Colchester Hospital University NHS Foundation Trust

The Ipswich Hospital NHS Trust

Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust

Outline Business Case for the Partnership between Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust

August 2017

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Contents

Abbreviations

Abbreviation	Definition
AAA	Abdominal Aortic Aneurysm
ACC	Acute Care Collaborative
A&E	Accident & Emergency (Emergency Department)
AHP	Allied Health Professional
AP/AR	Accounts Payable/Accounts Receivable
BC	Borough Council
BTA	Business Transfer Agreement
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CGH	Colchester General Hospital
CHUFT	Colchester Hospital University NHS Foundation Trust
CIBA	Confidentiality and Information Barrier Agreement
CIP	Cost Improvement Plan
CMA	Competition and Markets Authority
CNST	Clinical Negligence Scheme for Trusts
CoE	Centre of Excellence
CoG	Council of Governors
CoRG	Commissioning Reference Group
CQC	Care Quality Commission
CRG	Clinical Reference Group
CRL	Capital Resource Limit
CT	Computerised Tomography
CTC	Cardio-thoracic Centre
DC	District Council
DH	Department of Health
EBITDA	Earnings before Interest, Taxation, Depreciation and Amortisation
EBME	Electro Bio-mechanical Engineering
ECH	Essex County Hospital
ED	Emergency Department
EIA	Equality Impact Assessment
EMC	Executive Management Committee
ENT	Ear Nose & Throat
EPED	Every Patient Every Day
ESD	Early Supported Discharge
FBC	Full Business Case
FM	Facilities Management
FOM	Future Operating Model
FT	Foundation Trust
G&A	General & Acute (beds)
GI	Gastro-intestinal
GIRFT	Getting it Right First Time
GP	General Practitioner
H&S	Health and Safety
HASU	Hyper Acute Stroke Unit
HOSC	Health Overview Scrutiny Committee
HR	Human Resources
HSMR	Hospital Standardised Mortality Ratio
HWB	Health & Wellbeing Board
I&E	Income and Expenditure
IESCCG	Ipswich & East Suffolk Clinical Commissioning Group

Abbreviation	Definition
IHAM	Indicative Hospital Activity Model
IHT	The Ipswich Hospital NHS Trust
ICT	Information Communications & Technology
IP	Implementation Plan
IRO	In the region of
IT	Information Technology
JV	Joint Venture
KPI	Key Performance Indicator
LLP	Limited Liability Partnership
LTFM	Long Term Financial Model
MDT	Multi-Disciplinary Team
MoU	Memorandum of Understanding
MP	Member of Parliament
MRI	Magnetic Resonance Imaging
NED	Non-Executive Director
NEECCG	North East Essex Clinical Commissioning Group
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
nSTEMI	Non – ST Elevation Myocardial Infarction
OBC	Outline Business Case
OD	Organisational Development
ONS	Office for National Statistics
PAB	Partnership Advisory Board
PAS	Patient Administration System
PCI	Percutaneous Coronary Intervention
PDC	Public Dividend Capital
PFI	Private Finance Initiative
PMO	Programme Management Office
POD	People Organisation & Development
PPCI	Primary Percutaneous Coronary Intervention
PWG	Partnership Working Group
Q&A	Question & Answer
QIA	Quality Impact Assessment
RTT	Referral to Treatment Time
SHMI	Summary Hospital-level Mortality Indicator
SOC	Strategic Outline Case
SOP	Strategic Outline Programme
SSNAP	Sentinel Stroke National Audit Programme
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SU	Stroke Unit
SWLEOC	South West London Elective Orthopaedic Centre
T&O	Trauma and Orthopaedic Surgery
TOM	Target Operating Model
TRG	Transport Reference Group
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006
UCL	University College London
WTE	Whole Time Equivalent

1 Executive summary

1.1 Introduction

In May 2016, the Boards of both Colchester Hospital University NHS Foundation Trust (CHUFT) and The Ipswich Hospital NHS Trust (IHT) committed to entering into a long-term partnership (referred to as "the Partnership"). The Partnership is built on a foundation of collaborative working established between the two Trusts over recent years. With the support of NHS Improvement (NHSI), CHUFT concurrently appointed IHT's Chief Executive and Chair to their respective roles. A range of stakeholders support closer collaboration through the Partnership, including Commissioners, NHSI, NHS England (NHSE), and local government

The CHUFT and IHT Boards approved a strategic outline programme (SOP) in October 2016. The first phase of the programme was undertaken the strategic outline case (SOC) stage, which identified a range of scenarios that could provide a viable future through a Partnership between the Trusts.

Three of these scenarios were approved by the Trust Boards to be explored in this outline business case (OBC). **The preferred scenario described in this OBC is for a Partnership with full clinical integration and development of an ambitious model for corporate services**. The key benefits of the preferred scenario are:

- Quality: Delivering improved quality and patient outcomes by increasing standardisation, stronger subspecialty teams and compliance with national standards
- Access: Providing sustained and improved access to services that meet the needs of the population by managing capacity flexibly, increasing access to subspecialist care and creating more versatile skill mix within teams
- Workforce: creating a sustainable, skilled workforce based on the Partnership attracting, developing and retaining the staff needed to provide high quality healthcare in the local area
- Finance: Better value for money, including the ability to contribute to the short-term and longer-term financial sustainability of the Partnership and the wider system by maximising purchasing power and efficient capital investment

Subject to the approval of the OBC by the Trust Boards and NHSI, the next stage is a full business case (FBC); this will form the basis for the Boards' final decision on the future form of the Partnership and the services provided to patients.

1.2 Background and Case for Change

1.2.1 Background

CHUFT and IHT provide acute healthcare service in the Suffolk and North East Essex Sustainability and Transformation Partnership (STP). They provide secondary services including emergency departments (ED), maternity services, children's services, general medicine, and general surgery.

The trusts have different CQC ratings. As overall scores, CHUFT is rated as 'inadequate' and is currently in 'special measures'. IHT has been rated 'good'. CHUFT hosted a full CQC inspection 25-27 July 2017 and IHT are due to be inspected during summer 2017. This OBC sits within a context of significant national and local change of NHS and care services.

1.2.2 Case for Change

Both Trusts need to develop the Partnership to respond to the following challenges:

A step change in transformation is required

Both Trusts are undertaking ambitious programmes to meet the identified challenges, but these alone will not ensure sustainability in the face of an expected 4% annual growth in demand.

Increasing difficulty in recruiting and retaining staff

Across both CHUFT and IHT several clinical and clinical support specialties are already experiencing long-term recruitment challenges. This affects medical, nursing and allied health-professional staff in a number of specialties. Estimates from Health Education England (HEE) and local workforce partnerships indicate that many of these staffing shortages are likely to worsen over the next five years.

The workforce will be unsustainable and care to patients under threat unless the model of service delivery is changed, underpinned by training to change the skills mix of staff.

Some services are not sustainable against national guidance and new models of care

Some services at both CHUFT and IHT manage small patient cohorts due to their specialised nature. Some services are currently not meeting national guidance on minimum volumes. Changes in service provision are therefore required.

CHUFT and IHT are financially unsustainable in their current form

The forecast combined deficit for CHUFT and IHT in their current form is £39.9m in 2017/18, which increases to £44.5m by 2021/22 (assuming delivery of revised community services and internal productivity gains). In this forecast capital will remain constrained and opportunities for the improvement of estate will be limited.

1.3 The Partnership's ambition and objectives

The ambition, objectives and design principles reflect the aims that the CHUFT and IHT Boards and other stakeholders have for the Partnership. The ambition for the Partnership is:

> By working together CHUFT and IHT will secure sustainable and high-quality healthcare for Ipswich, East Suffolk and North East Essex

Four objectives for the Partnership have been agreed:

- Improved quality and patient outcomes
- Better value for money
- Sustained and improved access to services that meet the needs of the population
- A sustainable, skilled workforce

1.3.1 Design principles and fixed points

Design principles were developed to ensure that the combined organisation meets the ambition and objectives described above. The design principles also reflect the constraints within which the combined organisation will function. The design principles include a number of fixed points, which are high-level elements of the clinical model agreed in the SOC:

- Emergency Department (ED) services on both acute hospital sites
- Obstetric-led maternity services on both sites
- 24/7 acute medical take at both sites

1.4 Scenario Evaluation

Three scenarios are assessed in this OBC. They were assessed as a combination of clinical and corporate models:

- *Do nothing:* No change to corporate and clinical service models
- *Some Clinical Integration:* implementation of the proposed corporate model and some clinical integration
- *Full Clinical Integration:* implementation of the proposed corporate model and full clinical integration

The scenarios were evaluated in terms of both qualitative and financial benefits, using a set of weighted criteria linked to the Partnership's ambition and objectives.

1.4.1 Defining some and full clinical integration

The opportunities for clinical integration within a combined organisation were explored by the clinical specialties during the OBC phase.

A set of assumptions were developed to guide the clinical specialties in their thinking; these include a single board, a single main contract for the combined organisation, a single governance and performance framework including national standards reporting.

These assumptions are common to both clinical scenarios, but full clinical integration extends this to the furthest extent that clinicians at both Trusts felt was achievable in the short to medium term. These scenarios were originally defined in the SOC:

- Some clinical integration: "some clinical consolidation and harmonisation of practices and standardisation across sites". This means that although clinical services are subject to the same governance framework, the two hospitals within the combined organisation would continue to operate as largely separate organisations. This would include separate operational structures (such as divisions) and separate leadership below board level.
- Full clinical integration: "full clinical services consolidation, including a reconfiguration of service and centralisation where appropriate. Services and specialties are fully integrated and offered across sites from a single rota". This means that clinical services would function as single teams, albeit across two sites. The leadership, operational structures and management of resources would be combined.

Evaluation of opportunities relating to some and full clinical integration

Opportunities were identified by clinicians and were grouped into six strategic themes that describe the potential benefits to patients and staff. Some of the benefits are possible under both some and full clinical integration. A number of them rely particularly on full integration of clinical services to enable the close integrated working required to plan and deliver the benefits. The evaluation

therefore considered that the strategic themes applied differentially to the two scenarios. Examples of this include:

- Creation of centres of excellence (in the great quality local services theme) for some clinical services. This is highly dependent on the volume of patients treated or the number of procedures performed by the service and therefore the semi-independent nature of services in the some clinical integration scenario does not easily allow this.
- The development of posts with greater opportunities to develop skills (in the right people, right skills theme), through rotation or subspecialisation, requires those posts to function in a larger team. This is only feasible in the full clinical integration scenario.

The strategic themes applicable to the clinical integration scenarios are set out in Table 1-1.

Table 1-1 Strategic themes arising from the clinical integration scenarios

Strategic benefit theme	Some clinical integration	Full clinical integration
Right people, right skills		✓
Great quality local services		✓
24/7 resilience		✓
Best value for money	✓	✓
Right care in the right place		✓
Right systems and processes	✓	✓

1.4.2 Defining the corporate model

The corporate target operating model (TOM) will apply to the combined organisation in both some and full clinical integration scenarios. Services will be redesigned to take advantage of increased scale, based on the following principles:

- Technology enabled
- Responsive to customers
- Professional services model where possible
- Alternative provision
- Cost releasing and risk managed

1.4.3 Qualitative evaluation

The evaluation was undertaken by the Trusts' executive teams and by members of the reference and advisory groups involved in the OBC process. Stakeholders were invited to assess the three scenarios against the four qualitative criteria linked to the Partnership's ambition and objectives: quality (outcomes, safety and experience), access, workforce sustainability and deliverability. The riskiness of each scenario was evaluated through the deliverability criterion, which assesses the timeline for delivery and the level of risk inherent in each.

Each respondent's evaluation was given equal weight; this is consistent with the evaluation approach in the SOC.

Stakeholders rated the corporate model and each of the clinical models against the qualitative criteria on a scale from greatest loss of benefit to greatest gain of benefit. This rating was converted

into a score to enable comparison and ranking of the scenarios. This was based on assigning the greatest loss of benefit a score of minus five and the greatest gain a score of plus five, with no change as zero and the intervening values spread evenly between the extremes.

Evaluation outcome for corporate model

The weighted evaluation results showed a clear overall preference for implementing the proposed corporate model over the 'do nothing' scenario. This preference held across the quality, access, workforce sustainability and deliverability (time to deliver benefits) criteria. However, 'do nothing' was evaluated as easier to deliver than implementing the proposed corporate model.

Evaluation outcome for clinical integration models

The weighted evaluation results showed a clear distinction between the 'do nothing' scenario, which was evaluated negatively overall, and the clinical integration scenarios. The full clinical integration scenario was evaluated higher than some clinical integration on every criterion with the exception of deliverability; this reflects its greater complexity.

1.4.4 Financial evaluation

For 2016/17, the two organisations reported an aggregated deficit of £35.5m. From this base, the two scenarios (some and full clinical integration) were modelled in terms of:

- The financial benefits expected to be realised by the corporate TOM and the cost to implement it; these were assumed to be identical in both the scenarios
- The financial benefits and costs arising from the clinical integration scenarios

The summary financial position comparing the three scenarios is shown in Table 1-2.

Table 1-2 Summary financial position of the three scenarios

Financial element	Do nothing	Some clinical	Full clinical
Recurrent I&E positon 2021/22 (Surplus/(Deficit)) £m	(44.5)	(39.8)	(32.7)
Corporate TOM benefit by 2021/22 £m	0.0	6.5	6.5
Clinical integration benefit by 2021/22 £m	0.0	0.4	12.4
Capital expenditure beyond existing programme (total over 5 years)	0.0	(20.0)	(70.0)
Ranking (based on revenue performance)	3	2	1

1.4.5 Outcome of evaluation

The outcome of the scenario evaluation is shown in Table 1-3.

Table 1-3 Outcome of the scenario evaluation, weighted scores

Scenario	Qualitative Evaluation	Financial Evaluation	Total Evaluation Score (cf. Section 5)	Rank
Full clinical integration	**4.00**	**1.90**	**5.90**	**1**
Some clinical integration	3.48	-0.24	3.25	2
Do nothing	-1.00	-1.90	-2.90	3

The preferred scenario is full clinical integration.

