



**Hinchingbrooke Health Care NHS Trust
Next Steps Project**

Memorandum of Information

October 2009

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1 PURPOSE AND STRUCTURE OF THIS MOI

Purpose of this document

- 1.1 This MOI provides an overview of the Project and details of the:
- Procurement and its objectives;
 - Commissioner service requirements;
 - Procurement process;
 - Procurement commercial framework; and
 - Procurement governance and administration requirements.
- 1.2 The purpose of this MOI is to provide Potential Bidders with sufficient information on the Project to enable them to:
- make an informed decision about whether they wish to participate; and
 - submit a response to the PQQ.

Organisation of this document

- 1.3 This MOI is organised into the following sections:

- Section 1: Purpose and Structure of the MOI**
- Section 2: Introduction and Purpose of Project**
- Section 3: Hinchingbrooke Healthcare NHS Trust - Overview**
- Section 4: NHS Cambridgeshire**
- Section 5: Clinical Services Currently Provided at Hinchingbrooke**
- Section 6: Future Clinical Service Requirements**
- Section 7: Non-Clinical Services**
- Section 8: Facilities**
- Section 9: Workforce**
- Section 10: Financial Position**
- Section 11: Outline Transaction Structure**
- Section 12: Next Steps for Bidders**
- Annexes: Appendix A**
Detailing the PQQ
- Appendix B**

Clarification Questions Template

Appendix C
Supporting Documentation

Appendix D
Trust Revenue and Activity Plans 2009/10

2 INTRODUCTION AND PURPOSE OF PROJECT

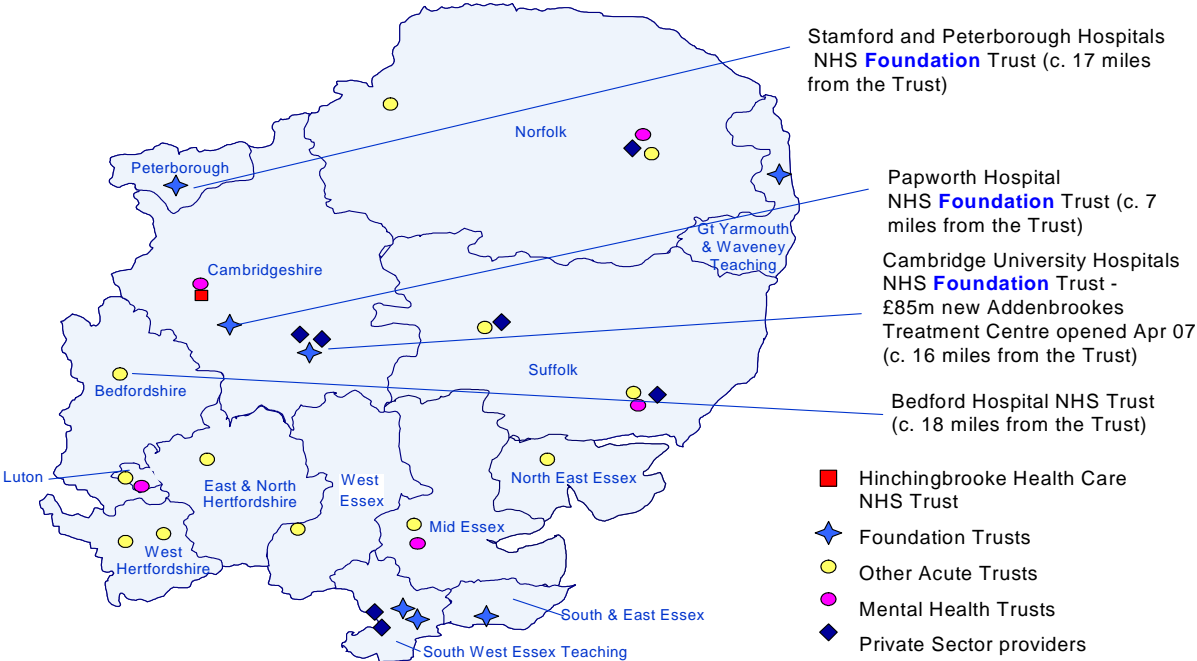
- 2.1 The Trust is a small district general hospital in Huntingdon providing a range of healthcare services serving a population of approximately 160,000 people. For the financial year 2008/2009 it had a cumulative financial deficit of £38.9 million.
- 2.2 Following the outcome of public consultation during 2007 and with the support of the DH, the NHS East of England is running an open and transparent competitive tendering process to find the best partner to operate a franchise for Hinchingbrooke Hospital. The objectives of the Project are to find a new partner who is capable of providing the full range of modern acute hospital services at Hinchingbrooke Hospital.
- 2.3 It is proposed that the Services will be provided under an innovative operating franchise agreement whereby full operational risk and responsibility will pass to the Franchisee whilst NHS assets and staff will be retained by the Trust.
- 2.4 The delegation of the Trust's functions to the Franchisee and the entry into the Franchise Contract 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.
- 2.5 The tender process is 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 Hinchingbrooke Hospital services and staff and to start the repayment process of the historic deficit while improving service quality for patients and securing value for money for tax payers.

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3 HINCHINGBROOKE HEALTHCARE NHS TRUST – OVERVIEW

3.1 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. It is estimated that the population will increase by 9% by 2021 compared with 22% for the wider Cambridge and Peterborough region. Although the scale of increase in number will be less, the local population will become more elderly and therefore likely to be increasingly dependent on healthcare; those over 65 increasing by 72% by 2021.

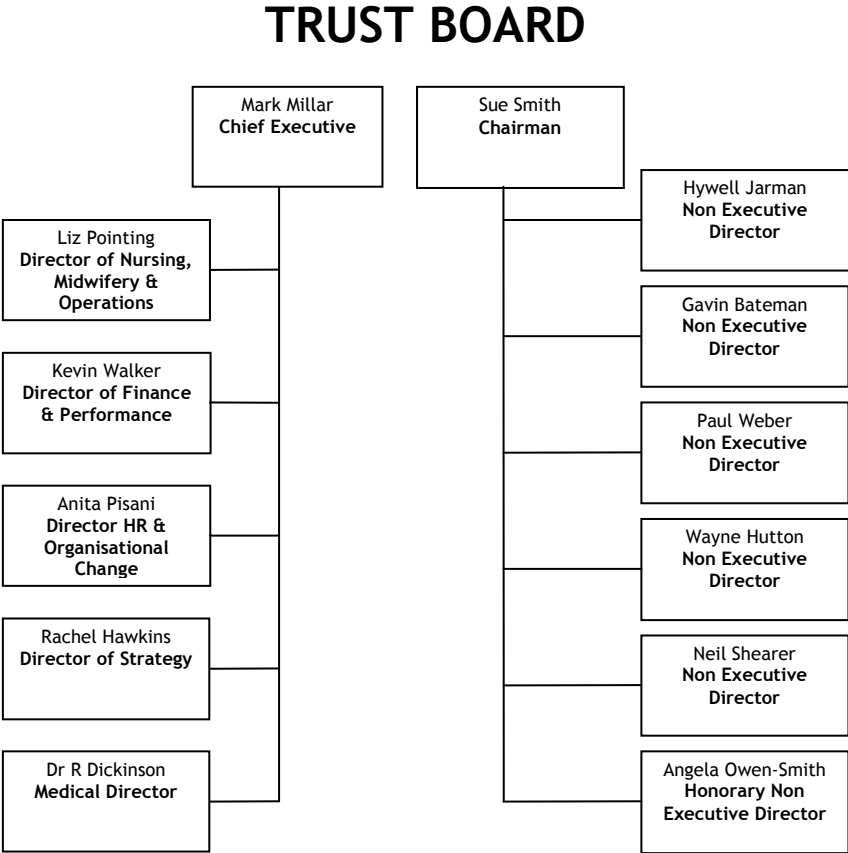
Hinchingbrooke Health Care NHS Trust



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

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.

3.2 The current Trust Board structure is outlined below:



- 3.3 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, daycase and inpatient services, a 24/7 Accident & Emergency Department and Maternity service.
- 3.4 Overall the Trust directly employs over 1600 staff, including 69 consultants.
- 3.5 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.

Provider of choice for local community

- 3.6 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 consultations have shown significant support from the local community to keep their Services.
- 3.7 The Trust works well with other local providers and agencies, and has well established links with GP networks.
- 3.8 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.

Hinchingbrooke's Annual Health Check 2007/08

3.9 The Annual Health Check is the system used by the Healthcare Commission to assess Trusts performance on an annual basis. This is the second year of the annual health check, which replaced the old star rating system. There are several components of this assessment, including core standards, existing targets, use of resources and new national targets.

3.10 Hinchingbrooke was awarded a 'weak' rating for its use of resources and a 'good' rating for its quality of services in 2007/08. The Trust has worked to improve its use of resources and has just learned that its ratings for 2008/09 are 'fair' for its use of resources and 'good' for its quality of services.

3.11 It is worth noting that even in the 2007/08 report:

- the Trust scored 'excellent' for its admissions management, diagnostic services and medicines management;
- the Trust's maternity service was judged to be 'better performing' and services for children were judged to be 'fair';
- on meeting core standards, judged to be "almost met", the Trust was fully compliant on:
 - clinical and cost effectiveness – improvements on NICE technology appraisals;
 - governance – improvements on discrimination and records management;
 - accessible and responsible care;
 - care environment and amenities – improvements on privacy and confidentiality;
 - public health;

The Trust did not meet the standard on 'safe use of medical devices, a situation which was rectified by the establishment of a medical devices library in January 2009;

- on existing National Targets, the Trust scored "fully met" and achieved nine out of 11 existing national targets. It underachieved with respect to:
 - maximum two week wait for rapid access chest pain clinic; and
 - information in place to support choice
- on new National Targets, the Trust scored "excellent" and achieved 11 out of 13 new national targets. It underachieved with respect to Clostridium difficile data quality and compliance with guidelines concerning self harm.

Cases of Clostridium difficile have reduced since 2007/08 but still present a significant challenge in 2009/10.

