative need to review the Franchisee's progress in implementing its Initiatives, the level of financial savings achieved and any variation the Franchisee wishes to make to its Initiatives and/or the Franchise Agreement. In the case of changes to the Franchise Agreement, the Change Mechanism Protocol set out in Schedule 6 is to be used.

All changes and variations to the Franchise Agreement are to be dealt with in accordance with the change mechanism protocol set out in Schedule 6 of the Franchise Agreement which contains a protocol for reaching agreement or using the dispute resolution procedure. Any material changes also require approval of the Secretary of State. Any changes in law which has a material impact of the Franchisee's ability to implement the Initiatives or which has adverse financial consequences on the Franchisee in complying with those legal changes, are also dealt with via the change mechanism protocol.

In respect of intellectual property rights ("**IPRs**") the Franchisee and Trust grant each other a non-exclusive licence during the Franchise

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Agreement to use their own IPRs for the purposes of providing the Services. At least 12 months before the end of the Franchise, the parties agree the terms of the licence to enable the Trust to use Franchisee IPR after the end of the Franchise.

The total liability of the Franchisee is capped at £7 million. The latter is made up of £5 million working capital contributions (i.e. the Franchisee has to make a support payment to ensure the Trust breaks even) and £2 million termination costs.

There are non-solicitation obligations imposed on the Franchisee during the Franchise Agreement and for 6 months afterwards and there are also full mutual confidentiality obligations. The Trusts insurances remain in place and in the event that CNST is not available to cover the services (and this is not expected to be the case), the Trust will indemnify the Franchisee accordingly.

To guarantee the termination costs Circle are obliged to place £2m into a security deposit account. PLC also act as guarantor for all Circle's obligations under the Franchise Agreement and is therefore a party for this reason.

The Franchise Agreement provides for regular flow of information from the Franchisee to the Residual Trust Board to enable the Residual Trust Board to properly performance manage the Franchisee. There is also a mechanism for the Residual Trust Board to be involved in the Franchisee's annual business plan and budget preparation, to provide comments and changes and ultimately to approve it or otherwise. If the Residual Trust Board require changes to be made which have financial consequences, the cost of complying with those changes will be deducted from the Franchisee contribution to historic deficit repayment in that year 9 if any).

There are a number of termination rights set out in the Franchise Agreement. The Trust may terminate on 12 months notice and the Secretary of State may revoke the Intervention Order at any time. In these circumstances, provided the Franchisee is not in breach, it is entitled to receive compensation. This compensation will be mobilisation costs if termination occurs prior to Services Commencement and after Services Commencement the compensation will be loss of profits, mobilisation costs, demobilisation costs, and any Franchisee support payment made and the total liability of the Trust, in any event is capped at £10 million.

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The Trust can terminate without paying compensation if the Franchisee commits a material breach, suffers the usual form of insolvency events, undergoing a change of control without the Trust and SHA's consent as well as if the Franchisee becomes obliged to pay a Franchisee support payment in excess of £5 million. The Franchisee can terminate for the SHA's or Trust's material breach such as where the Trust experiences failures in meeting the standard of quality and consistency expected by the Care Quality Commission (and compensation is at the full amount) and if it is required to pay more than £5 million by way of support payment (in which no compensation is payable). Either party can terminate if a force majeure event lasts for 3 months, and no compensation is payable. The Franchisee has to pay £2 million termination costs where it is at fault or in breach and that results in termination.

There are detailed provisions to ensure the implementation of the exit plan (set out in Schedule 14 of the Franchise Agreement).

The Franchise Agreement is personal to the parties and the Franchisee cannot sub-contract without the Residual Trust Board's consent.

Schedule 3 of the Franchise Agreement contains the detailed payment mechanism the details of which are set out in section 6 of this Report. Schedule 7 contains the KPIs which are capable of adjusting the Franchise Fee by plus or minus 10 per cent.