This scenario scored highest in both the qualitative benefits criteria (quality, access, workforce sustainability) and the financial evaluation. Full clinical integration performed significantly better in the financial evaluation. In the evaluation of the clinical models, full clinical integration scored higher than some clinical integration. The combined scores result in the preferred scenario scoring nearly twice as much as the next nearest, some clinical integration. In terms of the deliverability criterion however, full clinical integration scored the lowest. The evaluators considered that the highest level of benefit (financial and non-financial) arises from full clinical integration, and that the risks to delivery will need to be carefully managed to ensure that the benefits are realised.

1.5 Clinical case and patient benefits

Implementation of the preferred scenario, full clinical integration, will enable the combined organisation to deliver the following benefits for patients and staff:

- **Great quality local services**: Offering a wide range of high quality local services by centralising some aspects of clinical care, where this is required to maintain or improve standards. Shared delivery of services resulting in reduced waiting times and improved patient access. There will also be increased opportunity for clinician peer review, allowing for enhanced quality of care and compliance with national standards
- **Right people, right skills**: A unified approach to recruitment and retention will enable the development of the required skill mix and capacity to support sustainable services; reducing the current reliance on temporary staff. Working in larger teams will enable the development of the appropriate skill mix through combined training and rotations, as well as providing career progression opportunities. This will release clinician capacity, reduce agency costs and improve the continuity of care for patients
- **24/7 Resilience:** Integrated working across the two sites will create more versatile teams to meet patient demand and ensure service continuity. Patients will benefit from improved access, outcomes and safety. Co-ordinating capacity with staff cross cover, shared rotas and seven-day working in certain areas will reduce delays and cancellations
- **Best value for money:** Centralised purchasing and contract management to achieve economies of scale; realising efficiencies through increased buying power in clinical equipment and supplies. Some capital purchases, particularly of the latest equipment technology, become increasingly viable as a combined organisation. In turn, this increases the range of modern services that can be accessed locally
- **Right care in the right place:** Improved patient access to services in the most appropriate settings. For example, standardising discharge and rehabilitation pathways by sharing best practices and working with community services will ensure that the patient journey is coordinated with the right care in the most appropriate environment. Additionally, by better integrating services with local providers, there is the opportunity to manage demand at both hospitals more effectively
- **Right systems and processes:** There will be an increased level of standardisation, aligned to best practice and evidence, across the combined organisation. Standardisation of processes and protocols will provide continuity and best patient care across the wider population.

Integrating clinical IT systems will ensure efficient sharing of patient information, improving safety

1.6 Corporate model and organisation benefits

The corporate model will see the establishment of a single corporate function which will develop 'centres of excellence', an enhanced business partnering approach and a focus on technology-enabled self-service. In addition, there are further opportunities from economies of scale and alternative models of delivery.

- **One corporate service:** Services will be unified and integrated across the combined organisation. The elimination of duplicate roles and provision of a unified service will deliver workforce efficiencies, cost savings and increased consistency in delivery
- **Corporate centres of excellence:** The establishment of corporate centres of excellence will support the leadership of the combined organisation to establish strategic priorities and objectives. These centres of excellence will set priorities for business partners to deliver this vision working with clinical and support services
- **Business partnering:** Business partners will be responsible for providing professional support and advice to other teams. They will offer expertise and support development of solutions which are aligned with the combined organisation's strategy
- **Self-service:** Transactional services will be delivered through a self-service approach wherever practical. This will free up corporate staff to focus on the professional aspects of their work which add greater value, through the business partnering approach described above
- **Digital-enabled future:** The automation of high-volume low-value-added tasks will give staff greater capacity to focus on business partnering and more value-adding activities. The combined organisation will embed technologies such as tele-health, self-care tools, and remote clinical consultations. These approaches will provide both patients and staff with timely access to information by ensuring interoperability between systems and organisations
- **Unified process:** Alignment of processes across the combined organisation will reduce inefficiencies which arise from duplication of effort and inconsistent delivery of service
- **Joint procurement and supplier rationalisation:** Opportunities exist to rationalise suppliers. The combined organisation will benefit from a stronger negotiating position and greater opportunity to realise economies of scale. The benefits from this approach include cost savings and a more consistent delivery of service
- **Alternative models of delivery:** In carefully selected corporate sub-functions, outsourcing to a third-party provider or through an established or newly created public sector joint venture could realise efficiency benefits

1.7 Financial case

Key financial benefits of full clinical integration include:

- Gross financial savings are £22m before transitional costs and increased capital charges, including a reduction in agency spend of ca. £10m

- Capacity smoothing to enable the combined organisation to reduce outsourcing, providing a benefit of £1.9m per year by 2021/22 with only marginal additional non-pay costs incurred
- A corporate model recurrent annual revenue improvement of £6.5m by 2021/22 prior to the costs required to enable delivery of these schemes

1.8 Workforce case and staff benefits

Workforce benefits were identified based on the clinical and corporate cases and include greater access to education, training and development opportunities, improved career pathways, and increased organisational resilience.

Both Trusts bring elements of best practice to the Partnership. Therefore, the emphasis and approach to transition will be based on the principle of bringing two equal organisations together.

Enabling an effective transition and transformation to a combined organisation is essential. The operating structure and culture of the combined organisation are fundamental components of this. Developing the new culture will be based on understanding the motivations and ambitions of staff. Crucially future plans will include the design and implementation of interventions to achieve and embed the desired culture. These strategic interventions will form the basis of the organisational development plan.

1.9 Conclusion and recommendations

The OBC has concluded that full clinical integration is the preferred scenario for the Partnership between CHUFT and IHT; this includes the formation of a combined organisation with integration of corporate services and clinical teams. This scenario is recommended due to its higher level of patient benefits, and higher contributions to workforce and financial sustainability. The implementation of this scenario is more complex than for some clinical integration and therefore carries a greater degree of risk, which will be mitigated during the planning for implementation.

The patient, staff and system benefits have been identified by clinical and corporate services from both Trusts using a ‘bottom-up’, rather than a ‘top-down’, approach. As a result, there is confidence that the identified benefits are genuine and can be realised. However, this does mean that whilst the benefits included in this document are realistic at this stage, there is the potential that further benefits (some of which could be material) may be identified through the development of the FBC as further ‘bottom up’ analysis is carried out. Through the development of implementation plans, the balance between benefit and risk will be achieved, ensuring that benefits are realised by the greatest number of people. These benefits are only attainable as a single combined organisation.

1.9.1 Recommendations

The Boards of the two Trusts are recommended to:

1. Approve the preferred scenario of full clinical integration
2. Approve work on the next phase of the Partnership, including a full business case, implementation plan, and development of an operating structure and culture for the combined organisation
3. Adopt the eight corporate TOM strategic themes in planning a unified corporate service model for the combined organisation. These themes are:

- One corporate service
- Corporate centres of excellence
- Business partnering
- Self-service
- Digital-enabled future
- Unified process
- Joint procurement and supplier rationalisation
- Alternative models of delivery

4. Adopt the six clinical strategic themes in planning a unified clinical service model for the combined organisation. These themes are:
    - Right people, right skills
    - Great quality local services
    - 24/7 resilience
    - Best value for money
    - Right care in the right place
    - Right systems and processes

1.10 Next Steps

The next stage of the Partnership programme will follow agreement of the OBC by both Trust Boards, and will also require approval from NHSI. Following the OBC approval and decision to proceed to FBC the Trusts, with support from NHSI, will consider formal notification to the Competition and Markets Authority (CMA) which could initiate a formal review of the potential impact on competition. The legal form of the transaction to create the combined organisation will be agreed with regulators, principally NHSI and the necessary processes started.

During the FBC the model for the combined organisation will be developed into implementation plans. This will include:

- The organisational design, governance structures and processes
- Workforce and organisational development plans, including understanding each Trusts' current culture and defining the culture of the new combined organisation
- The clinical and corporate models
- The long-term financial model
- Equality impact assessment (and travel impact assessment)
- Quality impact assessment
- Due diligence

2 Introduction

Section synopsis

- **The outline business case (OBC) identifies a preferred scenario for the Partnership, evaluating the benefits for patients, staff and the wider health and care system, which will be taken forward to a full business case (FBC)**
- The SOC, approved by both Trust Boards in January 2017, shortlisted three scenarios, plus 'do nothing':
  - Merger with some clinical integration
  - Merger with full clinical integration
  - Acquisition [of one Trust by the other]
- The legal form of any transaction is **out of scope.** The OBC therefore seeks to identify the preferred future organisational (rather than legal) form of a combined organisation i.e. some or full clinical integration; and the model for corporate services

2.1 Business case framework and timeline

In May 2016, the Boards of both Colchester Hospital University NHS Foundation Trust (CHUFT) and The Ipswich Hospital NHS Trust (IHT) committed to entering into a long-term partnership ('the Partnership'). The Partnership is built on a foundation of collaborative working that has been established between the two Trusts over recent years. CHUFT concurrently appointed IHT's Chief Executive and Chair, who now lead both organisations with the agreement of NHSI.

A programme of work was set up to develop joint working between CHUFT and IHT. This programme is following the stages of the business case process as recommended by HM Treasury[1] and NHS Improvement guidance[2]. The stages of the programme are shown in the Table 2-1.

Table 2-1 The business case stages for the Partnership

Business case stage	Purpose	Timescale
Strategic Outline Programme (SOP)	• Determine strategic fit • Secure agreement and commit resources to develop the SOC	Completed October 2016
Strategic Outline Case (SOC)	• Develop and shortlist the scenarios • Recommend preferred scenario(s) • Secure agreement & commit resources for Outline and Full Business Case development	Completed January 2017
Outline Business Case (OBC)	• Identify the preferred scenario • Determine value for money (VFM), affordability, funding requirements • Planning for the FBC phase • External scrutiny/assurance as required	Due July 2017

[1] *Public Sector Business Cases: Using The Five Case Model*, HM Treasury (2015)
[2] *Supporting NHS providers: guidance on transactions for NHS Foundation Trusts*, Monitor [now NHS Improvement] (2015)

Business case stage	Purpose	Timescale
Full Business Case (FBC)	• Contractual arrangements • Assurance of Implementation Plan • Investment decision	Anticipated early 2018

The CHUFT and IHT Boards approved the Strategic Outline Programme (SOP) in October 2016. This described the work that would be undertaken in the subsequent SOC stage to identify a range of scenarios that could provide a viable future through a Partnership between the Trusts.

2.2 The strategic outline case

The purpose of the SOC was to develop and shortlist one or more scenarios for how the partnership between CHUFT and IHT could achieve its ambition and objectives. The scenarios described organisational forms or approaches which the partnership could take in order to realise the benefits of working together. In total 18 scenarios were identified, informed by a number of sources including the *Dalton Review*[3], models emerging from the Acute Care Collaboration vanguards[4], and examples from NHS Improvement.

The 18 scenarios are listed below; a summary of the outcome of the scenario evaluation can be found in Appendix A:

- Do nothing
- Clinical and strategic networks
- Joint venture (contractual)
- Service-level chain type 1 – outsourced
- Service level chain type 3 – policies and procedures
- Management contract – whole organisation
- Forming a foundation group
- Organisational merger, focus on back office plus some clinical integration
- Acquisition (full) [of one Trust by the other]
- Federation
- Buddying
- Corporate joint venture
- Service level chain type 2 – provision
- Management contract – single service
- Joining an existing foundation group
- Organisational merger, focus on back office
- Organisational merger, focus on back office plus full clinical integration
- Vertical integration

Three scenarios for the partnership were approved by the Boards to be explored further in this OBC, in addition to the 'do nothing' scenario. These scenarios are:

- Merger with some clinical integration
- Merger with full clinical integration
- Acquisition [of one Trust by the other]

[3] *Examining new options and opportunities for providers of NHS care: the Dalton Review*, Department of Health (2014)
[4] See www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/acute-care-collaboration/

These scenarios all imply corporate service integration but are differentiated by the level of clinical integration, defined as follows:

- Full clinical integration refers to the fullest level of integration, based on a series of assumptions such as having a single medical director, single governance and lines of accountability. Clinical specialties will be one team, but may be offered on one or both sites.
- Some clinical integration refers to a subset of this, where policies and procedures are shared and economies of scale realised, but the specialties remain individual.

Acquisition implies that there would be full clinical integration. A more detailed description of the scenarios under consideration is provided in Section 5.

The outline business case

2.2.1 Purpose

The purpose of the OBC is to describe:

- The background to the Partnership and the case for change
- The scenario evaluation process undertaken to identify a preferred scenario for the future of the Partnership
- The clinical, corporate, financial and workforce cases for the preferred scenario
- The benefits of the preferred scenario for the Partnership and the patients it serves
- The risks of each scenario
- The approach to engagement that has been taken to support development of the proposals

Subject to the approval of the OBC by the Trust Boards and the NHSI approval process, the next stage of the programme is the FBC; this will form the basis for the Boards' final decision on the future form of the Partnership.

2.2.2 Scope

At the end of the SOC it was envisaged that the OBC would evaluate the scenarios from two dimensions:

- The legal form of the transaction: whether CHUFT and IHT would become one organisation through a merger or acquisition
- The organisational form the combined organisation will take post transaction: the extent of clinical integration (some or full) and corporate integration

At the start of the OBC phase it was determined that there are a number of factors affecting the nature of the transaction that require significant legal and regulatory advice which will take a number of months to finalise. Although the form of the transaction is yet to be finalised, legal advice indicates that there are viable processes to create a combined organisation. The Trusts will hold further discussions with NHSI to agree a way forward for the legal form of the transaction. Therefore, for the purposes of this OBC the decision on the nature of the transaction is **out of scope**. Further information is provided in Section 5.

The OBC does not include detailed evaluation of service integration or the financial analysis of the implementation plan and its impact; this will be undertaken in the FBC phase. Assumptions have been made in the financial model regarding cost of change; these are not materially different in the two clinical integration scenarios.

2.2.3 Structure

The OBC is organised into the following Sections shown in Table 2-2.