4 NHS CAMBRIDGESHIRE

4.1 NHS Cambridgeshire (Cambridgeshire Primary Care Trust) is the co-ordinating commissioner for services provided at the Trust. The PCT's total commissioning budget for 2009/10 for health care in the county as a whole is just over £807 million.

4.2 Within NHS Cambridgeshire there are currently:

- 76 GP practices with over 400 GPs in post;
- 80 Dental practices, most of which have a contract with the PCT covering the work of nearly 230 dentists;
- 93 Pharmacies; and
- 95 Opticians.

4.3 Practice Based Commissioning (PBC) for Huntingdonshire is taken forward by HuntsComm, a PBC consortium which represents 22 of the 24 practices in the locality. The over-arching commissioning priorities for Huntingdonshire are to:

- support the Trust in its plans to become sustainable;
- stimulate alternative ways of providing services in the community;
- encourage alternative ways of managing patients through clinical pathways re-design; and
- commission in a way that helps achieve financial balance in the Huntingdonshire area.

Population Profile

4.4 The number of patients registered with GPs within the boundaries of NHS Cambridgeshire in July 2008 was 606,037. This includes some patients from other counties (e.g. Norfolk, Hertfordshire) and excludes some Cambridgeshire residents who are registered with GP practices outside Cambridgeshire. 31,663 people live in Cambridgeshire, but are registered with GP practices outside of NHS Cambridgeshire. Most of these are registered with NHS East and North Hertfordshire, NHS Suffolk and NHS Bedfordshire (Exeter System July 2008). The most recent population estimates for the population of Cambridgeshire county (not including Peterborough) are a total of 586,800 residents in mid-2007 according to Cambridgeshire County Council estimates, compared with 597,400 residents in mid-2007 according to Office of National Statistics estimates. Historically, Cambridgeshire County Council Research Group population estimates and forecasts, which include local information on housing development, school registrations etc., have proved more accurate than the national estimates and forecasts. Tables 1 and 2 set out the detail.

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4.5 **Table 1: Total population: population estimates, mid 2007 (Cambridgeshire County Council Research Group)**

Local authority	Age band										Total
	0-4	5-14	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	Over 85	
Cambridge City	5,850 5%	10,080 9%	27,880 24%	20,860 18%	14,770 13%	11,880 10%	10,050 9%	6,730 6%	4,950 4%	2,150 2%	115,200
East Cambs	4,970 6%	9,310 12%	8,600 11%	8,560 11%	12,710 16%	10,740 14%	10,160 13%	6,710 9%	4,670 6%	1,620 2%	78,050
Fenland	4,860 5%	11,290 12%	10,000 11%	10,590 12%	13,020 14%	11,980 13%	11,940 13%	9,120 10%	6,520 7%	1,980 2%	91,300
Huntingdonshire	9,210 6%	20,810 13%	19,110 12%	18,160 11%	26,770 17%	23,400 14%	21,180 13%	12,970 8%	7,560 5%	2,730 2%	161,900
South Cambs	8,190 6%	17,650 13%	15,480 11%	15,680 11%	22,770 16%	19,790 14%	18,880 13%	11,600 8%	7,680 5%	2,860 2%	140,580
Cambridgeshire	33,070 6%	69,150 12%	81,020 14%	73,790 13%	90,030 15%	77,770 13%	72,200 12%	47,080 8%	31,380 5%	11,340 2%	586,830

Source: Cambridgeshire County Council Research Group.
Definition: Mid 2007 population estimates.

Table 2: Total population: population estimates, mid 2007 (Office of National Statistics)

Local authority	Age band										Total
	0-4	5-14	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	Over 85	
Cambridge City	5,500 5%	9,600 8%	30,300 25%	23,500 20%	16,000 13%	11,500 10%	9,700 8%	6,600 6%	5,100 4%	2,400 2%	120,000
East Cambs	5,200 6%	9,600 12%	8,600 11%	9,800 12%	13,000 16%	10,900 13%	10,500 13%	7,000 9%	4,700 6%	1,800 2%	81,000
Fenland	4,800 5%	10,800 12%	9,900 11%	9,500 10%	13,500 15%	12,200 13%	12,700 14%	9,500 10%	6,300 7%	2,200 2%	91,400
Huntingdonshire	9,600 6%	21,200 13%	19,700 12%	20,000 12%	28,100 17%	23,500 14%	21,500 13%	13,200 8%	7,900 5%	2,900 2%	167,700
South Cambs	8,500 6%	17,200 13%	14,800 11%	15,700 11%	22,400 16%	19,500 14%	17,800 13%	10,900 8%	7,300 5%	3,000 2%	137,300
Cambridgeshire	33,700 6%	68,400 11%	83,400 14%	78,700 13%	93,100 16%	77,500 13%	72,100 12%	47,200 8%	31,400 5%	12,200 2%	597,400

Source: Office of National Statistics.
Definition: Mid 2007 population estimates.

Further detail is available in the NHS Cambridgeshire Five Year Strategic Plan (2009 to 2014) which can be accessed via the NHS Cambridgeshire website, (www.cambridgeshire.nhs.uk).

- 4.6 Population growth in the county is expected to be significant and, by 2016, an extra 37,400 dwellings are expecting to be built (Cambridgeshire County Council, Dwelling Stock Forecasts 2006-2016). This growth in housing stock, combined with other factors impacting on the area's population, will mean around 72,000 more people living in the county by 2016, many of whom will need the services which the PCT commissions (Cambridgeshire County Council, Population Forecasts 2006-2016).

Strategic Context - Policy

- 4.7 There is a good degree of consistency amongst the various national policies. The key messages could be characterised as:¹
- health and social care will be subject to continuous reform and transformation, led by the personalisation of services shaped by their users;

¹ Care Services Partnership: Department of Health Direction of Travel – Policy Framework for social care and health care delivery

- an emphasis on achieving financial balance and a shift of services from an acute hospital setting to a community setting;
- change being driven by a focus on individuals and communities and the outcomes they seek with money following the person;
- '*personalisation*' is seen as the key to success with 'choice' as an underlying theme. Users will have a voice and be empowered to take risks and manage their own conditions as appropriate;
- integration and partnership are deemed essential not optional; and
- as clinicians and front line staff are at the direct point of contact they are in a position to shape reform by responding to their users.

Strategic Context - Pressure on Resources

4.8 Locally, pressures on funding are most likely to arise from:

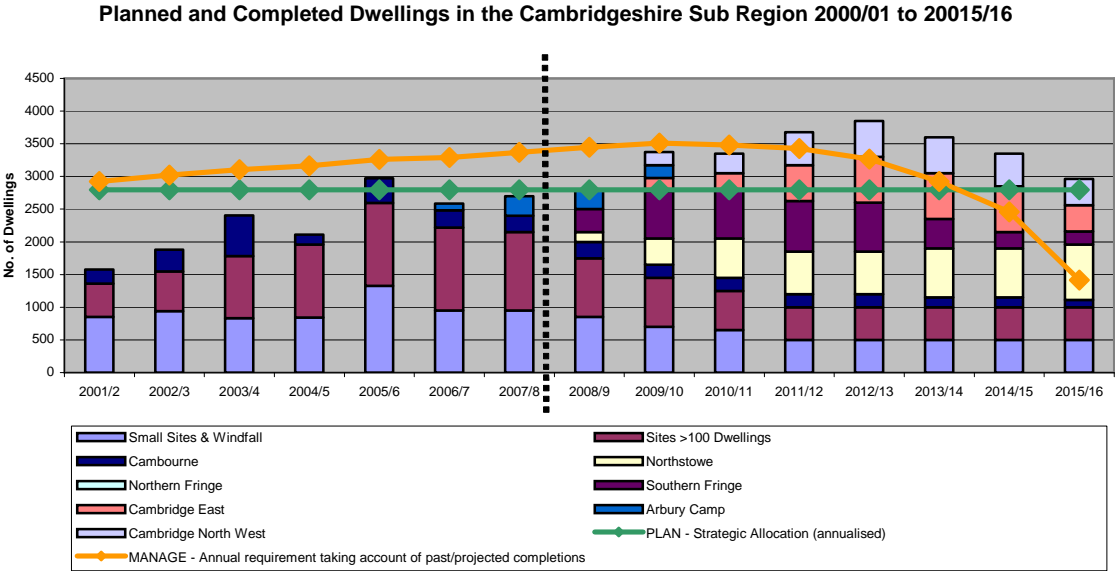
- the impact of the current economic downturn on future public sector financial allocations nationally and locally. Although there are no firm forecast figures yet, the impact is expected to be significant and will have far-reaching consequences for how NHS Cambridgeshire revises its current strategic planning framework and five year plan;
- establishment of new communities (population growth) and the year on year incremental growth of the population (population 'creep');
- demographic trends – ageing, especially in rural areas;
- technological 'creep', i.e. existing services are improved / extended through better technology leading to an incremental call on additional resources;
- National Institute for Health and Clinical Excellence (NICE);
- changes to national service and policy framework criteria e.g. NHS continuing care;
- public expectation creating an inflationary pressure;
- inability to shed cost pressures quickly and effectively; and
- delays in transforming services.

Strategic Context - Population Growth

4.9 Existing population growth is taken into account each year in NHS Cambridgeshire's and the Trust's capacity and financial plans. This usually takes the form of an agreed percentage uplift guided by the latest information provided by the Office of National Statistics.

4.10 The strategic challenge, however, will be to find means by which the impact of emerging new communities on health and social care services can be managed in the light of patient choice.

4.11 **Figure 1** below depicts the housing trajectory for the Cambridgeshire Sub Region *but please note that this is under constant review – slippage is expected.*



4.12 Approximately 7,500 new homes are planned to be built in Huntingdonshire District Council for the existing market towns and surrounding villages.

4.13 Of the other new developments, Northstowe potentially has most relevance to the Trust. The site is approximately 6 miles to the northwest of Cambridge and 13 miles south east of Huntingdon and is situated north of Oakington, bounded by the disused Cambridge to St Ives railway line to the east.

4.14 Approximately 9,500 dwellings are proposed, plus employment opportunities, a town centre, open space and a wide range of community and sports facilities. Building was to commence during 2009 but this has been delayed due to the economic downturn and other factors.