Schedule 8 sets out the composition and role of the Residual Trust Board. It reflects that the Intervention Order delegates all the Trust's functions to the Franchisee and certain statutory functions are reserved to the Residual Trust Board (e.g. signing statutory accounts). There are also a number of decisions which the Franchisee cannot make without the Residual Trust Board's consent. These include selling Trust assets, making redundancies beyond an agreed level, changing the Chief Executive Officer and entering into contracts that last beyond the life of the Franchise.

Schedule 13 contains the usual form of Trust indemnity used in the ISTC programme for use with the RoE model.

A copy of the Franchise Contract is attached as Appendix 6.

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6 Financial case

The purpose of the Financial Case is to provide an overview of any implications for affordability on the project, based on the final bid from the preferred bidder that was evaluated as having the best VfM.

6.1 Affordability Analysis

Under the proposed Franchise Agreement, the Franchisee will only receive payment when the Trust generates a surplus. Where the Trust does not generate a surplus in a given year, then the Franchisee will be required to inject a 'Franchisee Support Payment' to meet the Trust shortfall under Schedule 3 (Charges and Payment) of the Agreement. The Franchisee is therefore taking financial risk. If in subsequent years the Trust generates surpluses then any previous 'Franchisee Support Payments' can be repaid provided there are sufficient surpluses to cover the repayments. Under the Agreement the cap on the level of cumulative Franchisee Support Payment that the Franchisee would have to inject before it would have the option to terminate the Agreement for Franchisee default is £5m. The Agreement also provides the option for the Authority to terminate for Franchisee default if the £5m threshold is breached. However, if both parties agree then even if the £5m threshold is breached the Agreement can continue with the Franchisee injecting more than the cumulative £5m as support payments.

The Franchisee shall earn its fee through receipt of a share of the Trust Annual Surplus. The share allocation was bid at the ITT stage by bidders completing Annex C of Schedule 3 of the Franchise Agreement. The share allocation was banded by Trust Annual Surplus so that bidders could identify different levels of fee for different levels of surplus. It was anticipated that bidders would bid higher Franchisee allocations for lower bands of Trust Annual Surplus so that the Franchisee could recover transformation costs spent on implementing their initiatives. It was anticipated that at higher Trust Annual Surplus bands bidders would bid a lower Franchisee allocation so that a higher allocation would be made towards repaying the Trust historic deficit.

It should also be noted that for the purposes of establishing Trust Annual Surplus the Franchisee is not expected to bear the risk or take the benefit of losses/gains associated with 'impairments', 'disposals' or 'charitable funds'. This was a requirement set by the SHA.

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Given that there is no obligation for any payments to be made to the Franchisee other than from a share of Trust Annual Surplus, the project is affordable from a Trust and SHA perspective (parties to the Franchise Agreement).

The commissioners are not directly impacted by the Franchisee Agreement. Under the Agreement, the Franchisee will act on behalf of the Trust in negotiating the annual commissioning contracts.

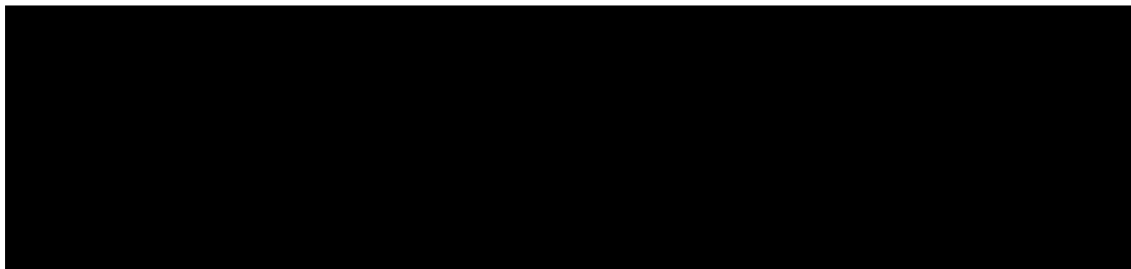
6.2 Impact on the organisation's income and expenditure

The Franchisee will be appointed to operate the Trust under an Intervention Order made by the Secretary of State. Although the Franchisee will be operating the Trust, all income and expenditure will flow through the Trust and be reported in the Trust annual accounts. Furthermore, regarding capital investment, in acting as the Trust the Franchisee will be required to comply with the NHS Trust capital regime.