Table 2-2 Sections within the OBC

Section	Contents
0. Background and case for change	• An overview of the two Trusts, a catchment population analysis and the local and national commissioners • The background and aims of the Partnership, and a summary of achievement to date • Summary of the national context, including the increasing expectations of quality and performance, the ongoing financial challenge and the expectations of the combined organisation form • Overview of the local context, including an overview of the local population, the significant care and quality issues and increasing demand, workforce challenges being faced, and commentary on the financial sustainability of both Trusts
4. Vision for the partnership	• The vision for the Partnership
5. Scenario evaluation	• Description of the scenarios being evaluated • Overview of the form of the evaluation • Qualitative and financial evaluation process and outputs • Identification of the preferred scenario
5. Clinical case and patient benefits	• The clinical strategy that has been developed for the preferred scenario • The expected benefits to patients and others related to the preferred scenario
7. Corporate model and organisation benefits	• The proposed corporate service model for the Partnership • The expected benefits and costs of the corporate service model
8. Financial case	• The financial case for the preferred scenario
8. Workforce case and staff benefits	• The workforce case and associated benefits case for the preferred scenario
10. Programme governance, timelines and risks	• The programme governance and risks for the Partnership • The timeline for FBC • The Implementation plan
11. Communications and engagement	• The communications and engagement carried out for the Partnership
12. Conclusions and recommendations	• Summary of the main findings from the OBC

2.3 The full business case

Subject to the approval of the OBC, an FBC will be produced according to timelines agreed by both Boards and the Trusts' regulators. The FBC will be the document upon which the final decision by the Boards will be made, subject to appropriate regulatory approvals.

The FBC will include the main conclusions contained in the body of the OBC but with a more detailed review of both organisations, the case for change and the opportunities and risks associated with any future transaction. In particular, the FBC will contain more detail on the preferred scenario, its benefits, and its financial impact. An implementation plan (IP) will be produced alongside the FBC that sets out the key deliverables for safe services on day one of the combined organisation, and the detailed plans and milestones for long-term integration of services. Significant areas of work are outlined in Table 2-3.

Table 2-3 Additional work during the FBC phase

Area	Contents
Clinical service areas (delivery and implementation plans to achieve patient benefits)	• The OBC outlines the draft clinical strategy based on work with six clinical specialties. The FBC will further develop this strategy and also set out how and in what timeframe the clinical collaboration and service sustainability/improvements can be achieved for the benefit of patients and staff • The implementation plan will set out the key clinical milestones and the detailed operational integration plans to transition to the combined organisation (see below)
Corporate service areas (delivery and implementation plans to achieve benefits)	• The OBC sets out the corporate target operating model based on work with four corporate areas (see Section 7). The FBC will further develop and extend this strategy to all corporate services. It will also set out how and in what timeframe the corporate transformation can be achieved to deliver the expected benefits • The implementation plan will set out the key corporate milestones and the detailed operational integration plans to transition to the combined organisation (see below)
Stakeholder engagement	• During development of the FBC there will continue to be engagement on the case for change and the preferred scenario. Public, staff and stakeholder views will be gathered in face to face meetings and other forums, to ensure the best possible understanding of what concerns need to be addressed and where the opportunities lie. Information gathered will be used to shape the FBC
Financial analysis	• Detailed financial analysis and modelling of the preferred scenario, including downside mitigations
Competition and Markets Authority (CMA)	• If any action is required this will be included in the FBC
Assurance	• Each Trust will carry out a Due Diligence exercise across a number of areas (e.g. clinical, financial, HR) • The Trusts will engage the services of a Reporting Accountant, based on a scope that will be agreed with NHSI

Area	Contents
Quality Impact Assessment (QIA) & Equality Impact Assessment (EIA)*	• A travel impact assessment will be undertaken as part of the development of the FBC • As the clinical strategy for the preferred scenario is developed, the impact of any proposed changes will be tested with the reference and advisory groups
Organisational Development	• During the FBC phase further work will be undertaken to determine the nature of culture and organisational development activities required to support the smooth transition to a combined organisation
Implementation Plan	• A detailed implementation plan will be developed that sets out the key milestones for the delivery of safe services for day one of the combined organisation, and the medium and long-term plans for each clinical and corporate area. During the FBC phase the timing and extent of transformation & integration of services will also be considered and incorporated into the implementation plan as required

* The EIA is normally used where major service change is proposed. Although this is not the case for the Partnership, the Trusts believe that undertaking the EIA will provide a valuable opportunity to both understand the impact of the Partnership on seldom-heard parts of the local population, and to engage with patients and the public

3 Background and case for change

Section synopsis

- **There are a range of factors that mean iterative changes and individual organisational responses will no longer be sufficient to maintain two separate organisations**
- CHUFT and IHT are two providers of acute healthcare (and community healthcare for IHT) services in the Suffolk and North East Essex Sustainability and Transformation Partnership (STP). They deliver a range of general hospital services and some specialist services to a local population of approximately 770,000. The health and social care context within which both Trusts operate is changing
- The NHS Five Year Forward View identified three emerging gaps in health and care nationally, which providers and commissioners of care must work to close. These are the:
    - Health and wellbeing gap
    - Care and quality gap
    - Finance and efficiency gap
- For Suffolk and North East Essex there are challenges in each of these categories, which are reflected in issues that have been identified locally for both Trusts. In its response to these challenges, the Suffolk and North East Essex STP has identified three priorities for creating a sustainable regional healthcare system:
    - Resilient communities
    - Managing demand
    - Acute reconfiguration
- There are a range of factors that mean iterative changes and individual responses will no longer be sufficient, and provide a rationale for Partnership:
    - A step change in the rate of transformation is required
    - It is becoming increasingly difficult to recruit and retain staff
    - Some services are not sustainable against national guidance
    - Both CHUFT and IHT are financially unsustainable in their current form
- For the acute reconfiguration priority, the objective of the STP is to create viable acute hospitals across the STP through the redesign of clinical services to deliver improved outcomes, underpinned by innovation. The local response to this is the Partnership between CHUFT and IHT
- CHUFT is subject to regulatory action by NHSI and the CQC. The latter rated it 'inadequate', and the Trust is currently in 'special measures'. The Partnership with IHT was part of the measures agreed with NHSI to address this. CQC inspection of both Trusts is due in summer 2017

3.1 Introduction

This section sets out the strategic context within which plans for the Partnership are being developed, and the rationale for the plans. It considers the challenges facing the wider NHS system in the context of a regional health economy. These challenges form the case for change.

3.2 Background

3.2.1 National drivers of change

The challenges facing the NHS as a whole including increasing need for services from an ageing population and a challenging financial context, are well documented[5]. In common with other parts of the health and care system, acute providers are facing increasing demand for services within Emergency Departments, elective care, and specialist and tertiary provision. Although government spending on health has been protected compared with other areas, there are still financial pressures on the sector as a whole. There is an expectation that providers will also identify efficiencies and productivity gains to enable them to meet demand whilst improving quality. This section describes the overall national context within which the NHS is operating.

Increasing expectations of quality and performance

The NHS *Five Year Forward View*[6] identified three gaps which must be closed:

- Health and wellbeing gap
- Care and quality gap
- Funding and efficiency gap

New models of service delivery and organisational integration are expected to be developed to meet these. This was reaffirmed in the recently published *Next Steps on the NHS Five Year Forward View*[7]. This explained that, whilst some progress had been made in addressing the gaps, there was further work to be done.

In particular the learning from the new models of care, as evidenced by the *RightCare*[8] initiative and *Get it Right First Time*[9] (GIRFT), should inform future service responses to the challenges being faced nationally. *RightCare* in particular has suggested that there should be reduced variation in the services across CCGs, with reviews published outlining areas of opportunity in both the quality of clinical outcomes and the cost of these treatments that can be implemented through the standardisation of processes with other, similar organisations. The responsibility for implementing these recommendations is with the CCGs and NHS Trusts based within the commissioner's geography.

[5] *NHS Five Year Forward View*, NHS England (2014); *Next Steps on the NHS Five Year Forward View*, NHS England (2017)
[6] *NHS Five Year Forward View*, NHS England (2014)
[7] *Next Steps on the NHS Five Year Forward View*, NHS England (2017)
[8] See: https://www.england.nhs.uk/rightcare/
[9] The wider Getting it Right First Time programme is based on: *A national review of adult elective orthopaedic services in England: Getting it right first time*, Briggs, T. (2015)

Ongoing financial challenge

The NHS planning guidance[10] for 2017-2019 makes sustainability and transformation funding (STF) available to acute trusts which meet strict financial control totals. This required providers to make a step change improvement in their financial plans for 2016/17 in order to obtain a portion of the sustainability fund. Funding will be increasingly targeted at "the STPs making most progress"[11]. At the same time, providers must continue to deliver 2% cost efficiency annually[12].

Although significant progress was made between 2015/16 and 2016/17, the last year for which full accounts are available, providers reported a combined deficit of £791m across England[13]. Providers are being asked, in 2018/19, to identify considerable efficiencies in order to return the system as a whole to financial balance.

Expectations of collaboration and transformation

The Sustainability and Transformation Plans[14] introduced in 2016/17 offer a wider area for collaboration and increase the potential for partnerships between acute hospitals. The *Dalton Review*[15] considered the options for provider sustainability and identified seven possible organisational forms for acute trusts. The *Carter Review*[16] identified efficiencies available from collaboration between NHS organisations (and other public services) with an expectation that trusts will significantly reduce their overheads.

3.2.2 Local drivers for change – the Suffolk & North East Essex STP

CHUFT and IHT both sit within the Suffolk and North East Essex STP. Across the STP the population faces a number of challenges.

The key demographic challenge in the STP is the expected increase in population[17,18] of 3.2% between 2016 and 2021; over the same timescale a 17.9% increase in population aged over 75 years is expected[19]. Healthy life expectancy (the number of years lived in good health) remains lower than overall life expectancy and is falling in some population groups. 11.5% of the population within the STP live in some of the most deprived areas of England (lowest 20%)[20]. This higher level of deprivation is correlated with a greater demand on health and care services. It also means that services need to be designed in such a way that they are easily accessible and relevant to the populations needs.

Additionally, health outcomes are inequitable across the STP. Mortality rates from causes considered preventable are variable across the geography. People within Suffolk and North East Essex are living

[10] *NHS operational planning guidance 2017/18-2019/20*, NHS England (2016)
[11] Ibid.
[12] Ibid.
[13] *Performance of the NHS Provider Sector year ended 31 March 2017*, NHS Improvement (2017)
[14] *Planning, assuring and delivering Service Change for Patients*, NHS England (2015)
[15] *Examining new options and opportunities for providers of NHS care*, Dalton Review (2014)
[16] *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, Carter Review (2015)
[17] *Suffolk and North East Essex Footprint 23 Midlands and East Region Sustainability and Transformation Plan* 30th June checkpoint submission (2016)
[18] There are significant plans for housing growth in Suffolk and North East Essex. Advice from public health colleagues is that ONS estimates are reasonable at this stage
[19] *Suffolk and North East Essex Footprint 23 Midlands and East Region Sustainability and Transformation Plan* 30th June checkpoint submission (2016)
[20] *Index of Multiple Deprivation*, Office for National Statistics (2016)

with a significant number of years in ill health or with a disability potentially increasing demand on health and care services. Locally this will mean that by 2018, approximately 45,000 people in the area will have three or more long-term conditions.

The NHS and local government within the STP have come together to develop a five year plan (the STP plan). This is a unified plan to improve the health and care of local people and bring the system back into a financially sustainable position. The system has agreed a plan that will deliver the vision for people across Suffolk and North East Essex to live healthier, happier lives by having greater choice, control and responsibility for their health and wellbeing. The plan will deliver against three priorities for creating a sustainable healthcare system in Suffolk and North East Essex:

- Resilient communities
- Managing demand
- Acute reconfiguration

The STP has senior collective leadership and a well-structured programme of work to address:

- The increase in the demand for services
- The workforce challenges
- Reduction of inequalities in health outcomes
- The key clinical priorities
- Reducing unwarranted variation in processes and quality of care

The overall structure of this response is shown in Figure 3.1.

Figure 3.1 Diagram showing the summary of the Suffolk and North East Essex STP

For the acute reconfiguration priority, the STP's objective is to achieve viable acute hospitals across the STP through the redesign of clinical pathways around outcomes, underpinned by innovation. For CHUFT and IHT, this ambition is being met through the Partnership between the two Trusts.

3.2.3 CHUFT and IHT

Overview of CHUFT and IHT

CHUFT and IHT are two providers of acute healthcare services in the Suffolk and North East Essex STP. They provide a range of secondary services including emergency departments, maternity services, children's services, general medicine, and general surgery. In addition, IHT also provides some community services in partnership with other local providers. Both Trusts offer some specialist services, for example spinal surgery at IHT and vascular surgery at CHUFT. However, in line with national policy, some specialist services have previously been centralised and are commissioned from other providers.

Although both Trusts serve a similarly sized catchment population, there is diversity in the demographic profiles of these populations. The catchment area includes large towns (Colchester and Ipswich), significant rural populations, traditional coastal resorts, port facilities, universities and armed forces.

Organisational profiles

Table 3-1 contains an overview of the two organisations. The organisational profiles show that the two Trusts are in many respects similar, in particular the population served, number of beds and number of employees. The main differences are the provision of some community services by IHT which are not provided by CHUFT, the CQC ratings of the two organisations, and the NHSI single oversight framework rating.

Table 3-1 Overview of both Trusts

	CHUFT	IHT
Profile	District General Hospital (DGH)	DGH and community services provider
Beds (General and Acute)	560	541
Turnover (2017/18)	£291.2m	£292.8m
Catchment population	380,000	390,000
Employees	4,200	3,800
Specialist areas	Vascular surgery Radiotherapy	Spinal surgery Radiotherapy Gynae-oncology
Latest CQC rating	Inadequate (July 2016)	Good (April 2015)
NHSI Single Oversight Framework: shadow segmentation[21]	"4 - Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures"	"2 - Providers offered targeted support: there are concerns in relation to one or more of the themes. We've [sic – NHSI] identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up"
Vision	Delivering great healthcare to every patient, every day	To be an outstanding provider of health services for the population

[21] NHS Improvement has segmented trusts (in shadow form) based on the level of support they believe is required. Segmentation is based on performance data and other information gathered before the SOF came into place on 1 October 2016. Score from 1 (lowest) to five (highest)

Services offered by each Trust

Table 3-2 provides an overview of the major services offered by each of the Trusts. This table shows that there is good alignment between the two Trusts in terms of services provided. There are some examples of services which operate as clinical networks between the Trusts already. For example, vascular surgery where major operations are carried out only at CHUFT but outpatient and more minor surgery are conducted at both Trusts. Pathology services are provided to both Trusts (and West Suffolk NHS Foundation Trust) through a partnership arrangement (North East Essex and Suffolk Pathology Services) which is managed by CHUFT; provision of laboratory services is partially centralised at IHT.