4.15 It is intended that Northstowe will be a sustainable town. It will be served by the Cambridgeshire Guided Busway to provide excellent public transport links to St Ives, Huntingdon (Hinchingbrooke Healthcare NHS Trust) and Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's) and easy access to a wide range of sub-regional employment and leisure facilities.

4.16 The development plan has undergone several changes and delays over the past couple of years and continues to be revised by the partner organisations involved with the planning of this development. NHS Cambridgeshire drew up an early commissioning model with partners which will be updated once development plans are further advanced.

4.17 The working presumption is that some of the new community of Northstowe will wish to use Hinchingbrooke but it is too early to have an agreed view at this stage of how many and which services. The population is expected to grow gradually and comprise

at least in the early years mainly younger people. It is expected that the initial impact over the first three years will be focussed on primary care services with a residual and relatively small demand for secondary care but demand for secondary care to grow as the population becomes more established. Early estimates of the impact on health services have been calculated but these will be revised and worked through in the light of growing NHS Reform implementation – e.g. the increasing trend for out of hospital care, the improved opportunities for demand management, extension of patient choice, etc.

- 4.18 One example of the increasing role for the Trust even now is in the provision of maternity services. The catchment area for West Cambridge (Cambourne and surrounding area) was re-aligned two years ago leading to a planned increase of referrals to the Trust for maternity care. This is likely to be an increasing pattern with Northstowe in addition to the Trust already gaining obstetric referrals from North Northants and North Beds.

NHS Cambridgeshire Consultation on Services at Hinchingbrooke

- 4.19 Given the review of the financial position at the Trust, NHS Cambridgeshire, in partnership with NHS East of England and the Trust, undertook a consultation in 2007² regarding a major reconfiguration of services for Huntingdonshire. The outcomes of the public consultation including approval of the preferred option (Option 2) were ratified by the NHS Cambridgeshire Board at their meeting on 27 June 2007³.
- 4.20 Option 2 in the consultation required a decrease in the level of current NHS activity at the Trust. The original commissioning intentions and the public consultation envisaged an overall decrease of activity by approximately 20% from the level of activity at the Trust in 2005/6.
- 4.21 A new Programme Board was established in 2009/10 to continue to oversee delivery of the jointly agreed Option 2 objectives and to conduct a formal review in the light of experience of implementation to date. As a result, it has become clear that the scale of reduction in hospital activity that underpinned the rationale for Option 2 has not been fully realised and the cost saving associated with the reduction in activity has not been delivered. The rationale underpinning Option 2 did not anticipate national increases in referral rates in both planned, unplanned and Out Patient attendance. The plan has been refreshed and the activity plans reflected in the table at Appendix D (Part 1).
- 4.22 Successful implementation of the plan will require continued close joint working between the Trust, HuntsComm (including its constituent GP Practices) and Cambridgeshire Community Services to ensure that planned changes in capacity at the Trust are counter-balanced, where relevant, by effective demand management schemes and enhanced community services.

² Cambridgeshire Primary Care Trust: Seeking Sustainable Health Services for the People of Huntingdonshire; Formal Consultation Document February 2007.

³ Cambridgeshire Primary Care Trust: Formal Response to Consultation: Seeking Sustainable Health Services for the People of Huntingdonshire; Board Meeting in Public 27 June 2007

5 CLINICAL SERVICES CURRENTLY PROVIDED AT HINCHINGBROOKE

Trust Clinical Activity and Revenue

- 5.1 The table at Appendix D (Part 1) summarises the current activity and corresponding revenue plans for the Trust for 2009/10.
- 5.2 The table at Appendix D (Part 2) shows a breakdown of the accident and emergency activity levels.
- 5.3 Other PCT commissioned activity includes capacity for intensive therapy, coronary care and radiology services.
- 5.4 In addition to this activity, Cambridgeshire Community Services (CCS) has arrangements in place for the Trust to provide pharmacy services, paediatric magnetic resource imaging (MRI) and electroconvulsive therapy (ECT) service on their behalf.
- 5.5 The Trust currently receives further revenue from the delivery of other clinical services through arrangements in place with the following organisations:
- Cambridge University Hospitals NHS Foundation Trust (CUHFT) to provide dermatology, rheumatology, medical oncology, vascular surgery, ear, nose and throat (ENT), urology, ophthalmology, gynaecology, plastic surgery and chemical pathology services;
 - Papworth Hospital NHS Foundation Trust (PHFT) to provide cardiology, respiratory medicine and microbiology services;
 - CCS to provide inpatient physiotherapy, occupational therapy, SALT and dietetics services; and
 - Peterborough and Stamford Hospitals NHS Foundation Trust (PSFT) to provide histology services.

Clinical Services provided by other organisations at the Trust.

- 5.6 The Trust has agreements in place with several local providers who use the Trust's facilities to deliver clinical services. These include:
- CUHFT for the provision of neurology, breast screening, renal dialysis and paediatric surgery;
 - CCS for the provision of diabetic medicine, paediatric services (including the special care baby unit) and outpatient physiotherapy;
 - CPMHT for the provision of mental health services; and
 - Navas for the provision of vasectomies and minor operations.

Pathology

- 5.7 Pathology services at the Trust are provided in several ways.
- 5.8 The histopathology and mortuary services are provided by PSFT.
- 5.9 Gynaecological cytology services are provided off site by CUHFT.
- 5.10 Microbiology services are provided by the Health Protection Agency (HPA) from a site located at PHFT. This service is in the process of relocating to CUHFT from 1 April 2010. All other Pathology Services are provided on site by Hinchingbrooke staff.

Private patient activity

- 5.11 The Trust operates a private patient facility under its own brand of Mulberry Private Healthcare. Mulberry provides a range of outpatient and inpatient services operating a dedicated outpatient and check in facility located on the first floor of the main hospital. Inpatient care is provided on private en-suite rooms located on Birch Ward, Juniper Ward and the Treatment Centre:
- orthopaedic rooms on Birch Ward;
 - general surgical rooms on Juniper ward; and
 - rooms on the Treatment Centre for surgery and diagnostic procedures.
- 5.12 Post operative care is provided by existing NHS nursing staff. A dedicated hostess service is also provided to all private patients along with a drop in nursing service as required.
- 5.13 The Trust has contracts with all the major insurance companies as well offering private treatment to self funding patients. The facility offers the opportunity to all Trust consultants to undertake private practice, which facilitates in the recruitment and retention of medical staff.
- 5.14 The Trust's actual revenue from private patient activity for 2008/2009 was approximately £886,000.

6 FUTURE CLINICAL SERVICE REQUIREMENTS

- 6.1 The franchisee shall be expected to operate the Hospital and meet any activity commitments made prior to the Service Commencement Date.
- 6.2 The Option 2 public consultation of 2007 led by NHS Cambridgeshire supported the provision of the same range of services through the site but with remodelled pathways at lower activity volumes.
- 6.3 There is a commitment for the Trust to maintain the provision of accident & emergency and maternity services from the Trust site for the foreseeable future.
- 6.4 The PCT is currently reviewing several options for the future case mix for the Trust. They are working closely with the Trust and other stakeholders to continue to develop pathways across primary, secondary and community care, with activity benchmarked against similar PCT clusters. The aim is to be in the upper quartile.
- 6.5 Specific workstreams being examined include:
- urgent care, including minor injuries, and illness in and out of hours;
 - reducing new outpatient attendance and planned admissions in clinical areas that are above national and cluster averages, if clinically appropriate;
 - ensuring long term sustainability of clinical services, thus obviating the need for non recurrent financial subsidies; and
 - developing pathways of care across the whole system of care to make sure that people are admitted to secondary care appropriately and do not remain in an acute hospital setting for longer than clinically necessary.

Further details about the scope of services and indicative activity information shall be provided at the competitive dialogue stages.

7 NON-CLINICAL SERVICES

Finance

- 7.1 The Trust runs a full financial management and accounts service. The payroll and pension service is contracted externally and run by Queen Elizabeth Hospital NHS Trust. Payroll records are held on the national payroll system called the Electronic Staff Record (ESR). The Trust is a member of the local SHA Procurement HUB. Internal audit is also provided by an external organisation, Deloitte. The Trust's external auditors are the Audit Commission. The finance ledger is Integra and run as a bureau service by IB Solutions. The Trust also administers Charitable Funds on behalf of the Hinchingbrooke Health Care Charity.

Human Resources (HR)

- 7.2 A comprehensive HR service is provided which includes employee relations, recruitment and retention, workforce planning and information and equality and diversity. Education and Learning is provided covering mandatory requirements as well as further professional development. A full Post Graduate Medical Education Centre and Library is supported by the Trust and the Eastern Deanery on the site. Occupational Health services are also provided and sub-contracted to other organisations. Resources are also available within the HR team to manage internal and external communications.

Information Technology (IT)

- 7.3 The IT team support the daily requirements and development needs of both the Trust and the Huntingdon GP community. The desktop support team are required to support any user for any call and are multi skilled in all the necessary teams to do so. Given the history of health community IT development all the development staff are jointly funded by the Trust and PCT so resources can be deployed effectively and efficiently. The Trust runs a number of owned IT systems and non-owned systems such as Choose and Book. These systems are clinical and non-clinical. They also provide IT support to other organisations using the site.

Information

- 7.4 The increasing information requirements of the Trust are supplied by a small team of 3 senior analysts and some administrative support. The coding team will need to expand to meet the needs of the new operating framework and contract.

Facilities Management

- 7.5 Facilities management services cover several areas which include:
- Capital Services, dealing with capital projects, planning, accommodation;
 - Site Services, dealing with building and engineering works, utilities, switchboard, car parks (attendants provided externally), General Offices; and
 - Support Services, providing Catering, Portering and Security with Domestics. Laundry is provided externally.

These services are provided on the whole by Trust staff although a new domestic services contract with an external provider is due to commence shortly.

- 7.6 The Trust provides facilities support to a number of NHS and non-NHS organisations using the site who pay for the full range of services they receive such as utilities, cleaning and rental.