There are many uncertainties around the Trust's future income and expenditure with or without the Franchise. NHSC is the main commissioner of services from the Trust. As part of the procurement process, NHSC provided activity and revenue projections up to 2013/14 to align with their 5 year commissioning strategy. These projections were reflected in the Base Case projections used for the procurement (see Appendix 5 for financial projections provided to bidders at ITPD2 and ITT). Under the Base Case scenario it is envisaged that cumulative savings of approximately [REDACTED] over 7 years and [REDACTED] over 10 years would need to be made by the Trust in order for it to breakeven. This does not include the additional requirement to contribute to repaying the Trust historic deficit.

The projected financial impact on the Trust's I&E under the Base Case scenario based on the Preferred Bidder (Circle) proposals are summarised below. However, it should be noted that these projections assume that all of the initiatives are successfully implemented and generate the level of savings projected. Based on these indicative projections, if all of the projected levels of Trust surplus are achieved, then by the end of the tenth year then all of the Trust historic deficit would be expected to be repaid. By the end of the seventh year the projections show that [REDACTED] of the Trust historic deficit would be expected to be repaid.

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Circle's projections of the impact of their initiatives on the I&E are included in Appendix 5 for the Base Case and two upper case scenarios for a 7 year and 10 year franchise term.

6.3 Balance Sheet Impact

The Franchisee will operate the hospital on behalf of the Trust by exercising the statutory management functions delegated to it. All income and expenditure will flow through the Trust. The level of investment in capital expenditure to implement the initiatives is estimated at under £1m and this is expected to be paid for under the discretionary capital available within the Trust. Therefore, the appointment of the Franchise is not expected to have an implication for the Trust balance sheet.

6.4 VAT

Given that all income and expenditure will continue to flow through the Trust, the rules applicable to the Trust regarding VAT and recovery of VAT will continue to apply.

The Franchisee shall earn its fee through its share allocation of the Trust Annual Surplus (the "Franchisee Fee").

It is anticipated that the Franchisee shall be making VATable supplies to the Trust for the management and operation of the hospital. The Franchisee shall be able to recover VAT on costs it incurs in relation to these supplies, subject to normal VAT rules. It is also anticipated that the VAT charged to the Trust on the Franchisee Fee shall be recoverable by the Trust under COS heading #45 '*Operation of hospitals, healthcare establishments and healthcare facilities and the provision of any related services*' on the special Contracted Out Services (COS) list.

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7 Management case

This section of the FBC details how scheme implementation will be undertaken following signature of the Franchise Agreement, focusing on the project management arrangements.

The programme management arrangements are as follows:

7.1 Franchise Management Structure

7.1.1 Regulatory Framework

The Franchisee must comply with the same regulatory framework and standards as the Trust applicable to the provision of clinical services as specified by the NHS from time to time.

7.1.2 Governance

The franchise management arrangements for this Project are designed to encapsulate a clear commitment to partnership working, where the Franchisee operating as the Trust integrates and regularly consults with the local Health Service Bodies.

In support of this, and following appointment by the SHA, the Franchise Manager (“**FM**”) will work with the Residual Trust Board, the NHS and the Franchisee to ensure collaborative, robust governance during mobilisation and throughout the term of the Franchise Agreement.

The FM appointment is confirmed by the Residual Trust Board to provide consultancy to the NHS and guidance to the Franchisee within the Franchise Agreement and will have access to subject matter experts in the areas of commercial, legal, clinical governance, franchise management, performance management and dispute resolution and supports the Residual Trust Board by advising on contractual obligations and liabilities.

7.2 Management Structures during Mobilisation and Service Delivery

The Franchise Agreement covers two specific phases - mobilisation and service delivery. These two phases require different management

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structures. The Franchisee will be expected to ensure that the appropriate skill sets are applied to each phase. For example the composition of teams will require an understanding of project management during mobilisation in order to ensure that deliverables and milestones are met, whilst service delivery will require an operating knowledge of patient focus, franchise management and commercial skills.