Areas of divergence include those where the provision of services is overwhelmingly in a community setting; in these cases IHT often continues to provide the service whereas there is an alternative provider for CHUFT[22].

Table 3-2 Services provided by CHUFT and IHT

Service	CHUFT	IHT
General Surgery	✓	✓
Vascular Surgery	✓	✓
Breast Surgery	✓	✓
Urology	✓	✓
Trauma & Orthopaedic Surgery	✓	✓
ENT	✓	✓
Ophthalmology	✓	✓
Oral/Dental Services	Partial (not Orthodontics)	✓
Emergency Medicine	✓	✓
Gastroenterology	✓	✓
Endocrinology/Diabetes	✓	✓
Respiratory Medicine	✓	✓
Cardiology	✓	✓
Endoscopy	✓	✓
Care of the Elderly	✓	✓
Stroke	✓	✓
Rheumatology	✓	✓
Neurology	✓	Partial (not neurorehabilitation)
Renal Medicine	✓	✓
Dermatology	×	✓
Palliative Medicine	✓	✓
Oncology	✓	✓
Clinical Haematology	✓	✓
Sexual Health	✓	×
Women's Health	✓	✓
Children's Services	✓	✓

[22] Anglian Community Enterprise (ACE) Community Interest Company provide community services to North East Essex

Service	CHUFT	IHT
Anaesthetic Services	Partial (not Chronic pain)	✓
Imaging	✓	✓
Allied Health Professions	✓	✓ (not Psychology)

Catchment populations

CHUFT and IHT currently serve diverse populations within their respective catchment areas. There are a number of similarities within this diversity, though. For example both populations are growing at a fast rate[23]. In particular the population aged over 70 years is expected to grow at a rate exceeding 25% over a five year period for some local districts[24].

Analysis of the population data suggests that the urban populations of both Colchester and Ipswich are in line with the national and regional average with respect to age structure[25]. However, there is a greater number of 25-34 year olds in both than the national and regional averages[26]. This is the group typically considered to be of childbearing age.

For other areas, including Suffolk Coastal, Mid Suffolk and Tendring there is a significant population aged 65 years and older[27]. The portion of the population in this age group in these areas exceeds both the national and local averages.

Quality

The Trusts have different CQC ratings. As overall scores, CHUFT is rated as 'inadequate' and is currently in 'special measures'. IHT has been rated 'good'. CHUFT hosted a full CQC inspection 25-27 July 2017 and IHT are due to be inspected during summer 2017.

National performance standards

All Trusts are expected to meet national performance standards, which show the overall performance of the system against key metrics. Table 3-3 shows the performance of both CHUFT and IHT in Q4 2016/17 against the national performance. This shows that CHUFT is meeting one of the five standards, whilst IHT is meeting three.

Table 3-3 CHUFT, IHT and national performance against performance metrics

Standard	Period	National standard	Performance					
			CHUFT		IHT		National	
Cancer: 2 week wait	Q4 2016/17	93%	95.5%		96.3%		94.7%	
Cancer: 31 day first treatment	Q4 2016/17	96%	93.7%		96.6%		97.5%	
Cancer: 62 day standard	Q4 2016/17	85%	69.5%		83.6%		81.1%	
Emergency: 4 hour standard	Q4 2016/17	95%	91.2%		89.2%		87.6%	
Elective: Incomplete RTT	March 2017	92%	86.9%		93.1%		90.3%	

[23] Derived from: *ONS 2016 Mid-year estimates*, Office for National Statistics (2017) and *ONS 2014 based sub-national population Projections*, Office for National Statistics (2016)
[24] Ibid.
[25] Ibid.
[26] Ibid.
[27] Ibid.

Financial performance

In common with the challenging financial context across the NHS, both Trusts were in a deficit position in 2016/17, as they were for the previous two years. The deficits were reduced in 2016/17 compared with 2015/16, in part due to the receipt of sustainability and transformation funding (STF). Cost improvement programme (CIP) performance does vary between the Trusts; in 2016/17 CHUFT achieved 54% of planned savings whilst IHT achieved 97% of planned savings. Further detail on the historical performance of both Trusts is provided in Section 8.2.

3.2.4 Local and national commissioners

There are two main local commissioners of health services for CHUFT and IHT: NHS North East Essex Clinical Commissioning Group (NEECCG), and Ipswich and East Suffolk Clinical Commissioning Group (IESCCG). These two Clinical Commissioning Groups (CCGs) contract with the respective acute trust; these contracts include the requirements of other NHS commissioners such as neighbouring CCGs. This local commissioning is in addition to the regional commissioning of specialised services that is carried out by NHS England Specialised Commissioning and by local government including public health commissioning (e.g. sexual health services).

3.3 Case for change

3.3.1 Background to the Partnership

Following an inspection by the CQC in September 2015[28], CHUFT was rated 'inadequate', the lowest rating that is awarded. Following a further inspection in early 2016 the Chief Inspector of Hospitals mandated that CHUFT find an "immediate alternative solution" to Trust Special Administration[29]. As a result, NHSI required that CHUFT enter into a long-term partnership arrangement with another Trust and approached IHT to undertake this role.

In May 2016 the Boards of both IHT and CHUFT committed to entering into a long-term partnership (the Partnership). The Partnership is built on a foundation of collaborative working that has been established between the two Trusts over recent years. CHUFT concurrently appointed IHT's Chief Executive and Chair, who now lead both organisations with the agreement of NHSI.

The Partnership is a key part of the STP plan, which sets the strategic direction for health and care services in the North East Essex and Suffolk area. The STP plan contains an ambition not only for closer working between the Trusts, but also for reconfiguration of acute services.

3.3.2 Drivers for Partnership

There are a number of drivers for the Partnership, these include:

- A step change in transformation is required
- It is increasingly difficult to recruit and retain staff
- Some services are not sustainable against national guidance and new models of care
- CHUFT and IHT are financially unsustainable in their current form

[28] *Colchester General Hospital Quality Report*, Care Quality Commission (2016)
[29] *Colchester Hospital University NHS Foundation Trust Quality Report*, Care Quality Commission (2016)

A step change in transformation is required

The STP has put in place an ambitious programme of work that requires community resilience, demand management and acute reconfiguration. In relation to acute reconfiguration the aim is to create viable acute hospitals that have fully integrated patient pathways across the STP, achieved through the redesign of clinically-led patient pathways to improve outcomes; underpinned by innovation. Both Trusts are undertaking ambitious programmes to meet the identified challenges, but these alone will not ensure sustainability in the future.

The CHUFT 'do nothing' forecast shows that radical change is needed to achieve sustainability. CHUFT has also had well-documented safety challenges[30]. CHUFT priorities are therefore to implement improvements to safety and performance and to make financial improvements which will be underpinned by the Partnership with IHT. To address its sustainability challenges, CHUFT is undertaking a major transformation programme (Every Patient, Every Day).

Where costs and expenditure are concerned, IHT benchmarks well; however like many other trusts, it has struggled to achieve financial sustainability for a number of years and faces increasing deficits due to rising demand and increasing staffing costs. IHT has developed a strategy that agrees with the STP that radical change is needed, and is aligned with the overall plan. High-level goals show that the Trust wants to improve patient safety, productivity and staff experience to amongst the best in the country.

Strategic plans are being developed but clearly involve getting maximum benefits from the partnership between CHUFT and IHT, whilst also pursuing redesigned pathways in a community alliance within the Ipswich and East Suffolk area. IHT is also exploring the opportunities from the *Carter Review*[31] and from redesigning the interactions with the rest of the health system, for example creating a single point of access to services.

These programmes will not, by themselves, deliver the clinical, operational, and financial sustainability IHT needs.

It is becoming increasingly difficult to recruit and retain staff

The NHS planning guidance for 2017-18 has reconfirmed the commitment towards seven-day working[32]. To provide this in the current configuration of acute services as a seven-day model would require a 14% increase in the workforce across both Trusts[33].

Across both CHUFT and IHT several clinical and clinical support specialties are already experiencing long-term recruitment challenges. This affects medical, nursing and allied health-professional staff in a number of specialties (including acute medicine, emergency medicine, gastroenterology, endoscopy, respiratory medicine, and care of the elderly). The current levels of vacant posts are shown in Table 3-4.

[30] For example: *Colchester Hospital University NHS Foundation Trust Quality Report*, Care Quality Commission (2016)
[31] *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, Lord Carter of Coles (2016)
[32] *NHS operational planning guidance 2017/18-2019/20*, NHS England (2016)
[33] *Suffolk and North East Essex Sustainability and Transformation Plan* (2016)

Table 3-4 Current vacant posts at CHUFT and IHT by category (at 30th June 2017)

Area	CHUFT		IHT	
	WTE	% of posts vacant	WTE	% of posts vacant
Vacant posts				
Consultant vacancies	28	12.7%	8	2.6%
Junior doctor vacancies	44.2	14.0%	14	6.7%
Registered nurses/midwives	263.5	19.1%	158.3	12.0%
Non-registered nursing	64	11.0%	4.5	1.0%
AHP vacancies	30.3	9.5%	27	9.0%
Overall vacancies	667	14.0%	271	6.8%
Temporary Staffing				
Long-term locum consultants	NHS: 11 Agency: 7		NHS: 7 Agency: 3	
Agency use (Registered nurses/m'wives)	6.2%		4.2%	
Agency use (Non-registered nurses)	1.6%		0.1%	
Annual turnover of posts				
Overall turnover rate	13.9%		9.3%	

These vacant posts exist despite significant efforts from both trusts to fill these posts, including:

- Quarterly overseas recruitment drives to multiple countries
- Ongoing advertising efforts through NHS Jobs and similar relevant forums
- Job reviews and internal training and promotion schemes

The inability to fill vacant posts reflects the position of many providers nationally. Additional local factors include the proximity to London and regulatory action at CHUFT. These pressures are not unique to the acute sector; recruitment and retention challenges are also being faced in the community and general practice sectors. In addition, estimates from Health Education England (HEE) and local workforce partnerships indicate that many of these staffing shortages are likely to worsen over the next five years, and that other specialties will also experience shortages of supply.

The workforce will be unsustainable and care to patients under threat unless the model of service delivery is changed.

Some services are not sustainable against national guidance and new models of care

Some services at both CHUFT and IHT manage smaller cohorts of patients due to the specialised nature of their practice. In some cases, these services are not meeting, or are likely to not meet in the future, minimum national guidance; for example, cases seen per year or number of staff in post. Change in provision of these services is therefore required to adapt to the challenges as they arise. Some specific examples of services likely to be affected by change in the future are:

- The National Radiotherapy Review – radiotherapy commissioning arrangements under review
- Hyper Acute Stroke Units – national advice is to increase the scale of these services to cover larger populations
- Services facing fragility due to low overall staffing numbers, such as:
    - Spinal surgery (CHUFT)

- Gynaecological cancers (CHUFT)
- Foot and ankle surgery (both Trusts)
- Rare tumour site oncology (both Trusts)

Other services are subject to accreditation or reaccreditation, often to more stringent standards. An example of this is in endoscopy. CHUFT does not currently have a unit accredited by the Joint Advisory Group on GI Endoscopy (JAG). IHT does have JAG accreditation, but there is a possibility that this may not be maintained in the future as the physical unit no longer meets the latest specification.

There are further areas where the physical capacity to offer the service is currently, or will become, limited. As part of the development of the STP, the overall bed requirement in the area was modelled and forecast over a five year period. This showed that without changing the model of care there would be a requirement for an additional 56 beds at CHUFT and an additional 53 beds at IHT[34]. Meeting increased demand solely through additional beds requires additional physical capacity and workforce, and will add further pressure to an already strained local healthcare system. Alternative models of care offer a better long-term solution to meeting increased demand.

CHUFT and IHT are financially unsustainable in their current form

The forecast combined deficit for CHUFT and IHT is £39.9m, which increases to £44.5m by 2021/22. This forecast includes various cost mitigation and efficiency assumptions, in line with those set out within the STP plan. Both Trusts are in receipt of STF to support their financial positions, and despite this are not projecting a return to a break-even position within the next five years.

More detailed information on the historic and forecast positions of the Trusts in future years can be found in Sections 8.2.

3.3.3 Support for closer collaboration

Commissioner support

NEECCG and IESCCG have committed, via the STP, to promote 'more effective collaboration' through the hospital configuration and transformation vision. Collaboration between the two CCGs is also encouraged by the NHS England's *Model Collaborative Commissioning Agreement*[35].

Both the NEECCG and IESCCG are represented on the Partnerships programme's commissioner reference group (see Section 11 for more information). They have been invited to evaluate the scenarios presented in the scenario evaluation (see Section 5 for more information). In addition they have been represented at clinical specialty workshops to provide commissioner input into the emergent clinical strategy.

A formal confirmation of support by both CCGs will be needed for the preferred scenario in the process of ratifying this OBC, following the approval of the individual Trust Boards.

[34] Beds modelling for the Suffolk and North East Essex STP
[35] *Model Collaborative Commissioning Agreement - Multiple Contract option*, NHS England (February 2014 Updated June 2016)

Regulator support

NHSI on a national and regional level has been kept aware of all the relevant plans through a series of meetings relating to the Partnership. NHSI are due to review the plans and progress of the OBC after approval by the Trust Boards.

NHS England (NHSE) has also been engaged throughout the development of the business case for the Partnership. NHSE has a particular interest where a major service change is proposed. If this is the case then a formal service change review process will be followed[36].

Trust support

Both CHUFT and IHT Trust Boards have committed to working collaboratively which includes improving and reconfiguring clinical services by assessing challenges or issues that may arise through joint working. Both Boards have separately approved the SOP and SOC, the preceding business cases stages. They have had oversight, from the perspective of CHUFT and IHT, of the process of developing the Partnerships plans.