8 FACILITIES

State-of-the-Art Facilities

8.1 The Hospital was initially built in two stages, opening in 1979 and 1983. In recent years the Trust has invested heavily in the site and a number of the services have been significantly updated and modernised including:

- new £22m Treatment Centre (opened 2005);
- new £7.5m state of the art Children's unit (opened September 2007 – PCT run);
- new £6.5m Emergency Care Centre and Reception (opened Jan 2006);
- new £1.2 Medical Assessment Unit (2001);
- upgraded £300k physiotherapy treatment centre (2006); and
- new Addenbrooke's Dialysis Centre (2008).

8.2 By the end of March 2010 the bed stock out of which the Trust operates all clinical services is 369 all of which are single sex compliant. The breakdown of these are:

- 8 30-bedded wards (6 medicine and 2 surgery);
- a 20 bedded medical assessment unit;
- 23 day case cabins;
- 24 short stay beds;
- 46 maternity beds including delivery suites and Maternity Led Birthing Unit;
- 5 critical care beds and 4 coronary care beds (a strategic case for a new unit has been agreed by the Trust Board and a final business case (FBC) is under development) ;
- 7 bedded isolation ward
- 8 minor and 8 major cubicles in A&E and a resuscitation room for 2 patients;
- surgical private patients are accommodated in the single en-suite rooms in the surgical wards and treatment centre;
- the Treatment Centre which has 5 operating rooms and three dedicated endoscopy rooms. Two of the Treatment Centre theatres have been fitted with the latest Storz laparoscopic equipment allowing for complete sterile control of all equipment by the operator and also the opportunity for remote real-time teaching; and
- in the main building of the Hospital there are a further 6 theatres, 2 of which are laminar flow for orthopaedics. The theatres operate Monday to Friday with weekends predominately for emergencies.

8.3 The Trust has recently (2008) upgraded six 30 bed wards, all having five 5 bedded bays with an en-suite shower room and toilet in each bay. Bays will be single sex but wards will not. There are also 5 single rooms with ensuites in each ward. Additional infection control measures are being designed into the new wards with hand washing areas before the entrance. There are 4 medical wards, zoned into specialities and 2 surgical wards with one taking cold elective orthopaedics and trauma and the other general surgery.

8.4 Each bay on the wards has sliding glass doors which can be closed should infection occur so that only the bay needs to be isolated not the closure of the whole ward.

Single Sex Compliance

8.5 Works are in progress to upgrade two wards at the back of the Hospital into 30 bedded wards comprising 5 single and five 5 bedded bays all with ensuites. New nurse's stations and reception are included.

Medical Assessment Unit (MAU)

8.6 A 20 bedded MAU is situated at the front of the hospital next to the Emergency Care Centre. This facilitates smooth transfer, achievement of 4 hour waits and the provision of A&E beds if required. The unit has 4 bays and 2 single rooms. This area is also planned to be developed to meet single sex compliance with a reconfiguration of beds and additional ensuite toilets and washing facilities.

Obstetrics

8.7 The pre and post natal ward – Lilac – is situated opposite the Main Theatre and delivery suite. It comprises of five 5 bedded bays and three single rooms all with ensuites.

Emergency Care Centre

8.8 This is located next to the main entrance and with Out of Hours GP service co-located with a shared reception. Split into majors and minors with a number of minor cubicles and 10 major cubicles and 2 resuscitation areas. The area also includes a quiet room designed for use with mental health patients.

Treatment Centre

8.9 Opened in 2005 this consists of a self contained, large 8,500 square-metre, two-storey purpose built building procured through the Private Finance Initiative (PFI). It is maintained and made available to the Trust by Prospect Healthcare under a 30 year operating concession. It provides one of the most up to date NHS facilities in the country.

8.10 The centre is open five and a half days per week. Patients are referred from local GPs and surrounding hospitals, they attend initially for pre-operative assessment, imaging and consultation before being given a choice of dates to return for their procedure.

8.11 The facility contains:

- 23 second stage recovery places (cabins), 6 single-bed rooms and 5 3-bed rooms plus 1 infusion room, all with en-suite facilities;

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- 5 operating rooms; two with laminar flow ventilation;
- 2 operating rooms with fully automated Karl Storz digital minimally invasive technology (MIT) endoscopy equipment;
- 2 minor treatment rooms and three endoscopy suites;
- extensive diagnostic imaging provision including three ultrasound rooms, a mammography unit and X –ray room;
- MRI and 16 slice GE CT are shared with the main hospital;
- outpatient clinics, Community Dental Services;
- 1st stage recovery area; and
- Endoscopy, day patient cabins (22) and 23 hour or longer stay beds.

All operations are planned for a Friday discharge as the centre is not available after Saturday lunchtime.

Main Hospital building - Downstairs

- 8.12 Outpatients clinic for fracture clinic, rehabilitation and maternity day assessment, Physiotherapy, A&E, GP out of hours service, Medical Assessment Unit, X-Ray, Pathology, Audiology, Dialysis Centre and Children's Centre .

Main Building - Upstairs

- 8.13 There are a further 6 theatres 2 of which are laminar flow for orthopaedics. The theatres operate Monday to Friday with weekends predominately for emergencies.
- 8.14 All inpatient ward areas including maternity and isolation are located on the first floor along with Critical Care and SCBU.

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9 WORKFORCE

- 9.1 As at 30 September 2009 the staff numbers in terms of full time equivalent (FTE) and head count (excluding bank/locum staff) at Hinchingbrooke are 1423 and 1671 respectively. The Trust's workforce is well balanced and consistent with the needs of a smaller district general hospital. The majority of staff are employed directly by the Trust and are based primarily on site. A small amount of work on site is performed by employees of other trusts, including the PCT (see Section 5) under service level agreements with the Trust. A small number of FM staff employed by the Trust are seconded to Kier, a FM service provider to the Treatment Centre and they are not included in the table below. The Trust has an in house bank arrangement with a view to minimising the marginal cost of using commercial agency staff. Industrial relations are generally good. Set out below is a breakdown of the staff profile:

Staff in Post

	Headcount	FTE
Administrative & Clerical	320	253.97
Ancillary	149	115.51
Estates & Maintenance	18	18.00
M&D Consultant	69	65.18
M&D Junior Dr	81	78.20
M&D NCCG	24	23.85
Managers	35	33.09
Non-Execs	6	6.00
Registered AHP	42	34.61
Registered HCS	29	26.59
Registered Midwife	102	83.07
Registered Nurse	450	389.71
Registered ST&P	69	61.41
Senior Managers	23	22.70
Support Worker N&M	185	153.81
Support Worker ST&P	69	57.75
Total	1671	1423.45

Gender

	Headcount	FTE
Female	1353	1119.92
Male	318	303.53
Total	1671	1423.45

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Working Pattern

	Headcount	FTE
Full Time	968	968
Part Time	703	455.45
Total	1671	1423.45

Age Range

	Headcount	FTE
25 & Under	161	147.34
26-35	305	271.60
36-45	465	385.70
46-55	490	420.64
56-65	238	189.06
66+	12	9.11
Total	1671	1423.45

Attrition Rate

- 9.2 During 2008 staff turnover ranged from 15.08% to 16.94% and as at 31 August 2009 stood at 13.89%.

Sickness

- 9.3 The cumulative sickness percentage rate during 2008 ranged from 3.71% to 4.05% and as at 31 August 2009 stood at 3.8%.

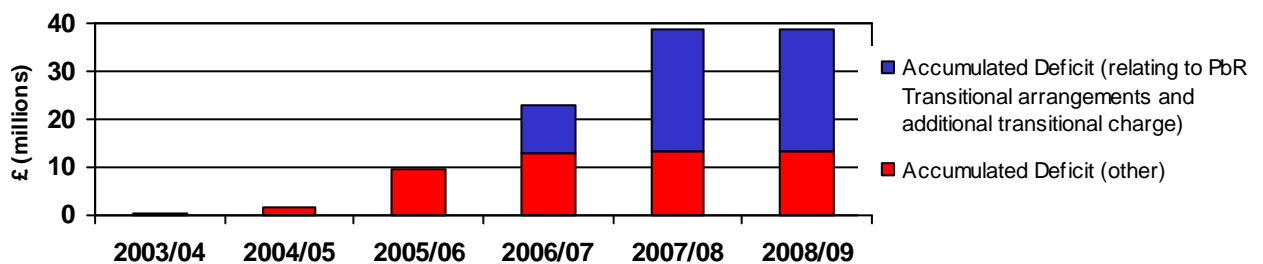
Joint Appointments

- 9.4 To enable the Trust to deliver the full range of services detailed in this MOI there are a number of joint appointments and service level agreements in place with other providers.

10 FINANCIAL POSITION

Overview

- 10.1 In 2008/09 the Trust had a turnover of approx £91.6m and generated an in-year operating surplus of approximately £0.1m. This reflected a 25% increase in 2007/08 revenues, predominantly due to the Trust being paid for activity at full NHS Tariff prices.
- 10.2 As at 31 March 2009, the Trust reported an accumulated deficit of £38.9m. As can be seen from the diagram below, this deficit has been building up since 2004/05.



- 10.3 Prior to 2008/09, the Trust's financial deficits were predominantly driven by low unit costs tied to historic low funding relative to the work it undertook. The introduction of full national unit pricing under Payment by Results (PbR) along with good management has enabled the Trust to achieve operational breakeven in 2008/09.
- 10.4 However, for the 4 years prior to 2008/09, under the national transition rules for PbR, the increase in tariff was stepped up each year. The difference in payment received between full payment and the transition amount equated to a total of £5.5m in 2006/07 and approximately £15.5m in 2007/08. Therefore, approximately £21m of the £38.9m accumulated deficit relates to the PbR transition for these two years alone.
- 10.5 Another contributing factor to the deficit arose when the additional activity planned for the new Treatment Centre (opened in October 2005) did not materialise. Increased activity was expected to be generated by a shift in referrals to the Trust. However, the PCT changed its commissioning intentions and moved activity away from hospitals and into the community, in line with DH guidance. This contributed in part to the £7.8m deficit incurred in 2005/06.