In keeping with this, structure, governance and performance management have been addressed individually for mobilisation and service delivery below.

Bidders have noted the NHSC Commissioning Strategy and Intentions for future management of demand shifting from the PCT to the GP Clusters which will require Bidders to consult, where required, with bodies during mobilisation and throughout the term of the Franchise Agreement.

7.3 Franchise Management – Mobilisation

Pursuant to the Franchise Agreement, the Trust Board will delegate authority to the FM to work with the Franchisee, NHS EoE and Referring Health Service Bodies, to manage performance under the Franchise Agreement on a day-to-day basis. The FM has access to and is supported by the Trust Board and acts as their point of contact with both the Referring Health Service Body and the Franchisee. The Franchisee must appoint a Franchisee Representative in a reciprocal role.

During the Contract Transition Period the FM will undertake the following key activities with NHS EoE, the Referring Health Service Bodies and Franchisee organisations:

7.3.1 Creating a Franchise Management Board

The FM will work with the Residual Trust Board and Referring Health Service Bodies to set up a Franchise Management Board (“**FMB**”) and governance structures. The FMB will involve NHS EoE and other local Health Service Bodies and will operate to enable the local Health Service Bodies to raise local issues arising out of the Franchise Agreement through a representative of the Referring Health Service Bodies and the FM.

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7.3.2 Creating a Mobilisation Board

To enable joint management of the Contract Transition Period, the FM shall work with NHS EoE, the Referring Health Service Bodies, and the Franchisee to establish a mobilisation board. The mobilisation board membership comprises representatives from NHS EoE, the Trust the Referring Health Service Bodies and the Franchisee in addition to the FM. The mobilisation board's role is to monitor the progress of the Franchisee, and the Referring Health Service Bodies against the Transition Plan.

7.3.3 Creating an Integrated Transition Plan

The FM will work with NHS EoE, the Trust, the Referring Health Service Bodies and the Franchisee to ensure that Trust and the Referring Health Service Bodies' deliverables are incorporated into the Franchisee's mobilisation plan to form an overall, integrated Transition Plan. This integrated plan defines the required deliverables, timescales and resources for mobilising. This includes identification and development of critical interfaces to integrate the Franchisee's agreed requirements into the Trust and the local health economy.

This integrated plan should also include the implementation plans per initiative indicating the deliverables and interdependencies during mobilisation.

A monthly report will be provided against the agreed form Transition Plan. This will be further detailed in Franchise Agreement.

7.3.4 Creating joint Workstream teams

The Transition Plan is organised by the appropriate workstream as shown in the diagram below. The FM will work with the Trust, Referring Health Service Bodies and the Franchisee to form joint workstream teams to deliver the activities identified in the plan. The workstream leads report progress to the Trust Board.

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FIGURE 1 – MANAGING MOBILISATION – MOBILISATION BOARD

7.3.5 Franchise Management – Service Delivery

During the Contract Transition Period and prior to Services Commencement Date, the mobilisation board will establish the following management structures and mechanisms:

The Franchise Management Board (“FMB”)

The FM will manage the relationship and engagement with the Residual Trust Board, NHS EoE and Referring Health Service Bodies through a FMB. The FMB will allow the Referring Health Service Bodies and the Residual Trust Board to raise issues or concerns with the performance of the Franchise Agreement. From time to time, the Franchisee’s Representative may be invited by the FM to attend the FMB to discuss specific concerns which have been raised.

The Franchise Review

Franchise performance management by the Residual Trust Board and the Franchisee will take place through the process of the Franchise Review (“FR”). The FR will be a formal body for assessing and managing performance and relating it to the Franchise Agreement, with membership comprising equal numbers from the Residual Trust Board (including the FM), NHS EoE and Franchisee organisation with the casting vote held by NHS EoE. From time to time, a Referring Health Service Body representative may be invited by NHS EoE to attend the FR. The FR is intended to be a neutral process for managing performance and facilitating agreement between the Residual Trust Board and the Franchisee. The FR shall have the authority to mandate corrective actions to resolve performance issues.