Local government support

The Partnership is a core part of the response to the STP, which is overseen by the STP Board that includes local government representation.

Development of the Partnership is scrutinised by the Health Overview and Scrutiny Committees (HOSC) in Essex and Suffolk. In addition, because the STP and the Partnership cross county boundaries, a Joint Health Overview and Scrutiny Committee (JHOSC) has been formed to scrutinise the planning. The JHOSC scrutinise the plans and make recommendations to ensure that these are in the best interests of the populations served by CHUFT and IHT.

District and Borough councils are also involved in the programme through a stakeholder reference group. Further details on this engagement, and public involvement to date, can be found in Section 11.

[36] *Planning, delivering and assuring service change for patients*, NHS England (2015)

4 Vision for the Partnership

Section synopsis

- The ambition for the Partnership is: **By working together CHUFT and IHT will secure sustainable and high quality healthcare for Ipswich, East Suffolk and North East Essex**
- Four objectives for the Partnership have been developed that address the key challenges identified in the case for change; these are (with associated case for change challenge):
  - Improved quality and patient outcomes (a step change in transformation is required)
  - Better value for money (CHUFT and IHT are financially unsustainable in their current form)
  - Sustained and improved access to services that meet the needs of the population (some services are not sustainable against national guidance and new models of care)
  - A sustainable, skilled workforce (it is becoming increasingly difficult to recruit and retain staff)
- A set of design principles have been developed to enable the Partnership to deliver the objectives whilst operating within the constraints of the current system. These contain three 'fixed points':
  - Emergency department services on both acute hospital sites
  - Obstetric-led maternity services on both sites
  - 24/7 acute medical take at both sites

4.1 The Partnership aims and objectives

The ambition and objectives of the Partnership were initially developed for the SOC. These were reviewed and approved by the clinical reference group (CRG), the commissioning reference group (CoRG), and the Boards of both Trusts.

During the development of the OBC the ambition and objectives were reviewed, alongside the design principles that have been derived from them. This review confirmed that the ambition, objectives and design principles are still reflective of the Partnership.

4.1.1 Ambition

The ambition of the Partnership is as follows:

By working together CHUFT and IHT will secure sustainable and high quality healthcare for Ipswich, East Suffolk and North East Essex

4.1.2 Objectives

Four objectives for the Partnership were identified:

- Improved quality and patient outcomes
- Better value for money
- Sustained and improved access to services that meet the needs of the population
- A sustainable, skilled workforce

The four objectives articulate the aims that the Boards of CHUFT and IHT and other stakeholders have for the Partnership. These are also designed to respond to the challenges identified in the case for change (see Section 3.3), as shown in Table 4-1.

Table 4-1 Link between the case for change and Partnership objectives

Case for change area	Related objective	How this responds
A step change in transformation is required	Improved quality and patient outcomes	Working in partnership to deliver the transformational change required to ensure long term quality improvement
It is becoming increasingly difficult to recruit and retain staff	A sustainable, skilled workforce	Working together to improve staff recruitment and retention and offer greater staff development opportunities
Some services are not sustainable against national guidance and new models of care	Sustained and improved access to services that meet the needs of the population	Ensuring that the needs of the local population are met and that access is sustained or improved through the maintenance and development of service
CHUFT and IHT are financially unsustainable in their current form	Better value for money	Working together to achieve efficiencies, plan for the future and work towards long-term financial sustainability

4.2 Design principles for the Partnership

Design principles were developed to ensure that the combined organisation for the Partnership would meet the ambition and objectives described above. The design principles also reflect the constraints within which the combined organisation will function.

4.2.1 Constraints

The constraints identified align to the wider system challenges described in Section 0, and are summarised in Table 4-2.

Table 4-2 Constraints

Constraint	Description
Constrained funding	Significant additional NHS funding for acute care is unlikely within the current planning period; at the same time there will continue to be a requirement to deliver cost improvement efficiencies
Rising demand	There is an increasing demand for services driven by changing demographics and development of clinical technologies
Quality variations	There are unwarranted variations between the CHUFT and IHT in quality of care, clinical outcomes and user experience

4.2.2 Design principles

Design principles have been developed, including a number of fixed points. Fixed points describe high-level elements of the model that have been agreed in advance; the detailed design should support these and should not conflict with them.

Fixed Points

- Emergency Department services on both acute hospital sites
- Obstetric-led maternity services on both sites
- 24/7 acute medical take at both sites

The fixed points are supplemented by broader principles intended to guide the design of different parts of the model and ensure coherence.

Broader Principles

The Partnership will:

- Provide hospital-based services appropriate to the needs of the local population
- Develop specialist services where improvements for patients from improved access and/or outcomes can be demonstrated
- Make best use of resources within a service and ensure co-dependent services work well together
- Enhance teaching and training to develop future clinical workforce
- Move at a pace that minimises disruption to services whilst maximising the delivery of benefits

These design principles were defined to support the development of the overall organisational form, as well as the clinical model. Proposed models can be tested against the design principles to establish their suitability for the Partnership and the extent to which they are likely to deliver the ambition and objectives.

5 Scenario evaluation

Section synopsis

- **Full clinical integration was identified as the preferred scenario following a qualitative and financial evaluation**
- The shortlist of three scenarios, plus 'do nothing', is derived from the SOC evaluation:
  - Merger with some clinical integration
  - Merger with full clinical integration
  - Acquisition [of one Trust by the other]
- These scenarios can be distinguished by two elements: the **legal form** of the transaction (merger or acquisition) and the **organisational form** (based on the clinical and corporate models). The acquisition scenario differs from merger with full clinical integration only with respect to the transaction process used to create a combined organisation
- The legal form of a transaction to create a combined organisation requires further input from regulators and legal advice; this will be completed during the FBC phase; regardless of the form of the transaction, the result will be a single organisation with one underlying clinical and corporate model
- **The scenario evaluation therefore considered only organisational form**, evaluating the clinical and corporate service models underpinning the scenarios
- Focusing on the organisational form, the scenarios were expressed in terms of their clinical and corporate models:
  - *Do nothing*: No change to corporate and clinical service models
  - *Some Clinical Integration*: Implementation of the proposed corporate target operating model (TOM) and some clinical integration
  - *Full Clinical Integration*: Implementation of the proposed corporate TOM and full clinical integration
- The main difference between 'some' and 'full' clinical integration is the extent to which clinically-identified opportunities enabled by Partnership can be implemented. Evaluators assessed the extent to which this meant that the scenario could meet the objectives of the Partnership
- Evaluation criteria were developed that are linked to objectives of the Partnership. These in turn respond to areas of challenge identified in the case for change. The scenarios were assessed by a wide range of stakeholders using the following four evaluation criteria: quality, access, workforce sustainability and deliverability; a separate assessment for financial sustainability was also completed
- The outputs from the qualitative and financial evaluation were combined to create an overall evaluation score for each of the three scenarios, which identified the preferred scenario as **full clinical integration**

5.1 Approach

The OBC scenario evaluation follows on from the evaluation conducted in the SOC phase, in which a longlist of 18 possible scenarios for the Partnership was assessed and reduced to a shortlist. This shortlist is made up of three scenarios, plus 'do nothing':

- Merger with some clinical integration
- Merger with full clinical integration
- Acquisition [of one Trust by the other]

These scenarios can be distinguished by two elements: the legal form of the transaction (merger or acquisition) and the underlying organisational form (based on the clinical and corporate models) (see Section 5.1.4 for further details on scenario definitions). Consequently, the evaluation was separated into two parts to assess the scenarios based on:

- The legal form of the transaction: agreeing the legal form of the transaction, based on legal advice and engagement with NHSI
- The organisational form: evaluating the clinical and corporate service models underpinning the scenarios

5.1.1 Legal form of the transaction treatment

The evaluation of the legal form of the transaction requires a technical assessment with input from regulators and further legal advice. Although the form of the transaction is yet to be finalised, legal advice indicates that there is are viable processes to create a combined organisation. The Trusts will hold further discussions with NHSI to agree a way forward for the form of the transaction. This part of the evaluation process has therefore not been completed in the OBC phase. During the FBC phase a more detailed legal assessment of the transaction forms will take place. As a result, the OBC focuses on evaluation of the organisational form, including corporate and clinical models.

Two of the scenarios (merger with full clinical integration and acquisition) differ *only* in the legal form of the transaction required to form a single organisation (i.e. merger or acquisition). The underlying organisational form (the combination of corporate and clinical models) is the same for both of these scenarios. Given the decision to consider the legal assessment of the transaction forms in the FBC phase, and not in the OBC phase, the remainder of the scenario evaluation presented below considers only the organisational form. This means that the *acquisition* scenario has not been considered further as its organisational model is the same as that for *merger with full clinical integration*.

Regardless of the form of the transaction, the result will be a single organisation with one underlying clinical and corporate model. The Boards will retain overall control of the process to achieve a single organisation and the model will be mutually designed and agreed; one Trust will not have more influence than another. The Boards will seek to build on best practice from both Trusts.

5.1.2 Organisational form evaluation

The four scenarios from the SOC are reduced to three for the purposes of evaluation in the OBC:

- *Do nothing:* No change to corporate and clinical service models
- *Some clinical integration:* Implementation of the proposed corporate TOM and model for some clinical integration (based on the draft clinical strategy)
- *Full clinical integration:* Implementation of the proposed corporate TOM and model for full clinical integration (based on the draft clinical strategy)

'Some' and 'full' clinical integration are defined in the following section. The evaluation is therefore an assessment of organisational form consisting of the clinical and corporate models as shown in Figure 5.1. Further detail on the corporate and clinical models is provided in Section 5.1.3.

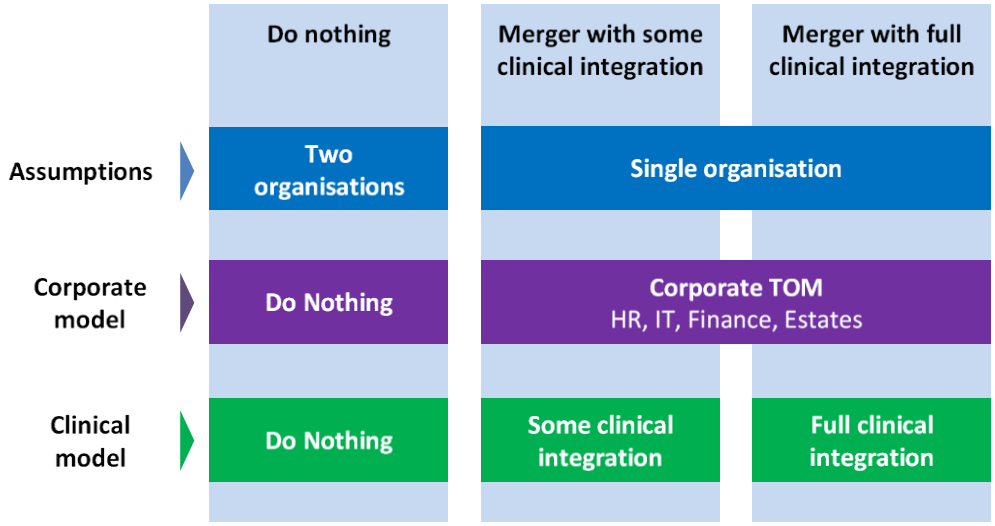

Figure 5.1 Overview of the clinical and corporate combinations that make up the organisational form scenarios

5.1.3 Definition of the scenarios

As described above, the organisational form of the Partnership can be described in terms of its two components: the degree of clinical integration (full or some); and the corporate TOM. Each is described in more detail below.

Definition of 'some' and 'full' clinical integration

The opportunities for clinical integration within a combined organisation were explored by the clinical specialties during the OBC phase. This process was framed by a set of assumptions that were developed to guide the clinical specialties in their thinking. These include a single board, a single main contract for the combined organisation, a single governance and performance framework, including national standards reporting, as detailed in Table 5-1.

Table 5-1 Assumptions for both clinical integration scenarios

Assumption	Definition
Board	• A single board responsible for the combined organisation • Combined organisation Board size will not exceed that of the predecessor organisations
Leadership	• A single executive team for the organisation • A single leadership structure for the Partnership
Workforce	• A single employer for all staff • A common set of terms and conditions
IT	• A single IT infrastructure and single contracts with service providers • Implemented through incremental change over a number of years (based on contract expiry / exit cost analysis)
Procedures	• Standard clinical and non-clinical operating procedures • Best practice guidelines consistently implemented across both sites
Governance	• A single governance framework and reporting structure • Single risk reporting and management approach
Estates	• A single estates strategy • Common approach to valuation, depreciation and disposal
Finance	• A single ledger • Single standing financial instructions
Accountability	• Single lines of accountability to regulators for the organisation • Single accountability within the organisation
Contracts	• A single set of contracts with commissioners for the organisation • Single negotiation with host commissioner
Waiting lists	• Single waiting lists for each specialty • Targets measured for the combined organisation

These assumptions are common to both clinical scenarios, but full clinical integration extends this to the furthest extent which the clinical specialties felt was achievable in the short- to medium-term. These scenarios were originally defined in the SOC:

- **Some clinical integration**: "some clinical consolidation and harmonisation of practices and standardisation across sites". This means that although clinical services are subject to the same governance framework, the two hospitals within the combined organisation would continue to operate as largely separate organisations. This would include separate operational structures (such as divisions) and separate leadership below board level
- **Full clinical integration**: "full clinical services consolidation, including a reconfiguration of service and centralisation where appropriate. Services and specialties are fully integrated and offered across sites from a single rota". This means that clinical services would function as single teams, albeit across two sites. The leadership, operational structures and management of resources would be combined

Definition of the corporate model

The corporate TOM will apply to the combined organisation in both some and full clinical integration scenarios. Services will be redesigned to take advantage of increased scale, based on the following principles:

- Technology enabled
- Responsive to customers
- Professional services model where possible
- Alternative provision
- Cost releasing and risk managed

The scenarios were evaluated in terms of both qualitative and financial benefits, using a set of weighted criteria linked to the Partnership's ambition and objectives.

Summary of the scenarios

Based on the clinical and corporate components described above, the two scenarios are therefore defined as shown in Table 5-2.