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Income and Expenditure Account

10.6 The Income and Expenditure accounts for the Trust's latest 3 years of audited financial accounts are shown below.

TRUST INCOME AND EXPENDITURE ACCOUNT			
	31-Mar-09	31-Mar-08	31-Mar-07
	£000's	£000's	£000's
Income from activities	81,855	63,059	63,440
Other operating income	9,775	9,947	8,917
TOTAL INCOME	91,630	73,006	72,357
Operating expenses	(88,181)	(85,293)	(82,889)
OPERATING SURPLUS / DEFICIT	3,449	(12,287)	(10,532)
Profit/(Loss) on disposal of fixed assets	(117)	(1,113)	(51)
SURPLUS / DEFICIT BEFORE INTEREST	3,332	(13,400)	(10,583)
Interest receivable	175	557	163
Interest payable	(24)	0	0
Other finance costs -unwinding discount	(13)	(13)	(14)
SURPLUS / DEFICIT FOR THE FINANCIAL YEAR	3,470	(12,856)	(10,434)
Public Dividend Capital dividend Payable	(3,372)	(3,181)	(2,920)
RETAINED DEFICIT FOR THE YEAR	98	(16,037)	(13,354)

10.7 Trust income increased by approximately 25% between 2007/08 and 2008/09. This was predominantly driven by the Trust receiving payment for activity at full NHS Tariff prices, i.e. the Trust did not have to make any PbR transitional repayments to DH as in previous years. The Trust posted an operating surplus of £0.1m in 2008/09.

10.8 The Public Dividend Capital dividend is an annual charge to the Trust, reflecting the forecast cost of capital utilised by the NHS Trust. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the forecast average carrying amount of all assets less liabilities, except for donated assets and cash with the Office of the Paymaster General.

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10.9 A breakdown of the Trust income is summarised below:

	31-Mar-09 £000's	31-Mar-08 £000's	31-Mar-07 £000's
Income from DH/NHS activities:			
- PCT's	73,066	72,797	64,640
- SHA's	15	-	-
- NHS Trusts	26	-	7
- NHS FTs	195	-	-
- DH			
Market Forces Factor (MFF)	7,284	6,519	6,741
Other	11	-	63
Repayments to DH (incl. PbR trans. payment)	-	(18,395)	(10,114)
	80,597	60,921	61,337
Income from non DH/NHS activities:	886	1,326	1,197
- Private patients	51	108	-
- Overseas patients (non-reciprocal)	291	147	-
- Injury cost recovery	30	557	906
- Other			
	1,258	2,138	2,103
Other operating income:			
- Education, training and research	2,714	2,601	2,524
- Charitable and other contributions	13	17	29
- Transfers from donated reserve	171	157	158
- Non-patient care services to other bodies ⁽¹⁾	2,802	4,061	4,378
- Rental income from operating leases	1,331	876	-
- Income generation	1,923	1,443	1,583
- Other income	821	792	245
	9,775	9,947	8,917
TOTAL INCOME	91,630	73,006	72,357

⁽¹⁾ Refers to income from car parking, catering etc

10.10 Income from Cambridgeshire PCT (including MFF from DH) represented approximately 87% of income to the Trust in 2008/09. PCT income is predominantly NHS Tariff based with 77% of PCT income in 2008/09 paid on Tariff. The additional Market Forces Factor (MFF) income refers to the uplift paid to the Trust on NHS Tariff based activity and is defined based on the Trust's geographical location.

10.11 Prior to 2008/09, the repayments to DH mostly related to the PbR transitional charges.

10.12 Private patient income has reduced in 2008/09 as a result of restructuring the facility.

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The reduction in non-patient care services income is due to the introduction of a new general ledger and revised national coding structure. Other sources of income generation include car parking and catering income with rental income covering items where other organisations use space on the Hospital site.

10.13 A breakdown of key operating expenses are summarised below:

	31-Mar-09	31-Mar-08	31-Mar-07
	£000's	£000's	£000's
Staff			
- Permanent	50,059	48,469	50,941 ⁽³⁾
- Locums, agency, bank staff	3,101	1,373	
	53,160	49,842	50,941
Supplies and Services			
- Clinical (excluding PFI facility)	13,084	12,702	11,498
- PFI facility ⁽¹⁾ (Treatment Centre)	3,562	3,267	3,180
- General	2,488	1,185	1,202
- Services from NHS bodies (PCTs/FTs/Trusts)	4,213	4,705	3,359
	23,347	21,859	19,239
Clinical Negligence	1,104	1,230	1,306
Establishment and Premises ⁽²⁾	4,703	4,705	4,627
Depreciation	3,866	4,938	4,714
Other	2,001	2,719	2,062
TOTAL OPERATING EXPENSES	88,181	85,293	82,889

¹⁾ PFI contract due to expire in 2035

²⁾ This includes maintenance and management of estate, utilities, rates etc

³⁾ Split of permanent/ non-permanent not specified in accounts

10.14 The PFI contract represents an annual committed cost. Further details of this contract including the pricing indexation mechanism will be provided at the competitive dialogue stages of the Procurement.

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Balance Sheet

10.15 The balance sheet for the last 3 years is shown below.

TRUST BALANCE SHEET			
	31-Mar-09 £000's	31-Mar-08 £000's	31-Mar-07 £000's
FIXED ASSETS			
Intangible assets	1,962	1,186	0
Tangible assets	82,911	90,106	90,193
TOTAL FIXED ASSETS	84,873	91,292	90,193
CURRENT ASSETS			
Stocks and Work in Progress	1,351	1,428	1,496
Debtors	8,163	4,441	26,405
Cash at bank and in hand	2,888	672	165
TOTAL CURRENT ASSETS	12,402	6,541	28,066
CREDITORS: amounts falling due within 1 year	(7,835)	(3,977)	(13,511)
NET ASSETS	4,567	2,564	14,555
DEBTORS: amounts falling due after more than 1 year	536	921	982
TOTAL ASSETS LESS CURRENT LIABILITIES	89,976	94,777	105,730
DEBTORS: Due >1 year			
CREDITORS: amounts falling due after more than 1 year	(202)	-	-
PROVISIONS FOR LIABILITIES AND CHARGES	(2,048)	(2,025)	(830)
TOTAL ASSETS EMPLOYED	87,726	92,752	104,900
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital (PDC)	82,760	79,146	75,387
Revaluation Reserve	38,128	47,873	45,863
Donated Asset Reserve	1,413	1,460	1,320
Income and Expenditure reserve	(34,575)	(35,727)	(17,670)
TOTAL TAXPAYERS' EQUITY	87,726	92,752	104,900

10.16 Public Dividend Capital (PDC) represents the outstanding public debt of an NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS Trust. In 2006/07 the Trust received temporary PDC funding of £30m in order to strengthen its cash position. In 2007/08 a further £12.5m PDC was received (although this was offset by repayments not previously accrued, resulting in an increase in PDC of £3.8m). In 2008/09 the Trust received a further £3.6m PDC to support the delivery of capital schemes related to Option 2. The cumulative PDC is shown on the Trust's Balance Sheet.

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Capital Expenditure

10.17 NHS Trusts must control capital expenditure to meet a predetermined Capital Resource Limit (CRL). The government introduced this constraint to ensure that resources allocated for capital spending were actually used for capital, rather than used to support revenue budgets.

10.18 The Trust identifies its capital requirements via the annual DH driven planning process. The Capital Plan has to be approved by the NHS East of England. The key constraint for the Trust is accessing cash to support the programme and so all other things being equal the level of CRL would equate to the level of depreciation being budgeted for as this provides the cash to fund the programme.

10.19 The Trust CRLs over the past 3 years are summarised below:

	31-Mar-09 £000's	31-Mar-08 £000's	31-Mar-07 £000's
Capital Resource Limit	8,816	6,845	7,200
Trust Capital Expenditure	<u>6,682</u>	<u>5,770</u>	<u>6,874</u>
Underspend against CRL	2,134	1,075	326

10.20 The Trust is not allowed to carry its underspend forward to the next year.

10.21 The CRL allocation for 2009/10 is £5.058m and is assumed in the 2009/10 Annual Plan to be approximately £5m for 2010/11 and 2011/12. The Trust's programme of capital expenditure based on these CRLs is summarised below. This is for indicative purposes only.

Capital Expenditure Programme	31-Mar-10 £000's	31-Mar-11 £000's	31-Mar-12 £000's
Fixed Assets (non-maintenance)			2,000
MARS upgrade	2,065		
Critical Care Development	640	3,500	
HSDU Compliance	750	200	
Front of House	103		
Fixed Assets (maintenance)			1,800
Fire Regs and H&S	200	100	200
Assets - Other			
Medical equipment	300	200	300
IT	200	200	200
Labour Ward	700		
Radiology		700	500
Other Equipment	100	100	
TOTAL BUDGET	5,058	5,000	5,000

10.22 The higher CRLs shown for 2006/07 to 2008/09 reflect a combination of a higher value of the assets used for depreciation purposes and additional funding secured via

the NHS East of England to support Option 2.

- 10.23 Where the Trust requires additional capital funding over and above the cash generated by the Trust and where schemes are above £6m, then it has to apply to the NHS East of England for additional funds.

11 OUTLINE TRANSACTION STRUCTURE

Overview

- 11.1 It is intended that the functions of the Trust and the ability to provide services as an NHS operator are to be delegated to the Franchisee using a Franchise Contract by virtue of the Secretary of State issuing an Intervention Order.

Intervention Order

- 11.2 Any delegation of the functions of the Trust will need to be authorised by the Secretary of State using an Intervention Order under section 67 of the NHS Act 2006. An Intervention Order can do any or all of the following:

- alter the composition of the Trust board;
- require the Trust to delegate certain of its functions to a specified person (i.e. the Franchisee); and/or
- specify the terms and conditions on which such delegation takes place (i.e. to enter into the envisaged Franchise Contract).

- 11.3 The actions taken in compliance with the Intervention Order by the Franchisee will in effect be taken on behalf of the Trust.

- 11.4 An Intervention Order cannot extend the existing powers of the Trust or disapply any of the Trust's statutory or public law duties. However, the Secretary of State may choose to disapply or modify the effect of statutory regulations regarding internal procedures of the Trust by using the Intervention Order. In this sense the healthcare operations of the Trust will continue as before, albeit being directed and controlled by the appointed Franchisee.

Trust Board

- 11.5 Discussions will be progressed during the competitive dialogue stages regarding the composition of the Trust Board but it is anticipated that the Franchisee should be able to exercise full operational control and management flexibility.