Operational sub-groups

It is intended that the FR will be an executive forum for decision making/ratification and that the FR will be supported on a day-to-day basis by joint FM/Franchisee operational sub-groups to address ongoing operational issues. The operational sub-groups will manage performance (and develop action plans, where necessary, for approval by the FR). The operational sub-groups will meet with a frequency

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required to support the FR and to ensure good operational performance and ongoing communication.

The Franchise Service Investigation

Where the FR has insufficient information to approve an action plan it may commission a Franchise Service Investigation (“**FSI**”) to investigate the performance issue and provide the additional information. As a general guide, a FSI should be commissioned when the FR is unable to determine whether a Franchise anomaly has occurred, whether it does in fact signify a problem, the nature of the problem, or the appropriate action to be taken. It is expected that members of the appropriate operational sub-group will undertake FSIs, when they are required.

It should also be noted that it is not necessary to convene a FR to commission a FSI. A FSI may be commissioned by NHS EoE without reference to a FR whenever a serious incident or other Franchise anomaly occurs requiring urgent action.

Communication

It is envisaged that the FM and the Referring Health Service Bodies and the Franchisee will communicate frequently between Franchise board meetings and Franchise reviews, and that as issues arise, these will be discussed openly. It is expected that the Franchisee will bring relevant information to FR meetings (including internal investigations by the Provider which have not been commissioned by the FR as a FSI) so that, as far as possible, the FR can take appropriate decisions without the need for a FSI.

The anticipated structure for the performance management of the Services Agreement is shown below.

FIGURE 2 – PERFORMANCE MANAGEMENT – THE FR/FSI PROCESS

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8 Mobilisation

8.1 Service delivery

NHS EoE, the Referring Health Service Bodies and the Trust are in the process of finalising the regime for contract and performance management which will be that operated by the Trust Board applicable to the Franchise Agreement. The expectation is that the regime will operate as follows, but this is subject to confirmation.

8.2 Performance management

8.2.1 General Expectations on the FM, the Residual Trust Board and Referring Health Service

Bodies and Franchisee

all the parties are expected to act reasonably in assessing performance indicators, in commissioning investigations, and in interpreting the results of these investigations. The FM and the Franchisee are expected to adopt a neutral stance in their approach to performance indicator data and any subsequent investigations that are carried out. The FM is expected to avoid any suggestion of a deficiency in the service provided by the Franchisee until and unless a neutral investigation has demonstrated a Franchisee deficiency.

The Franchisee is expected to co-operate fully with the FM and any representatives from NHS EoE, any relevant Referring Health Service Body in investigating possible deficiencies in service, and to make all material facts available to any reviewers. The Franchisee is expected to admit deficiencies where these have occurred. The performance management system has been designed to reward co-operative behaviour and to avoid any temptation the Franchisee may have to be defensive in order to avoid financial deductions.

The Residual Trust Board, NHS EoE, the Referring Health Service Bodies and the Franchisee are expected to put the interests of Patients first, and to participate in FMB and FR meetings and FSIs with a view to establishing the facts and any necessary improvements.

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Quality assurance and improvement

The Performance Monitoring Regime will recognise that, even in the best-run facilities, problems will occur. It will reward co-operative behaviour on the part of the Franchisee. Although sanctions will be available, these will apply only to a failure to take action to rectify problems that have been identified.

The performance management system for the Franchise will:

- be built on a quality improvement model;
- assume that some things will go wrong some of the time;
- assume that the FM, Referring Health Service Bodies, and the Franchisee will work closely together for Patient benefit;
- combine robust performance management with a cooperative approach;
- assign associated costs to be paid to the Residual Trust Board by the Franchisee in defined circumstances without the FM having to prove fault;
- employ sanctions only when Franchisee fails to implement a remedial action plan for demonstrated deficiencies; and
- assume investigations are neutral in intent.