Table 5-2 High level definition of 'some' and 'full' clinical integration

Scenario	Clinical model	Corporate model
'Some' clinical integration	• One executive medical director, executive director of nursing, and Board • A single set of reporting frameworks and governance procedures • Common policies and procedures would be implemented across the organisation • Two hospitals within the combined organisation would continue to operate as **largely separate organisations**	Same corporate model, based on increased scale and following a set of high-level design principles
'Full' clinical integration	• One executive medical director, executive director of nursing, and Board • A single set of reporting frameworks and governance procedures • Common policies and procedures would be implemented across the organisation • **Clinical services would function as single teams**, albeit across two sites	

Information on the scenarios, and the strategic benefit themes, were provided to evaluators. They then assessed the scenario against the criteria shown in Section 5.1.4. This allowed for an assessment of the extent to which the scenarios addressed the challenges identified in the Case for Change.

5.1.4 Evaluation criteria

Five evaluation criteria were agreed in the SOC phase of work, based on the ambition and objectives for the Partnership. The criteria and their assigned weightings were established by a wide range of stakeholders. During the OBC phase of work the weightings were validated by the reference groups and were unchanged.

The definition and weighting for each criterion is shown in Table 5-3. This also shows the related partnership objective (these are described in more detail in Section 4.1.2, including the relationship to the case for change), which in turn ensures that the highest ranked scenario will be the one best able to realise the ambition for the Partnership.

Table 5-3 Evaluation criteria with descriptions and weighting

Criterion	Objective	Definition	Weighting
Quality: outcomes, safety and patient experience	Improved quality and patient outcomes	The extent to which a scenario enables the improvement of quality and safety in a consistent way and improves or maintains patient experience across the area covered by the Partnership, and the wider system.	29%
Access	Sustained and improved access to services that meet the needs of the population	The extent to which the scenario enables equitable access to high quality services within the catchment area for all population groups.	15%
Workforce sustainability	A sustainable, skilled workforce	Assess whether the scenario will allow the Partnership to attract, develop and retain the staff needed to provide high quality healthcare in the local area.	20%
Financial sustainability	Better value for money	The scenario's ability to contribute to the short-term and longer-term financial sustainability for the Partnership as well as the wider system.	19%
Deliverability	N/A	The extent to which the scenario enables sustainable change to be delivered by the dates that have been set out, including assessing the risks associated with the implementation, and the potential level of difficulty that this involves.	17%

Note that although deliverability does not map directly to an original objective, it is implicit within all. The deliverability criterion is made up of two elements: the timescale to deliver benefits and the risks to deliverability. This means that the achievability and inherent riskiness of each scenario is captured within this criterion, whilst the qualitative benefits are considered through the quality, access and workforce sustainability criteria.

5.1.5 Evaluating the three organisational form scenarios

The evaluation of the three scenarios was carried out in two parts with separate assessments of the *corporate* and *clinical* service models:

- Corporate model evaluation: an assessment of 'do nothing' and 'corporate TOM'
- Clinical model evaluation: an assessment of 'do nothing', 'some clinical integration' and 'full clinical integration'

The clinical and corporate models were assessed against the five evaluation criteria (quality, access, workforce sustainability, financial sustainability and deliverability) established during the SOC phase using the process shown below (see Section 5.1.4 for criteria definitions).

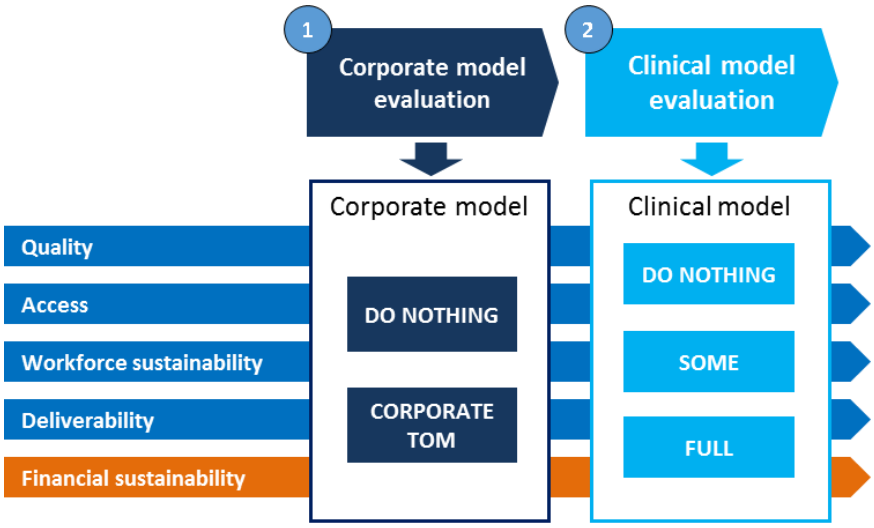

Figure 5.2 Overview of the scenario evaluation approach for organisational form

This evaluation of the scenarios against the first four criteria (quality, access, workforce sustainability, and deliverability) was conducted as a qualitative assessment in which a range of stakeholder groups scored the ability of each scenario to satisfy the requirements of each criterion. Evaluation against the financial sustainability criterion was carried out by the Trusts' finance teams (see Section 5.4 for details on the financial assessment). The scores obtained for the clinical and corporate models were used to determine the scores for the three scenarios by combining the results as shown below:

- *Do nothing* = 'Do nothing' (corporate) score + 'Do nothing' (clinical) score
- *Some Clinical Integration* = 'Corporate TOM' score + 'Some clinical integration' score
- *Full Clinical Integration* = 'Corporate TOM' score + 'Full clinical integration' score

These overall scores allowed for the preferred scenario for the organisational form of the Partnership to be identified.

5.1.6 Financial evaluation approach

Each Trust has produced a five-year long term financial model (LTFM) based on its current individual configuration and known future plans. These models have then been combined to produce an aggregated baseline forecast. The main assumptions been used for this are listed in the section below.

The combined baseline forms the basis for the comparative financial modelling of all other scenarios. These scenario models include a set of financial implications from both the clinical and corporate models, aligning with the combinations described in Section 5.1.5 above. The income and expenditure (I&E) position for each scenario is compared to the 'do nothing' model, along with the relevant impact on capital requirements. The detailed assumptions are described in Section 8 and in Appendix G.

5.2 Scenario benefits

The three scenarios will have different benefits associated with them, based on the different combinations of the clinical and corporate models. As described in Section 5.1.3, the scenarios are described by the level of opportunities that they can deliver; these opportunities in turn result in benefits from both a clinical and corporate perspective. These benefits, and the extent to which each of the scenarios are able to realise these, is considered in this section. These benefits were considered by evaluators against the evaluation criteria in their assessment of the scenarios.

5.2.1 Clinical scenario benefits

As described in Section 5.1.3 clinical specialties were asked to identify opportunities that were enabled through working in partnership. Opportunities identified by clinical specialties were then aggregated and grouped into six strategic themes that describe the potential benefits to patients and staff. These themes described at a high level the six main areas of benefit that could only be achieved through the Partnership:

- **Great quality local services**: Offering a wide range of high quality local services by centralising some aspects of clinical care, where this is required to maintain or improve standards
- **Right people, right skills**: A unified approach to recruitment and retention of clinical and non-clinical staff will enable the development of the required skill mix and capacity to support sustainable services
- **24/7 Resilience**: Provide sustainable services that meet the needs of patients and demands of the modern healthcare system
- **Best value for money**: Sharing capital expenditure and other investment through centralised purchasing and contract management to achieve economies of scale
- **Right care in the right place**: Improving patient access to care with services provided using optimal pathways combined with the most appropriate settings
- **Right systems and processes**: There will be an increased level of standardisation of systems, processes and protocols to enable efficient delivery of care and a consistent patient experience

Some of the benefits are possible under both some and full clinical integration. However, a number of them rely particularly on full integration of clinical services. The evaluation of benefits therefore considered that the strategic themes of benefit applied differentially to the two scenarios. Examples of this include:

- Creation of centres of excellence (in the *great quality local services* theme) for some clinical services. This is highly dependent on the volume of patients treated or the number of procedures performed by the service and therefore the semi-independent nature of services in the some clinical integration scenario does not easily allow this.
- The development of posts with greater opportunities to develop skills (in the *right people, right skills* theme), through rotation or subspecialisation, requires those posts to function in a larger team. This is only feasible in the full clinical integration scenario.

In addition the strategic themes each require different factors to be in place in order to realise the benefits associated. These factors can be considered as the mechanism for delivery, and without which the benefit is unlikely to be achieved. A high-level view of these factors is shown in Table 5-4.

Table 5-4 Mechanisms for the delivery of benefits

Strategic theme	Mechanism for delivery
Great quality local services	• Centralisation of some services and subspecialties to increase scale and quality • Increased capacity to work with tertiary networks • Increased scale to offer research and trials
Right people, right skills	• Pooled trainees and training resources • Larger departments and services that can offer an expanded range of career opportunity and development
24/7 resilience	• Increased scale as a single unit in order to meet clinical standards • Increased capacity to smooth demand, potentially through offering services from multiple locations
Best value for money	• Increased organisational scale to expand buying power • Procurement processes
Right care in the right place	• Increased organisational capacity to enable repatriation • Standardisation to enable coordination of pathways
Right systems and processes	• Standardisation of governance structures • Organisation-wide systems and processes

These mechanisms were reviewed and assessed against the level of clinical integration that was required to deliver the opportunities and realise the benefits. All six themes were assessed to require organisational merger to deliver them, which aligned with expectations given the starting point for their development. Four themes were assessed to require a deeper level of clinical integration before the mechanism delivery would exist; this aligns with the examples provided above. The outputs from this assessment with respect to the two scenarios are shown in Table 5-5.

Table 5-5 Strategic benefits that 'some' and 'full' clinical integration are assumed to deliver

Strategic benefit theme	Some clinical integration	Full clinical integration
Right people, right skills		✓
Great quality local services		✓
24/7 resilience		✓
Best value for money	✓	✓
Right care in the right place		✓
Right systems and processes	✓	✓

5.2.2 Corporate benefits

The process of developing the corporate model also tasked corporate teams with identifying opportunities that could be implemented through working in partnership. In common with the clinical approach, these were then aggregated and benefit themes established:

- **One corporate service**: Services will be unified and integrated across the combined organisation, and leadership aligned
- **Corporate centres of excellence**: The establishment of corporate centres of excellence will support the leadership of the combined organisation to establish

strategic priorities and objectives. These centres of excellence will set priorities for business partners to deliver this vision working with clinical and support services

- **Business partnering**: Business partners will be responsible for providing professional support and advice to other teams. They will offer expertise and support development of solutions which are aligned with the combined organisation's strategy
- **Self-service**: Transactional services will be delivered through a self-service approach wherever practical. This will free up corporate staff to focus on the professional aspects of their work which add greater value, through the business partnering approach described above
- **Digital-enabled future**: The combined organisation will support the shaping of the future workforce by training staff and leaders in digital technologies and processes. The combined organisation will also embed digital technologies such as video conferencing, tele-health, self-care tools, and remote clinical consultations
- **Unified process**: Alignment of processes across the combined organisation will reduce inefficiencies which arise from duplication of effort and inconsistent delivery of service
- **Joint procurement and supplier rationalisation**: The combined organisation will benefit from a stronger negotiating position and greater opportunity to realise economies of scale. The benefits from this approach include cost savings, more consistent delivery of service and, particularly in the case of ICT, a smaller portfolio of systems to manage, support and maintain
- **Alternative models of delivery**: In carefully selected corporate sub-functions, efficiency benefits could be realised by outsourcing to a third-party provider or through an established or newly created public sector joint venture.

Again these benefits were assessed with respect to the mechanisms required for delivery. It was determined that the main delivery requirement that all benefits had in common was the requirement for a change in organisational form. Moving to a combined organisation, through a transaction, was a requisite for achieving the level of benefit identified above. This was in comparison to a 'do-nothing' scenario, which was assessed as unviable for implementation of most of the underlying opportunities.

5.3 Scenario evaluation: qualitative evaluation

Stakeholders were invited to undertake the qualitative evaluation of the proposed clinical and corporate models (details on the stakeholders that completed the evaluation are shown in Section 5.3.1). Each respondent's evaluation was given equal weight, consistent with the evaluation approach in the SOC. Stakeholders rated the corporate TOM and each of the clinical models against the qualitative criteria on a scale from greatest loss of benefit (minus five) to greatest gain of benefit (plus five), as shown in Figure 5.3.

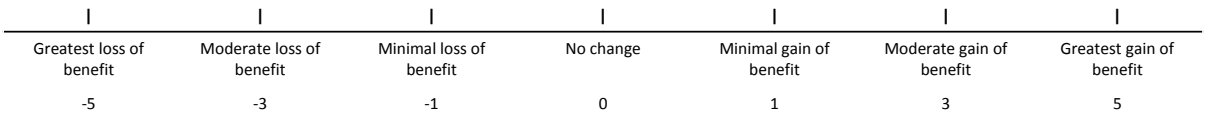

Figure 5.3 Scale of responses in the qualitative evaluation

This scale allowed the evaluators qualitative views to be expressed as a number, although these numbers were not shown to the evaluators. This allowed the outputs from the qualitative evaluation to be combined with the outputs of the financial evaluation (described in Section 5.5), to get to a total evaluation score, as well as rank scenarios.

5.3.1 Evaluators

Stakeholders were invited to complete a qualitative evaluation of the organisational form scenarios. The evaluation was carried out using an online survey, and those invited to complete the evaluation were supplied with supporting information on each of the scenarios. Overall 58 people completed the evaluation, which included:

- Members of the patient and carer reference groups at CHUFT and IHT
- Members of the staff involvement groups from CHUFT and IHT
- Members of the Clinical Reference Group
- Commissioner representatives
- Governors from CHUFT and members of the Ipswich Hospital User Group
- Executives from CHUFT and IHT
- Public sector partners including local government (county and district / borough) and other NHS services

A greater number and range of stakeholders completed the OBC evaluation (58 participants) compared with that undertaken during the SOC phase (41 participants). The breakdown of stakeholders by group is shown in Figure 5.4 showing that there was broad representation across the reference groups.