- 11.6 The Trust Board will be responsible for performance managing the Franchise Contract and a sub-committee of the Board could be established comprising existing directors to carry out that role. It is also anticipated that a number of material decisions (for example the disposal of Trust assets) will be reserved to them and require their specific approval. These details will be included in the Franchise Contract which will be formulated during the competitive dialogue stage.

Contract Structure

- 11.7 The contract structure will be developed in the competitive dialogue stages of the Procurement. However, an indicative contract structure is shown below based on current thinking. Under this proposal, trading will continue through the Trust with it being the prime party to NHS clinical contracts, service contracts and sub-contracts. The Franchisee will be delegated authority to operate the hospital on behalf of the Trust (including contract negotiation), via a Franchise Contract with the Trust.

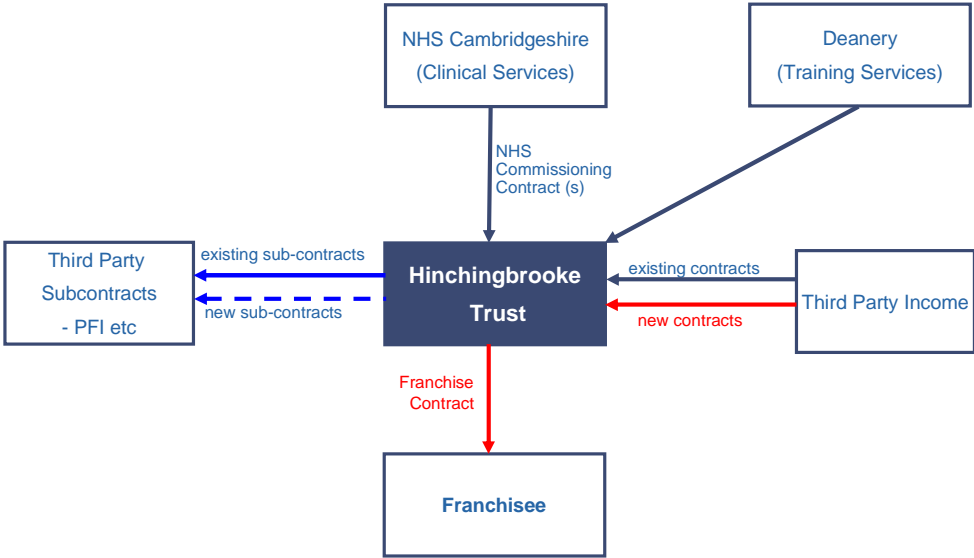
- 11.8 The Franchise Contract will set out the terms and conditions under which Franchisee

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delivers its services. It will set out the broad range of services that the Franchisee will be required to deliver on behalf of the Trust at the start of the contract and a willingness to vary these services from time to time as the commissioning needs change. It will require the Franchisee to negotiate with the PCT on behalf of the Trust. The details of the service requirements, together with the terms and conditions under which they will be delivered, will be contained in the service contracts between the commissioners and Trust.

11.9 At contract award the Franchisee will inherit the existing contract and subcontract arrangements. However, as most of these will be relatively short term (with the exception of the PFI contract), it is expected that the Franchisee will have the opportunity to renegotiate these contracts on the Trust’s behalf early in the Franchise.

Indicative Contract Structure



11.10 Given that the commissioning contract with NHS Cambridgeshire represents approximately 87% of income to the Trust (when MFF is included), it is the most significant contract held by the Trust. At the start of the Franchise Contract, the Franchisee will be required to operate under the existing PCT contract arrangement at the time. Future commissioning contracts with the PCT will be negotiated by the Franchisee on the Trust’s behalf but will be required to align with the terms and conditions of the standard form NHS commissioning contract published at the time of negotiation. The frequency of negotiation of the commissioning contract will be at the discretion of the PCT but subject to DH/NHS East of England guidance at the time. It is expected that the frequency of negotiation will be somewhere between 1 and 3 years. It is not anticipated that any contractual restriction will be placed on the ability of the Franchisee to expand the scope of the Trusts’ services.

Contract Term

11.11 It is currently anticipated that the Franchise Contract will be for a minimum duration of seven years, although views on an appropriate length of contract will be sought during the competitive dialogue stage.

Indicative Payment Mechanism under Franchise Contract

- 11.12 In return for holding the Franchise Contract it is anticipated that the Franchisee will pay the Trust a fee which will be used to contribute to repaying the Trust's historic deficit. During the competitive dialogue stages views will be sought on different payment mechanism options.
- 11.13 One Franchise Fee structure currently under consideration comprises a combination of a Fixed Fee and a banded Variable Fee. Under this arrangement it would be for Bidders to determine the fee they want to bid for the opportunity of holding the Franchise Contract:
- The Fixed Fee would reflect an amount the Franchisee would guarantee to pay for holding the Franchise Contract. Bidders would be invited during dialogue to bid the guaranteed amounts they would be prepared to pay each year over the term of the Franchise Contract. The Fixed Fee could vary from year to year and could potentially be zero in the early years of the contract.
 - The Variable Fee would be defined by financial bands either linked to revenues (or potentially to profits) generated by the Trust. Bidders would be invited during dialogue to bid the percentage share they would pay to the Trust within different financial bands. It is anticipated that at the lower bands the share to the Franchisee would be higher than to the Trust but at higher bands the Trust would be allocated the higher share.

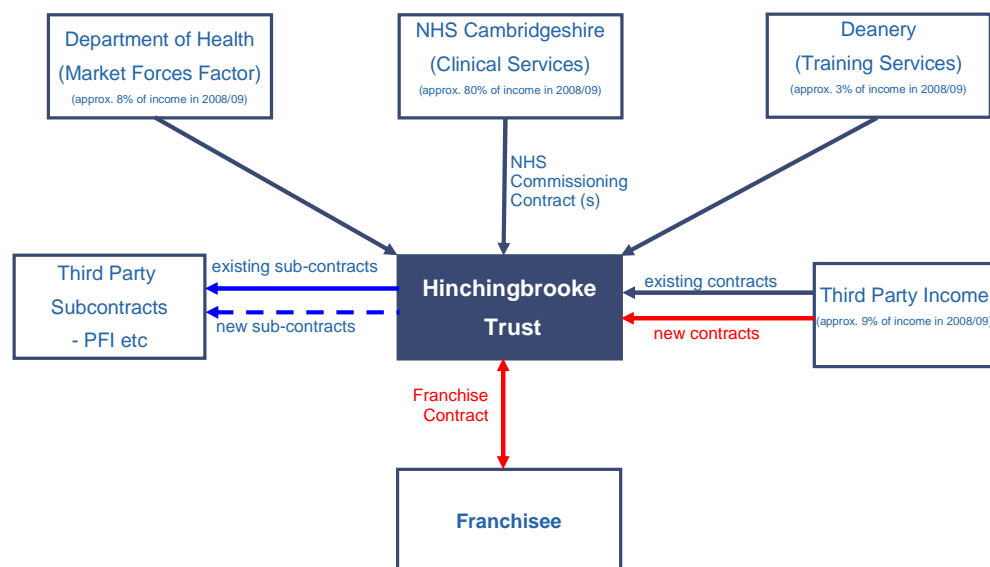
Funds Flow

- 11.14 An indicative funds flow schematic aligning with the indicative contract structure is shown below. Under the proposed arrangement, the Trust will continue to receive income from all the existing and new service contracts. Under the PCT commissioning contracts a significant % of income will be based on NHS Tariff prices (approximately 77% of PCT income in 2008/09). The DH, under Payment by Results (PbR) set national NHS Tariff prices on an annual basis. The Trust receives a further payment from DH relating to the Market Forces Factor (MFF). This reflects an uplift on NHS tariff prices to reflect the Trust's geographical location.
- 11.15 Under the standard NHS contract acute services, PCTs will pay the Trust for services delivered in the middle of the month of service delivery. While monthly payments are made on the basis of an annual projection of activity, these payments are reconciled quarterly to reflect payment for actual activity delivered.
- 11.16 The Franchisee will be responsible for making payments on behalf of the Trust, but subject to checks by the Trust sub-committee responsible for monitoring the Franchise Contract.

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Indicative Funds Flow



Scope of Services

- 11.17 Under the Franchise Contract the Franchisee will be expected to commit to providing broadly the same range of services currently provided at Hinchingbrooke Hospital whilst offering flexibility to accommodate commissioners evolving needs and requirements. However, as part of the competitive dialogue stages, views will be sought on how innovative solutions could be used to deliver these services in collaboration with the PCT more effectively from the start of the Franchise Contract.
- 11.18 The Franchisee will be encouraged to optimise use of the existing assets to increase income to the Trust. Potential sources of income could include activity from neighbouring PCTs (through the extended choice network), from additional private patient work (currently this reflects approximately 1% of income), from improved more efficient delivery achieved by a reconfiguration of services at the hospital site, service re-design to extend care pathways out of the hospital setting, etc.
- 11.19 Going forward, the Franchisee will be encouraged to work closely with the PCT to continually seek to improve the quality and effectiveness of service delivery to meet patients needs.

Flexibility on Trust's cost base

- 11.20 While the Franchisee will inherit the Trust's existing sub-contract arrangements, it will be for the Franchisee going forward to manage and control the majority of these costs.
- 11.21 The costs which the Franchisee will not be able to negotiate over the duration of the Franchise will relate to the PFI contract (approximately £3.5m in 2008/09) and the Public Dividend Capital dividends (approximately £3.3m in 2008/09) as described in paragraph 10.16. The Clinical Negligence payment (approximately £1.1m in 2008/09) is also an ongoing cost to the Trust.
- 11.22 Staff costs represent over 60% of the underlying cost base. The Franchisee will have

control over recruitment and management of the staff going forward to optimise efficiencies. They will also be able to performance manage staff within the existing NHS performance structures.

- 11.23 The Trust currently purchases a significant proportion of its clinical supplies from the NHS national supply chain. There is no commitment from the Trust to continue with this approach and therefore the Franchisee will have an opportunity to consider alternative sources of supplies.