The performance management tools are being developed on this basis, with the Residual Trust Board, NHS EoE, Referring Health Service Bodies and Franchisee collaboration as an essential element throughout as follows:

- NHS EoE and the Trust are developing a comprehensive performance management system to enable the FM to manage performance effectively.
- This system will ensure that performance management becomes an integrated part of the daily work process, resulting in clear and consistent communication of current performance, risks and lessons learned to all those involved in the performance management process.
- It is expected that the Residual Trust Board, NHS EoE, the Referring Health Service Bodies and the Franchisee will use this system to manage their own performance under the Franchise Agreement

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8.2.2 Exit Strategy

Bidders have provided as part of their bid an outline description of their proposed exit strategy detailing the steps envisaged to successfully disengage from the NHS at the end of the term of the Franchise Agreement or earlier termination pursuant to the Franchise Agreement.

8.2.3 Milestones

Circle have provided the following milestones relating to the Contract Transition Period:

- set up project structures, start high level communication;
- retrieve and analyse data;
- plan communication and implementation;
- start detailed implementation planning and communications; and
- where appropriate start implementation.

8.3 Arrangements for benefits realisation

Attached as Appendix 8 is the Benefits Realisation Schedule for The Franchise describing the Benefit, the Measuring Criteria, the Implementation Timetable and it's cost benefit or dis-benefit if achieved or not.

These benefits will be progressively reviewed by either the NHS EoE or the Residual Trust Board, that review process commences June 2011 and will be validated by Gateway Review (see below)

Examples of the criteria used are:

- Staff satisfaction;
- Patient satisfaction;
- Commissioner's satisfaction;
- Implementation and delivery of Initiatives;
- An early agree Exit Plan incorporating NHS strategy for after expiry of term;
- Gateway Review.

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8.4 Arrangements for risk management

Risks are managed pro-actively by the Franchisee and the Franchise Manager and reported on at the Monthly Progress Meeting.

The Franchise Contract Schedule will be agreed during Mobilisation between the Trust, Franchisee and Franchise Manager. An early example of some potential Risks would be:

- Non – performance of Franchisee;
- Circle do not meet their Financial Reporting targets;
- TUPE transfers do not work;
- Commissioning Contract negotiations fail;
- Initiatives need Public Consultation.

A copy of the Project Risk Schedule is attached as Appendix 9.

8.5 Gateway review arrangements

The impacts/risks associated with the project have been scored against the Risk Potential Assessment (“**RPA**”) for projects. The RPA score is 48

A Gateway 2 review - Procurement Strategy, was undertaken 7-9 December 2009. As an outcome of the review the project was given an ‘amber’ delivery confidence assessment. The subsequent report set out nine recommendations, these were:

- the Project team should ensure a Trust Comparator is produced that accurately reflects any realistic future business model against which potential franchisee bids can be assessed;
- the SRO should seek DH Transactions Board and HMT guidance and support after evaluating bids at ITPD1 stage and before moving on to ITPD2 stage of the Project;
- the SRO should ensure reinforcement of the communications activity to focus on the published project objectives;
- the Project Director should ensure that the objectives of the stakeholder panel are reconsidered in the light of the Project timescale;
- the Project Director should continue to develop the risk management process;

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- the Project team should agree with the PCT how bids (including alternative bids) will be evaluated in terms of the commissioning strategy and potential impact upon the wider health economy;
- the SRO should ensure that there is clarity regarding the functions, make up and establishment of any new Residual Trust Board function;
- the SRO should ensure that contingency plans are developed in case of significant delay or a failed procurement process; and
- the SRO should ensure the development of a benefits capture and realisation process and ensure that lessons learned can be disseminated.