Analysis of responses to the evaluation survey shows that there is a good level of consistency across contributors. A full analysis of the evaluators and their responses is provided in Appendix D.

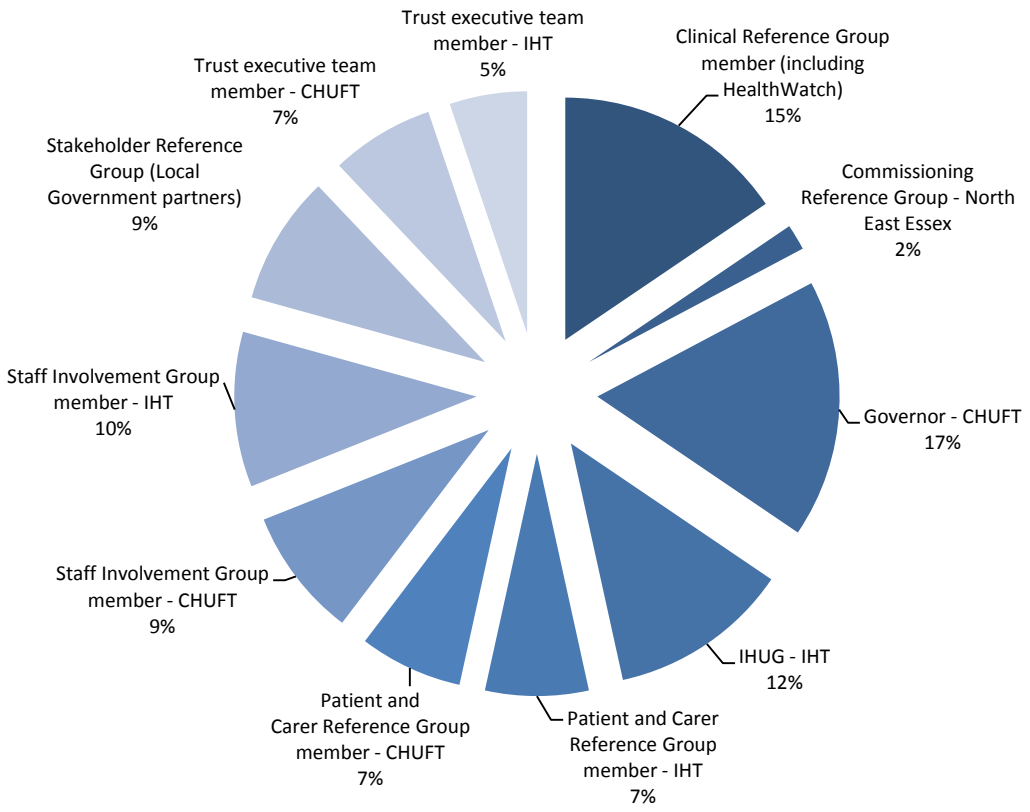

Figure 5.4 Scenario evaluation respondents by organisation type (n = 58)

5.3.2 Evaluation outputs

Stakeholders were invited to assess the three scenarios against the four qualitative criteria: quality (outcomes, safety and experience), access, workforce sustainability and deliverability (see Section 5.1.3 for full descriptions). Each respondent's evaluation was given equal weight; this is consistent with the evaluation approach in the SOC.

As described in Section 5.1 the evaluation was carried out in two stages, with the outputs scored and aggregated to get a final output.

Evaluation outcome for corporate model

The weighted evaluation results by criterion for the corporate models are shown in Table 5-6.

Table 5-6 Weighted results of qualitative evaluation (corporate model)

Criterion	Quality	Access	Workforce sustainability	Deliverability (Risk to delivery)	Deliverability (Time to deliver benefits)	Overall
Weighting	29%	15%	20%	8.5%	8.5%	
Do nothing	-0.41	-0.15	-0.30	0.34	0.00	-0.52
Corporate TOM	0.92	0.36	0.52	0.21	0.02	2.03

Evaluation outcome for clinical integration models

The weighted evaluation results by criterion are set out in Table 5-7. There was a clear distinction between the 'do nothing' scenario, which was evaluated negatively overall, and the clinical integration scenarios. The full clinical integration scenario was evaluated higher than some clinical integration on every criterion with the exception of deliverability; this reflects its greater complexity.

Table 5-7 Weighted results of qualitative evaluation (clinical integration models)

Criterion	Quality	Access	Workforce sustainability	Deliverability (Risk to delivery)	Deliverability (Time to deliver benefits)	Overall
Weighting	29%	15%	20%	8.5%	8.5%	
'Do nothing'	-0.89	-0.25	-0.61	0.66	0.09	**-1.00**
Some clinical integration	1.53	0.53	0.88	0.44	0.10	**3.48**
Full clinical integration	1.98	0.65	1.14	0.32	-0.09	**4.00**

5.4 Financial evaluation

5.4.1 Evaluators

Financial models were developed for each of the scenarios by a team made up of representatives from both Trusts overseen by both Directors of Finance. These models, and their outputs, are described in more detail in Section 8.

5.4.2 Financial evaluation outputs

The I&E deficit position under each scenario over the period of assessment is shown in Table 5-8,

Table 5-9 and Table 5-10. These are followed by bridge charts (Figure 5.5 and Figure 5.6) which analyse the financial drivers of difference between 2017/18 aggregated revenue outturn and the expected position in 2021/22 for the 'some' and 'full clinical integration' scenarios.

Table 5-8 I&E summary of future years plan/projections for 'do nothing'

Income and Expenditure All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Income	584.0	588.9	590.6	596.3	615.2
Operating expenses	(595.7)	(601.7)	(601.3)	(608.8)	(629.1)
EBITDA	**(11.7)**	**(12.8)**	**(10.7)**	**(12.5)**	**(13.9)**
Non-operating expenses	(28.2)	(28.6)	(29.2)	(30.1)	(30.5)
Net (Deficit)/Surplus	**(39.9)**	**(41.4)**	**(39.8)**	**(42.5)**	**(44.5)**

Table 5-9 I&E summary of future years plan/projections for 'some clinical integration'

Income and Expenditure All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Income	584.0	589.0	590.6	596.2	615.2
Operating Expenses	(595.7)	(600.4)	(597.9)	(602.8)	(620.9)
EBITDA	**(11.7)**	**(11.5)**	**(7.3)**	**(6.5)**	**(5.7)**
Non-Operating Expenses	(28.2)	(28.8)	(30.1)	(32.6)	(34.1)
Net (Deficit)/Surplus	**(39.9)**	**(40.2)**	**(37.4)**	**(39.1)**	**(39.8)**

Table 5-10 I&E summary of future years plan/projections for 'full clinical integration'

Income and Expenditure All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Income	584.0	589.1	590.9	596.5	615.5
Operating Expenses	(595.7)	(599.3)	(594.8)	(593.7)	(608.9)
EBITDA	**(11.7)**	**(10.1)**	**(3.9)**	**2.8**	**6.5**
Non-Operating Expenses	(28.2)	(28.9)	(30.6)	(34.0)	(39.2)
Net (Deficit)/Surplus	**(39.9)**	**(39.0)**	**(34.5)**	**(31.2)**	**(32.7)**

This shows that full clinical integration contributes to an improved revenue position. Despite this in 2018/19 there are still likely to be challenges in meeting the control totals advised by NHSI for CHUFT and IHT individually (assuming that these are combined). This also includes the assumption that STF criteria will be delivered, and full anticipated monies received. Therefore, support from commissioners, through the STP, will still be required to enable the provider sector to achieve the expected financial target.

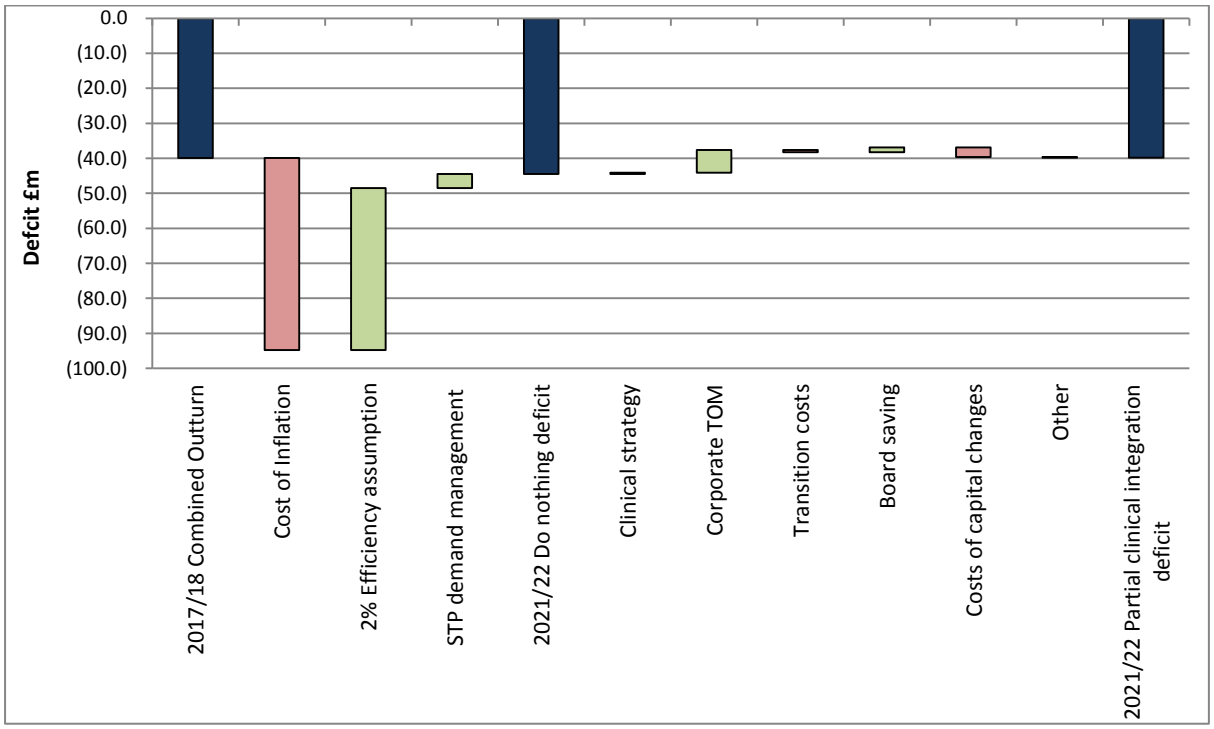

Figure 5.5 I&E position: movement from 2017/18 outturn to some clinical integration 2021/22

The financial position of the some clinical integration scenario is based on the following financial impacts:

- A 2017/18 outturn forecast of an aggregated (£39.9m) deficit position
- A 2% efficiency requirement of £46.3m over the next four years, alongside STP demand management schemes with a net saving £4.0m. These offset the costs of inflation and delivery of growth to produce an essentially flat revenue position of (£44.5m) deficit for 2021/22
- £20m of capital expenditure is anticipated to redesign the sites to realise the opportunities identified associated with some integrated clinical strategy and to enable the corporate TOM; this has a recurrent revenue implication on the cost of capital of (£2.7m) by 2021/22
- Some clinical integration model assumptions deliver an overall saving in 2021/22 of £0.4m
- Corporate model delivers an annual revenue saving by 2021/22 of £6.5m
- An additional saving is foreseen in relation to an assumed reduction in the Trust board costs of £1.4m
- It is recognised that during this transition period, one off revenue costs will be incurred alongside the capital requirements to set up the new processes and models. These are non–recurrent and their value in 2021/22 will be (£0.7m)

All of these adjustments reduce the deficit in 2021/22 from (£44.5m) deficit to (£39.8m) and show some progress towards achieving a break even position for the Trust.

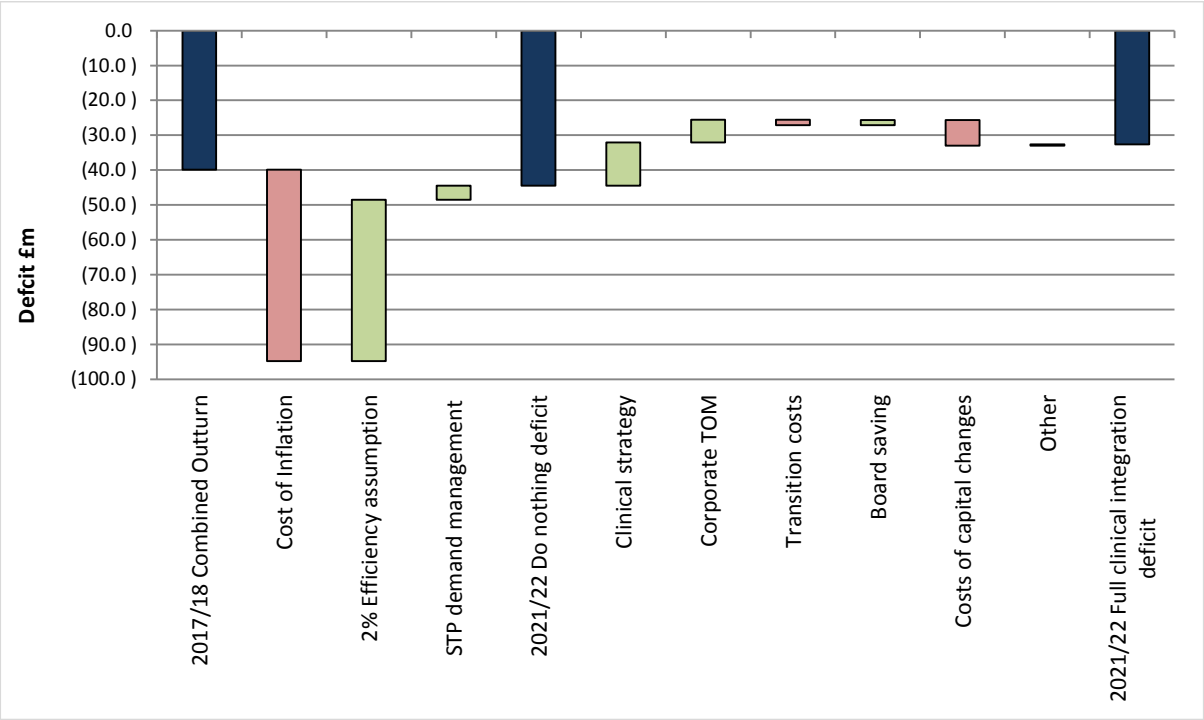

Figure 5.6 I&E position: movement from 2017/18 outturn to full clinical integration 2021/22

The financial position of the full clinical integration scenario is based on the following financial impacts:

- A 2017/18 outturn forecast of an aggregated (£39.9m) deficit position
- A 2% efficiency requirement of £46.3m over the next four years, alongside STP demand management schemes with a net saving £4.0m. These offset the costs of inflation and delivery of growth to produce an essentially flat revenue position of (£44.5m) deficit for 2021/22
- £70m of capital expenditure has been assumed for the redesign of the sites to realise the opportunities associated with full clinical integration and to enable the corporate TOM; this has a revenue implication on the cost of capital of (£7.3m) in 2021/22
- Full clinical integration model assumptions deliver an overall recurrent saving in 2021/22 of £12.4m
- Corporate model delivers an annual revenue saving by 2021/22 of £6.5m
- An additional saving is foreseen in relation to an assumed reduction in the Trust board costs of £1.4m
- It is recognised that during this transition period, one off revenue costs will be incurred alongside the capital requirements to set up the new processes and models. These are non–recurrent and their value in 2021/22 will be (£1.5m)

All of these adjustments reduce the deficit in 2021/22 from (£44.5m) deficit to (£32.7m) and show greater progress towards achieving a break-even position for the Trust.