Demand Risk

- 11.24 Under the standard NHS model contract for acute services, providers are required to take demand risk. However, in order to take demand risk the Franchisee will need to be comfortable that it has sufficient flexibility in the Trust's operating cost base to manage this risk. It is therefore envisaged that this will be a commercial issue that will involve further discussions with Bidders during the competitive dialogue stages, and may require consideration of provisions capping the Franchise's losses where there is justification that this is appropriate.

Clinical Negligence Insurance

- 11.25 CNST cover for the clinical services of the Trust will continue during the period of the Franchise Contract. Accordingly it is not anticipated that the Franchise Contract will require clinical negligence cover for these services.

Assets

- 11.26 All assets will remain owned by the Trust and as all services will remain performed by the Trust (albeit by the Franchisee on behalf of the Trust) there is no requirement to formalise the Franchisee's occupation of the Trust site by way of leases or licences. As far as the PFI building is concerned, the current contractual arrangements will remain in place and all payments currently made by the Trust to the PFI provider under that contract will continue to be made by the Franchisee on behalf of the Trust.
- 11.27 During the competitive dialogue stages the Franchisee will be encouraged to submit proposals that would optimise use of existing assets. This will need to take into consideration the Capital Resource Limits (CRLs) that will be applicable to the Trust and described in paragraph 10.17. Where additional funding is required over and above the CRLs, the Franchisee would have to submit a business case on behalf of the Trust to the NHS East of England.

Staff Transfers and Retention of Employment

- 11.28 By virtue of the Franchisee performing all services on behalf of the Trust under the Franchise Contract, it is possible that these arrangements could amount to the transfer of an undertaking or service provision change which could fall within the Transfer of Undertakings Protection of Employment Regulations 2006 ("TUPE").
- 11.29 The Trust wants to ensure that, where they wish to do so, staff should be given the opportunity to remain employed by the Trust rather than possibly automatically transferring to the Franchisee. To do this, it is proposed that staff should be given the opportunity to use the Retention of Employment model ("ROE"). Accordingly it is the intention that no staff TUPE to the Franchisee and that using ROE all staff remain employed by the Trust.

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Procurement

11.30 The procurement timelines and processes are summarised in paragraph 11.31 below and further detailed in paragraphs 11.32 to 11.37 below.

Timelines

11.31 The anticipated timelines for the Procurement are set out in Table 1 below. It should be noted that the dates are expected dates at the time of issuing this MOI and may be subject to change.

Table 1: Procurement Timetable

Key Programme Milestones	Date
Phase 1- MOI/PQQ	
Issue MOI and PQQ to interested parties (identified through expressions of interest)	26/10/09
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	01/02/10
ITPD1 Evaluation	02/02/10 – 15/03/10
Confirmation of Bidders recommended to proceed to ITPD 2	22/03/10
Phase 4 – ITPD2	
ITPD2 Issued	07/04/10
ITPD2 Submission deadline	24/05/10
ITPD2 Evaluation	25/05/10 – 21/06/10
Confirmation of Bidders recommended to proceed to ITT	28/06/10
Phase 5 – ITT	
ITT Issued	12/07/10
ITT Submission deadline	26/07/10
ITT Evaluation	27/07/10 – 31/08/10
Preferred Franchisee appointed	06/09/10

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Key Programme Milestones	Date
Phase 6 - - Approvals – subject to confirmation of approval & consultation process	
FBC/Approvals	06/09/10 – 30/11/10
Contract Award & Signature	01/12/10
Service Commencement	01/04/11
Staff and Public involvement	Ongoing

Procurement Process to Financial Close

11.32 Market:

- A national advert will be published.

11.33 MOI:

- This provides details of the Services. This MOI should provide Potential Bidders with sufficient information to enable them to make an informed decision about whether they wish to submit a response to the PQQ in accordance with the requirements set out in paragraph 11.34 below.

11.34 PQQ:

- The PQQ has been issued to Bidders with this MOI document. The PQQ provides detailed information on the PQQ process, guidance on how to complete the PQQ and a series of questions for Potential Bidders to answer.
- There is one PQQ for the Procurement. Each Potential Bidder wishing to bid must respond to the PQQ before the deadline stated in the PQQ.
- A clarification question and answer process will operate during the PQQ stage and is explained in the PQQ.
- The PQQ is designed to evaluate the capacity, capability and eligibility of Potential Bidders to provide the Services which are required by the commissioners. The PQQ evaluation will include a short-listing process and Potential Bidders will be informed whether or not they have been short-listed.
- All further details of the PQQ process and evaluation are set out in the PQQ itself.

11.35 Bidder Discussions:

- To ensure all Potential Bidders are given an equal opportunity to fully understand the requirements of the Procurement and have an equal opportunity to bid, it is intended to give Bidders the opportunity to discuss with the Project Team the requirements of the Trust and allow for Bidders to have a Commercial in Confidence discussion so as to answer any clarifications or concerns that they may have.
- Bidders are encouraged to participate in this dialogue. To this end Bidders should

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note that the Project Team held a Market Sounding Event on 2nd October 2009 and a copy of the presentation is attached as Appendix C.

- Bidders should contact:

Laura MacPherson
Project Coordinator

Laura.MacPherson@eoe.nhs.uk

if they wish to have a one to one discussion on any of the issues raised in this MOI and at the Market Sounding Event. Please be aware that the Project Team have allowed one hour for each discussion and that they should be held before **9th November 2009**.

11.36 Invitation to Participate in Dialogue 1 (ITPD1)

- Following the closure of the PQQ phase, the NHS East of England will issue selected Bidders (based on the application of the evaluation criteria) with an Invitation to Participate in Dialogue 1 (ITPD1) and Bidders will be requested to submit tenders in accordance therewith.
- The NHS East of England will then carry out a further evaluation to ascertain which Bidders will be selected to proceed to a second stage of dialogue, the Invitation to Participate in Dialogue 2 (ITPD2). At the completion and a further evaluation of ITPD2 the selected Bidders will be required to complete an Invitation to Tender (ITT) confirming the outcomes of ITPD2
- The NHS East of England will then carry out a further evaluation to ascertain which Bidder will be appointed the Preferred Bidder. For the purposes of the Franchise Contract any Bidder selected as a Preferred Bidder must note that following submission of final tenders, any finalisation of the Franchise Contract must relate only to clarifications and fine tuning of contract documentation. There is no scope for further negotiation at this stage on any aspects of the Franchise Contract that could distort competition or discriminate against other Bidders.
- The detailed requirements of these Phases, the information required from Bidders and the timescales for submission of final will be included in the relevant documents.

11.37 Contract Award:

- Following award of the Franchise Contract and in accordance with the Preferred Bidder's mobilisation plan, the Preferred Bidder shall be ready for service commencement by 1 April 2011.

Governance and Approvals

Roles & Responsibilities

11.38 The NHS East of England will lead the procurement process. A joint collaborative Project Board (including the Trust, the PCT and the NHS East of England) will make a

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recommendation to the NHS East of England Board which will in turn make a recommendation to the Secretary of State in relation to the making of an Intervention Order on specified terms.

11.39 The Franchise Contract will be entered into by the Trust and the Franchisee. The Franchisee will be required to perform the current commissioning contracts on behalf of the Trust.

Requirements

11.40 Bidder Procurement Costs:

- Each Organisation will be responsible for its own costs incurred throughout each stage of the Procurement process. Neither the NHS East of England, nor the Trust will be responsible for any costs incurred by any organisation or any other person through this process.

11.41 Conflicts of interest:

- In order to further ensure a fair and competitive procurement process, the NHS East of England requires that all actual or potential conflicts of interest are declared to NHS East of England and the Trust by 13:00hrs on 2nd November 2009
- Without limitation, such conflicts of interest may be perceived by EoE to arise in circumstances where:
 - A potential Bidder, including joint venture or consortia members or any person employed, sub-contracted to or engaged by or otherwise connected with a potential Bidder or such Bidder members has carried or is carrying out any work for the EoE, the Trust or the Commissioners in the last six months;
 - An organisation is providing services for more than one potential Bidder in respect of this project or procurement process.
- The 'Conflict of Interest Declaration', available on the e-portal must be completed by an authorised signatory, in his / her own name, on behalf of the potential Bidder and returned to EoE via the e-portal messaging system.
- In the event that any actual or potential conflict of interest comes to a potential Bidder's attention following the submission of the potential Bidder's 'Conflicts of Interest Declaration'. A new 'Conflict of Interest Declaration' must be completed by an authorised signatory, in his/her own name, on behalf of the potential bidder and returned to EoE via the e-portal messaging system. EoE will if it thinks it is necessary advise the Trust and/or the Commissioners of any Conflict of Interest Declaration.

11.42 Non-collusion and Canvassing:

- Each Potential Bidder and Bidder must neither disclose to, nor discuss with any other Potential Bidder, or Bidder (whether directly or indirectly), any aspect of any response to the PQQ and ITT documents.

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- Each Potential Bidder and Bidder must not canvass or solicit or offer any gift or consideration whatsoever as an inducement or reward to any officer or employee of, or person acting as an adviser to, either the NHS or the DH in connection with the selection of Bidders or the Preferred Bidder in relation to the Procurement.

11.43 Freedom of Information:

- The NHS East of England and the participating stakeholders are committed to open government and meeting their legal responsibilities under the Freedom of Information Act (**FOIA**). Accordingly, any information created by or submitted to the NHS East of England (including the information contained in the MOI, PQQ, ITPD or ITT and the submissions, bids and clarification answers received from Potential Bidders and Bidders) may need to be disclosed by the NHS East of England and participating stakeholders in response to a request for information under the FOIA.
- In making a submission or bid or corresponding with the NHS East of England and participating stakeholders at any stage of the procurement each Potential Bidder, Bidder and acknowledges and accepts that the NHS East of England and participating stakeholders may be obliged under the FOIA to disclose any information provided to it:
 - Without consulting the Potential Bidder or Bidder; or
 - Following consultation with the Potential Bidder or Bidder and having taken its views into account.
- Potential Bidders and Bidders must clearly identify any information supplied in response to the PQQ or ITT that they consider to be confidential or commercially sensitive and attach a brief statement of reasons why such information should be so treated and for what period.
- However, Potential Bidders should be aware that even where a Potential Bidder or Bidder has indicated that information is commercially sensitive, the NHS East of England and participating stakeholders are responsible for determining at their absolute discretion whether such information is exempt from disclosure under the FOIA, or must be disclosed in response to a request for information.
- Potential Bidders should also note that the receipt by the NHS East of England and participating stakeholders of any information marked “confidential” or equivalent does not mean that the NHS East of England and participating stakeholders accept any duty of confidence by virtue of that marking, and the NHS East of England and participating stakeholders have the final decision regarding the disclosure of any such information in response to a request for information under the FOIA.