To provide ongoing independent assurance of Project progress and likelihood of success of the Project to the senior responsible officer (“**SRO**”) and HNSPB a follow-up Gateway 2 review - Procurement Strategy was undertaken 25-26 March 2010. As an outcome of the review the Project maintained an ‘amber’ rating. The subsequent report set out five recommendations, several having been resolved since Gateway Review 2 review in December 2009:

- the SRO should review the activities and timescale for the production and approval of the Full Business Case and should ensure sufficient resources are dedicated to its production;
- the SRO should ensure that contingency plans are developed in case of significant delay or a failed procurement process and readiness for next phase – Investment decision;
- the SRO should ensure that there is clarity regarding the commissioning intentions of the PCT and how the benefits of any departures from Option 2 will be tested within ITPD2;
- the SRO should ensure that the functions, make up and establishment of any new Residual Trust Board are finalised within a realistic and defined timescale; and
- the SRO should ensure the HNS Project Team produce a robust benefits capture and realisation process for Full Business Case Production and beyond. A lesson learned process should also be implemented to inform future projects.

Copies of the Gateway Reports can be found attached in Appendix 9.

A Gate 3 (investment decision) will be undertaken on the project during December 2010.

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Further reviews are planned as follows:

- Gate 4 – April 2012; and
- Gate 5 – May 2013.

8.6 Internal Audit arrangements

At the three Stages of the Procurement an Internal Audit was carried out by West Midlands Internal Audit Consortium. At both ITPD(2) and ITT the reports noted that the Audit was Satisfactory with no recommendations.

At ITPD(1) the Audit recommended three actions which were all resolved prior to or during ITPD(2).

The detail of these actions were denoted as in the table below:

No (Ref)	Recommendation	Action Agreed	Responsible Officer	Implementation Date
1 (para 4.11, 6.7)	The rationale behind any scoring, ranking or qualifying decision that appears to be at odds with the “evaluation rules” should be explicitly recorded in the context of those rules	We acknowledge the recommendation of the auditors and will ensure that future evaluations provide for similar eventualities and that any variances are recorded in the minutes of adjudications and other meetings.	Director of Strategic Projects	Immediate
2 (para 6.8)	The rules by which bidders qualify for the next stage of a process should be robust enough to give the process demonstrable integrity and objectivity whilst allowing enough appropriate discretion for dealing with exceptional circumstances	We acknowledge the recommendation of the auditors and will ensure that future evaluations transparently refer to, rather than imply, the required level of discretion.	Director of Strategic Projects	Immediate

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No (Ref)	Recommendation	Action Agreed	Responsible Officer	Implementation Date
3 (para 6.9)	Overall evaluation scores should be subject to sensitivity analysis, particularly with regard to the weightings used in calculating them	The recommendation of the auditors is noted. Future evaluations will provide for "what if" sensitivity analysis where this adds to the assurance or outcomes required.	Director of Strategic Projects	Immediate

Full details of the three Internal Audit Reports are attached as Appendix 11

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Appendix 1 - GLOSSARY

“Authority”	means EoE who have organised the Procurement on behalf of the Trust and in liaison with NHSC
“Bidder” and/or “Potential Bidder”	means an organisation intending to secure the Franchise Agreement
“CCS”	means Cambridgeshire Community Services
“CNST”	means the Clinical Negligence Scheme for Trusts
“Contract Transition Period”	means the period between the effective date of the Franchise Agreement and the Services Commencement Date
“CQT”	means Care Quality Team
“CUHFT”	means Cambridge University Hospital NHS Foundation Trust
“Dataroom”	means the electronic dataroom for the Project hosted by Wragge & Co LLP
“DH”	means the Department of Health
“EMT”	means Circle’s executive management team
“ERP”	means Enhanced Recovery Programme
“FBC”	means this Full Business Case
“FMB”	means the Franchise Management Board
“Franchise Agreement”	means the contract to be entered into between the Franchisee and the Trust for the Services
“Franchise Manager” or “FM”	means the Trust’s authorised representative who will have the authority to liaise with the Franchisee
“Franchisee”	means the organisation selected as part of the Procurement to enter into the Franchise Agreement and

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	to provide the Services on behalf of the Trust
“FR”	means Franchise Review
“Franchisee Representative”	means the person to be appointed by the Franchisee as its representative under the Franchise Agreement
“FRP”	means the Trust’s financial recovery plan
“FSI”	means Franchise Service Investigation
“HCP”	means Health Care Projects
“HDC”	means Huntingdonshire District Council
“HHCT” / “Hinchingbrooke” / the “Trust” / “HNS”	means Hinchingbrooke Health Care NHS Trust
“HIHL”	means Health Investment Holdings Limited, being Circle’s parent company
“HOSC”	means Cambridgeshire County Council’s Joint Health Overview and Scrutiny Committee
“Hospital”	means Hinchingbrooke Hospital
“Intervention Order”	means the Intervention Order in respect of the Trust to be made by the SoS pursuant to the provisions of section 67 of the NHSA
“IPRs”	means intellectual property rights
“ITPD1”	means the Invitation to Participate in Dialogue (Stage 1)
“ITPD2”	means the Invitation to Participate in Dialogue (Stage 2)
“ITT”	means the Invitation to Tender
“NHS Act 2006”	means the National Health Service Act 2006
“NHS East of England” / “EoE” / the “SHA”	means the East of England Strategic Health Authority
“NPV”	means net present value

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"OBC"	means the Outline Business Case approved by the Hinchingsbrooke Project Board on 15 April 2008
"ONS"	means the Office of National Statistics
"PbR"	means Payment by Results
the "PCT", Cambridgeshire "NHSC"	"NHS and/or means Cambridgeshire Primary Care Trust
"PER"	means project evaluation review
"PFRSS"	Means Possible Future Revisions to Sustainable Services
"PIR"	means post implementation review
"PQQ"	means the Pre-Qualification Questionnaire of the Procurement
"Project"/"Procurement"	means the Hinchingsbrooke Acute Trust Hospital Next Steps Project
"PSC"	means the Public Sector Comparator
"QIT"	means Quality Improvement Programme
"Residual Trust Board"	means the board of directors of the Trust as set out in the Intervention Order or as constituted from time to time during the term of the Franchise Agreement
"RoE"	means Retention of Employment
"RPA"	means Risk Potential Assessment
"Secretary of State"	means the Secretary of State for Health
"Services Commencement Date"	means 1 June 2011 or such later date as may be agreed or directed under the Franchise Agreement
"SPT"	means the
"SRO"	means senior responsible officer

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"Transition Plan"	means the transition plan set out in the Franchise Agreement
"Treatment Centre"	means the self contained treatment centre on the Hospital site procured through the private finance initiative
"VfM"	means Value for Money

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APPENDIX 2 - Outline Business Case

HNS Project OBC Main Document 02-05-08_.pdf

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APPENDIX 3 - Support Letters

NHSC Letter of Support for HNS_PZR_06 10 10.pdf

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APPENDIX 4 - Stakeholder Support

Next Steps News (edition 1, Nov 09).pdf

Next Steps News (edition 2, Jan 2010).pdf

Next Steps News 3.pdf

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APPENDIX 5 - Evaluation Reports

HNS PQQ Evaluation Report final.pdf

HNS ITPD _1_ Evaluation Report v10 + Annexes.pdf

01_HNS Project Board Meeting 24 03 10 final.pdf

ITPD2 Evaluation Report v11.pdf

ITT Evaluation Report - Version 1.1.pdf

HNS FBC - Appendix 5.5 _Economic Appraisal_.pdf

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APPENDIX 6 - Franchise Agreement

Hinchingbrooke - Circle Franchise Agreement.DOC

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APPENDIX 7 – Trust Comparator Report

HNS Trust Comparator report v6.pdf

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APPENDIX 8 – Benefits Realisation Plan

Benefits Realisation Full Business Case.doc

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APPENDIX 9 – Project Risk Register

HNS Master Risk Register v6.1.pdf

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APPENDIX 10 – Gateway Review Reports

Final Gateway_2_Report_Hinchingbrooke Hospital.pdf

Final Gateway_2A_Report_Hinchingbrooke Hospital.pdf

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APPENDIX 11 – Audit Reports

ITPD1 Evaluation Report - Audit.pdf

ITPD2 Audit Report EOE 10-002 Final.pdf

ITT EOE 10-003