11.44 Disclaimer Information

- The information contained in this MOI is presented in good faith and does not purport to be comprehensive or to have been independently verified.
- Neither the NHS East of England nor the Trust or any of their advisers or any participating Stakeholders accepts any responsibility or liability in relation to its accuracy or completeness or any other information which has been, or which is

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subsequently, made available to any Potential Bidder, Bidder, provider, Bidder member, Clinical Services Supplier, financiers or any of their advisers, orally or in writing or in whatever media.

- Interested parties and their advisers must therefore take their own steps to verify the accuracy of any information that they consider relevant. They must not, and are not entitled to, rely on any statement or representation made by the NHS East of England or the Trust, the PCT, the DH or any of their advisers.
- This MOI is intended only as a preliminary background explanation of the NHS East of England's and the Trust's activities and plans and is not intended to form the basis of any decision on whether to enter into any contractual relationship.
- The NHS East of England reserves the right to change the basis of, or the procedures (including the timetable) relating to, the procurement process, to reject any, or all, of the PQQ submissions and ITT bids, not to invite a Potential Bidder to proceed further, not to furnish a Potential Bidder with additional information nor otherwise to negotiate with a Potential Bidder in respect of the Procurement.
- Neither the NHS East of England nor the Trust shall be obliged to appoint any of the Bidders and they reserve the right not to proceed with the procurement or any part thereof, at any time.
- Nothing in this MOI is, nor shall be relied upon as, a promise or representation as to any decision by the NHS East of England. No person has been authorised by the NHS East of England or its advisors or consultants to give any information or make any representation not contained in this MOI and, if given or made, any such information or representation shall not be relied upon as having been so authorised.
- Nothing in this MOI or any other pre-contractual documentation shall constitute the basis of an express or implied contract that may be concluded in relation to the Procurement nor shall such documentation/information be used in construing any such contract. Each Bidder must rely on the terms and conditions contained in any contract when, and if, finally executed, subject to such limitations and restrictions that may be specified in such contract. No such contract will contain any representation or warranty in respect of the MOI or other pre-contract documentation.
- In this section, references to this MOI include all information contained in it and any other information (whether written, oral or in machine-readable form) or opinions made available by or on behalf of the NHS East of England, the Trust, the PCT, DH or any of their advisers or consultants in connection with this MOI or any other pre-contract document.

11.45 Confidentiality Undertaking

- All Bidders in receipt of this MOI and PQQ documentation must comply with the following confidentiality requirements and requirements of the Data Protection Act 1998 throughout the procurement process and following award of the Franchise Contract(s):
 - keep confidential any information relating to the Procurement and not

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disclose it to any person without the NHS East of England's prior written consent, unless this is strictly necessary to fulfil the NHS East of England's requirements under the Procurement process;

- take all reasonable steps to ensure that no other person gains access to information in its possession and inform the NHS East of England immediately if it learns that a person not duly authorised has gained access to it;
 - immediately return any documents it obtains as part of the procurement process on the request of the NHS East of England.
- Where disclosure of the information is controlled by statutory provision, Bidders accept that they may be prosecuted for wrongful disclosure in such circumstances.

12 NEXT STEPS FOR BIDDERS

Interested parties wishing to participate in the Procurement are asked to submit a response to the PQQ, through the e-portal www.eoecph.bravosolution.co.uk. No paper submissions will be accepted.

PQQ Responses should arrive no later than 13:00hrs on **16th November 2009**.

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GLOSSARY

Throughout this Memorandum of Information the following definitions shall apply:

“Bidder”	and/or	means an organisation intending to respond to the PQQ and submit a bid to secure the Franchise Contract;
“Potential Bidder”		
“CUHFT”	or	means Cambridge University Hospitals NHS Foundation Trust
“Addenbrooke’s”		
“CCP”		means the Co-operation and Competition Panel;
“CCS”		means Cambridgeshire Community Services;
“CPMHT”		means Cambridgeshire and Peterborough Mental Health Trust;
“CNST”		means the Clinical Negligence Scheme for Trusts;
“DH”		means the Department of Health;
“Franchise Contract”		means the contract to be entered into between the Franchisee and the Trust for the Services;
“Franchisee”		means the organisation selected as part of the Procurement to enter into the Franchise Contract and to provide the Services on behalf of the Trust;
“Hospital”		means Hinchingbrooke Hospital;
“MOI”		means this Memorandum of Information;
“NHS Act”		means the National Health Service Act 2006;
“NHS Cambridgeshire”/ the “PCT”		means Cambridgeshire Primary Care Trust;
“NHS East of England”/ the “SHA”		means the East of England Strategic Health Authority;
“PBC”		means Practice Based Commissioning;
“PHFT”		means Papworth Hospital NHS Foundation Trust
“PQQ”		means the Pre-Qualification Questionnaire in the form attached at Appendix A;
“Preferred Bidder”		means the Bidder selected as the preferred Bidder for the Project;
“Project”/“Procurement”		means the Hinchingbrooke Acute Trust Hospital Next Steps Project;
“PSFT”		means Peterborough and Stamford Hospitals NHS Foundation Trust
“Secretary of State”		means the Secretary of State for Health;
“Services”		means the services currently provided by the Trust at the Hinchingbrooke hospital;
“Treatment Centre”		means the self contained treatment centre on the Hospital site procured through the private finance initiative;
“Trust”		means the Hinchingbrooke Health Care NHS Trust; and
“Transaction”		means the operational franchise model as envisaged by the Procurement.

APPENDIX A

Pre-Qualification Questionnaire

See attached document – Appendix A – Hinchingbrooke PQQ

APPENDIX B

Clarification Question Template

See attached document – Appendix B – PQQ Clarification Question Template

APPENDIX C

Supporting Documentation

Please note that the content of a number of slides contained in the Market Sounding Day slides has been superseded and the up-to-date thinking is as set out in this MOI.

See Attached Documents - Appendix C – Market Sounding Day Presentation and
Market Sounding Day Questionnaire

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APPENDIX D

Trust Revenue & Activity Plans 2009/2010

Part 1

Specialty	Elective Inpatient Spells		Non-elective Spells		First Outpatient Attendances		Outpatient Follow up Attendances		Outpatient procedures	
	Revenue	Activity	Revenue	Activity	Revenue	Activity	Revenue	Activity	Revenue	Activity
Accident & Emergency	N/A	N/A	296082	305	N/A	N/A	N/A	N/A	N/A	N/A
Anaesthetics	N/A	N/A	N/A	N/A	225194	2869	N/A	N/A	N/A	N/A
Anticoagulant Service	N/A	N/A	N/A	N/A	56977	413	N/A	N/A	622	2
Audiological Medicine	N/A	N/A	N/A	N/A	136941	1675	17676	278	N/A	N/A
Breast Surgery	262105	183	57030	15	192975	1289	74974	942	73188	183
Cardiology	45560	70	N/A	N/A	195066	950	209588	2120	N/A	N/A
Chemical Pathology	N/A	N/A	N/A	N/A	795	7	4250	55	N/A	N/A
Clinical Genetics	N/A	N/A	N/A	N/A	16102	141	0	0	N/A	N/A
Dermatology	185601	336	2055	2	189291	1165	116703	3752	N/A	N/A
Diabetic Medicine	N/A	N/A	9565	2	79078	338	77731	645	N/A	N/A
Diagnostic Imaging	1172	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ENT	1056785	770	693	1	336083	2864	153526	2479	363	1
Gastroenterology	456567	901	536582	386	240918	1393	278472	2925	14057	34
General Medicine	680304	1071	13163344	7012	259616	1289	231684	2436	N/A	N/A
General Surgery	2982713	2698	3303851	1529	607754	3883	167902	1989	612407	1488
Geriatric Medicine	N/A	N/A	15389	9	N/A	N/A	N/A	N/A	N/A	N/A
Gynaecology	1383704	1048	520075	465	554375	3635	223122	2635	484185	1094
Haematology (Clinical)	483915	807	4415	2	39328	156	131885	1462	N/A	N/A
Interventional Radiology	N/A	N/A	N/A	N/A	543044	6242	12675	146	1197	3
Medical Oncology	2010389	2817	12943	2	107724	478	389779	3696	684	2
Midwife Episodes	N/A	N/A	2572871	1665	N/A	N/A	N/A	N/A	N/A	N/A
Neurology	N/A	N/A	N/A	N/A	219165	802	124354	696	N/A	N/A
Obstetrics using Bed or Delivery	16640	7	3586477	1839	903894	5737	375103	5311	N/A	N/A

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Ophthalmology	2270874	3080	99222	63	836757	7453	435633	7426	N/A	N/A
Orthoptics	N/A	N/A	N/A	N/A	128734	1930	136129	3070	N/A	N/A
Pain Management	N/A	N/A	13001	3	N/A	N/A	N/A	N/A	N/A	N/A
Palliative Medicine	N/A	N/A	9985	5	5970	17	2779	12	N/A	N/A
Plastic Surgery	433579	510	2249	2	127508	882	82469	1147	N/A	N/A
Respiratory Medicine	29899	18	600754	259	274832	1282	104346	920	N/A	N/A
Rheumatology	32942	65	N/A	N/A	180914	737	280462	2606	N/A	N/A
Trauma & Orthopaedics	8621037	2738	2272596	770	1593154	11764	1114010	14649	N/A	N/A
Urology	922443	1701	2371	3	213494	1480	85178	1115	1452	4
Grand Total	21876226	18823	27081547	14338	8265684	60870	4830429	62510	1188156	2811

Part 2

A&E Attendances by HRG	Attendances
High Cost Attendance	12,259
Standard Attendance	3,460
Minor Injury Attendance	19,803