Scoring of scenarios

Scenarios have been assessed on the basis of the recurrent I&E position shown at the end of the assessment period in 2021/22. A graduated scale has been applied to score these as shown in Table 5-11. This is based on the weighted contribution of each scenario to reducing the deficit.

Table 5-11 Scoring and ranking of the scenarios

Scenario	Deficit 2021/22 (£m)	Score	Weighted score
'Do nothing'	(44.5)	-5	-1.9
Some clinical integration	(39.8)	-0.62	-0.24
Full clinical integration	(32.7)	5	1.9

The financial modelling shows that full clinical integration scenario is ranked first. This provides a recurrent benefit £7.1m higher than some clinical integration. It also provides a recurrent benefit from corporate TOM of £6.5m. This produces a revenue deficit position of (£32.7m) in 2021/22, an improvement of £11.8m over the 'do nothing' scenario and shows clear progress towards delivering financial sustainability. It should be noted that the full clinical integration scenario requires a significant capital investment.

5.5 The preferred scenario

5.5.1 Overall scenario rankings

The qualitative and financial evaluation scores were combined to produce the overall score for each scenario. This was ranked to identify the preferred scenario, as shown in Table 5-12.

Table 5-12 Overall weighted evaluation scores for the three scenarios

Scenario	Qualitative Evaluation	Financial Evaluation	Total Evaluation Score	Rank
Full clinical integration	**4.00**	**1.90**	**5.90**	**1**
Some clinical integration	3.48	-0.24	3.25	2
'Do nothing'	-1.00	-1.90	-2.90	3

Full clinical integration is the top ranked scenario. This scenario scored highest in both the qualitative benefits criteria (quality, access, workforce sustainability) and the financial evaluation. Full clinical integration performed significantly better in the financial evaluation. In the qualitative evaluation, full clinical integration scored 15% higher than some clinical integration. The combined scores result in the preferred scenario scoring more than twice as much as the next nearest, some clinical integration. In terms of the deliverability criterion however, full clinical integration scored the lowest. The evaluators considered that the highest level of benefit (financial and non-financial) arises from full clinical integration, and that the risks to delivery will need to be carefully managed to ensure that the benefits are realised.

Evaluators' assessment of deliverability

When completing their assessment evaluators were asked to provide comments on how they perceived the different scenarios and their benefits for patients, families, staff and the community as a whole. This feedback provides further evidence of the need to carefully manage the delivery of the preferred scenario, since full clinical integration is also the most challenging to implement.

Examples of this written feedback are provided below:

"The benefits from full clinical integration will be higher however deliverability in a reasonable timescale may be lower"

"Doing nothing present a high risk to patients because it will impact quality and compromise the sustainability of both Ipswich and Colchester. The alternative has risks associated with the speed with which it can be successfully achieved and subsequently embedded but has long term benefit"

"Gains in quality for patients will only be made with 'FULL' clinical support and involvement. No matter how well organised and committed the corporate service is, without clinical support it will fail"

"The potential gains for patients, of the [corporate] TOM, are not insubstantial. They should reduce cost allowing more money to be spent on patient care and some of the improvements should lead to real benefits in terms of patient interface with acute care. But it may be hard to actually realise some of the benefits"

"A common model could mean more staff having to work across both sites. Some staff will not like this and may look elsewhere for work"

"Full integration is the only viable scenario long term"

The greater the level of integration and operational change required, the greater the level of risk attached to the process. Full clinical integration in particular has associated risks due to the scale of change to be undertaken that may hinder its implementation within proposed timescales. These risks were identified during the OBC phase and are shown in Table 5-13. Full risk assessment will be undertaken during the FBC phase.

Table 5-13 Full clinical integration scenario specific risks

Category	Risks	Detail
Clinical	Service interdependencies	The programme of integration could put strain on a number of interdependencies between clinical services and supporting services.
	Patient experience	The degree of change in this scenario increases the possibility of some temporary deterioration in patient experience.
Operational	Integration of information systems including waiting list, performance and financial reporting.	The full integration of clinical teams requires the integration of clinical systems (over time) as well as other key information systems which would support the integrated approach.
Regulatory (including commissioner)	Commissioner alignment	The transition to a single contract for the two hospitals in the post-transaction organisation could create a period of instability or lack of alignment between commissioners.

Early identification of these risks allows the Partnership to effectively manage them and ensure that the benefits of full clinical integration are delivered within the expected timescale.

5.5.2 Detail of the preferred scenario

The evaluation outcome was definitive, therefore full clinical integration becomes the preferred organisational model scenario. This scenario is described in detail in the following sections:

- The clinical case and patient benefits are described in Section 6
- The corporate case and organisational benefits are described in Section 7
- The financial case is described in Section 8
- The workforce case and staff benefits are described in Section 9

6 Clinical case and patient benefits

Section synopsis

- **The preferred scenario has a wide range of clinical opportunities which have been identified from creating combined clinical teams that achieve patient benefits which could not be realised as individual organisations**
- The clinical case is based on the outputs of the work with specialty groups during the OBC phase and outlines the strategic themes for integrated clinical services and patient benefits as part of the Partnership
- The approach to developing the clinical case was based on a collaborative process with a clinically-led group of staff across 26 specialty groups in both Trusts. Six of these specialty groups received additional facilitation to maximise the understanding of the opportunities available from clinical integration
- The clinical case identified six strategic themes that encompass the opportunities available to the Partnership through the preferred scenario of full clinical integration. These are:
    - Great quality local services
    - Right people, right skills
    - 24/7 Resilience
    - Right care in the right place
    - Right systems and processes
    - Best value for money
- The benefits for patients arising from full clinical integration, identified by the specialty groups as part of their individual reviews, have been mapped against the six strategic themes. This demonstrates that there is a wide range of opportunities that will benefit the patients of the combined organisation. The FBC phase will look at each theme in more detail to identify specific achievable benefits across the specialty groups

6.1 Introduction to the clinical case

This section outlines the clinical case for the Partnership. The outputs of the work with clinical specialties were used to develop a draft clinical strategy which for the purposes of the OBC is known as the clinical case. This outlines the vision and strategic themes for integrated clinical services as part of the Partnership. Details of the underlying opportunities and benefits from integration of clinical services are provided in Section 6.4.1. Further work will be undertaken with clinical and clinical support services in the FBC phase to refine the draft clinical strategy and develop the final clinical strategy for the Partnership.

The clinical case has followed the Partnership ambition, objectives and design principles, as shown by the framework outlined in Figure 6.1.

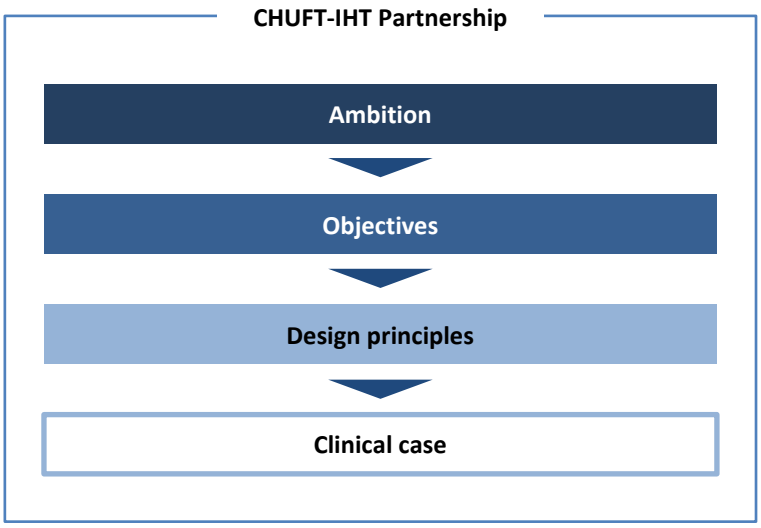

Figure 6.1 Framework for developing the clinical strategy

Details of the Partnership ambition, objectives and design principles are provided in Sections 4.1 and 4.2.

6.1.1 Design principles

The design principles specific for the clinical case are shown in Table 6-1. In common with the overall design principles shown in Section 4.2, these are developed from the objectives of the Partnership which respond to challenges identified in the case for change.

Table 6-1 Design principles for the clinical strategy organised into fixed points and broader principles

Category	Design principle
Fixed points	• Emergency Department services on both acute hospital sites • Obstetric-led maternity services on both sites • 24/7 acute medical take at both sites
Broader principles	• Provide hospital-based services appropriate to the needs of the local population • Develop specialist services where improvements for patients from improved access and/or outcomes can be demonstrated • Make best use of resources within a service and ensure co-dependent services work well together • Enhance teaching and training to develop future clinical workforce • Move at a pace that minimises disruption to services whilst maximising the delivery of benefits

6.1.2 Scope of the clinical case

The clinical case has been developed to understand the opportunities and benefits from working as a combined organisation and has been expressed as a series of strategic themes. Examples of opportunities and benefits at the level of these strategic themes are provided. The final clinical

strategy will be developed during the FBC phase, providing detailed plans for the future clinical model of the combined organisation and how it will operate.

6.2 Approach to developing the clinical case

The clinical case was developed with clinical specialty teams from the Trusts. In total, 26 specialty groups developed their individual specialty-level ambitions. The teams from the Trusts worked together to identify the potential opportunities, benefits and risks from integrating services. These specialty outputs were then used to form the foundation of the clinical case.

Facilitation was provided to six specialties as initial areas of focus. This allowed a deeper understanding of the opportunities from the Partnership, identifying the set of strategic themes used in the clinical case. These specialties were selected based on the significant potential opportunities and benefits they could realise through the Partnership. They were identified through an iterative process, starting from the STP, involving NHSI and commissioners, and oversight from the Clinical Reference Group (CRG). The specialties identified were:

- Cardiology
- Endoscopy
- Oncology
- Stroke Medicine
- Trauma and Orthopaedic Surgery
- Urology

A series of three workshops was held with each of the six specialties, bringing together the clinical teams from both organisations, including clinical leads, nursing representatives, clinical support staff and CCG representatives. The workshop outputs were then collated to develop the clinical vision and strategic themes as part of the clinical case.

6.2.1 Validation of the clinical case

The specialty-level outputs for the six initial areas of focus were subject to review and challenge by the CRG, executives, divisional clinical directors and specialty clinical leads to further refine and validate the opportunities and benefits. The clinical case was formally supported by the CRG and subsequently validated with over 100 clinicians in a collaborative review session.

Overall a significant level of clinical engagement was carried out over the course of developing and validating the clinical case:

- Introductory plenary meeting with all specialties
- 18 clinical workshops (six specialties and three workshops)
- Weekly drop-in sessions for all specialties
- Confirmation and challenge session with the six initial areas of focus
- Review meeting with all clinical specialties
- Four CRG meetings

6.2.2 Consideration of separation of emergency and elective care

One of the key elements in developing the clinical case was understanding the extent to which a model that centralises the delivery of emergency and elective care on separate sites is viable and suited to local needs. To identify the extent to which such a model needed to be considered in the clinical case, two approaches were taken:

- The first approach focused on the extent to which the specialty groups considered this as a priority for their clinical model across the two Trusts
- The second approach used a 'hypothesis testing' method which focused on three cardiovascular specialties (cardiology, stroke medicine and vascular surgery) as a representative subset of emergency care; this had been highlighted as a potential opportunity in discussions with regulators and commissioners during the early stages of the Partnership

For the first approach, the specialty workshop outputs indicated that this model was not seen as a priority by the clinicians across the two Trusts, despite having considered it.

For the second approach, a desktop review of evidence, guidance and local considerations was undertaken. The review did not find strong evidence that services would be significantly improved by centralisation. It was also considered that some centralisation has already been achieved: vascular surgery is already organised into a network and major surgery is centralised and urgent cardiac angioplasty is only carried out on a single (different) site. In some cases the local case for change, particularly in relation to stroke services, appears less compelling than when considered from a national perspective.

Based on these approaches, the recommendation was made not to further pursue large-scale centralisation as part of the clinical case. The full detail of this recommendation and the supporting information can be found in Appendix F.

6.3 Overview of the clinical case

The specialty-level outputs from the strategy development process were collated and synthesised to identify the key strategic themes, opportunities and benefits, and enablers and dependencies for clinical integration. These are described in this section.

6.3.1 Strategic themes

Six broad strategic themes of opportunity to improve care were identified which would not be possible within the two Trusts separately. These opportunities will ensure the long term sustainability of clinical services for the local area. These are the how the Partnership will deliver the objectives, as they comply with the design principles. Opportunities also assume that there is a transaction, as other alternative organisational forms were considered during the SOC phase but not taken forwards. Therefore the opportunities can only be achieved within the context of a combined organisation.

The strategic themes along with their sub-themes are outlined in Figure 6.2 and further detailed in Table 6-2. A set of projected patient benefits organised by strategic theme is shown in Table 6-3.

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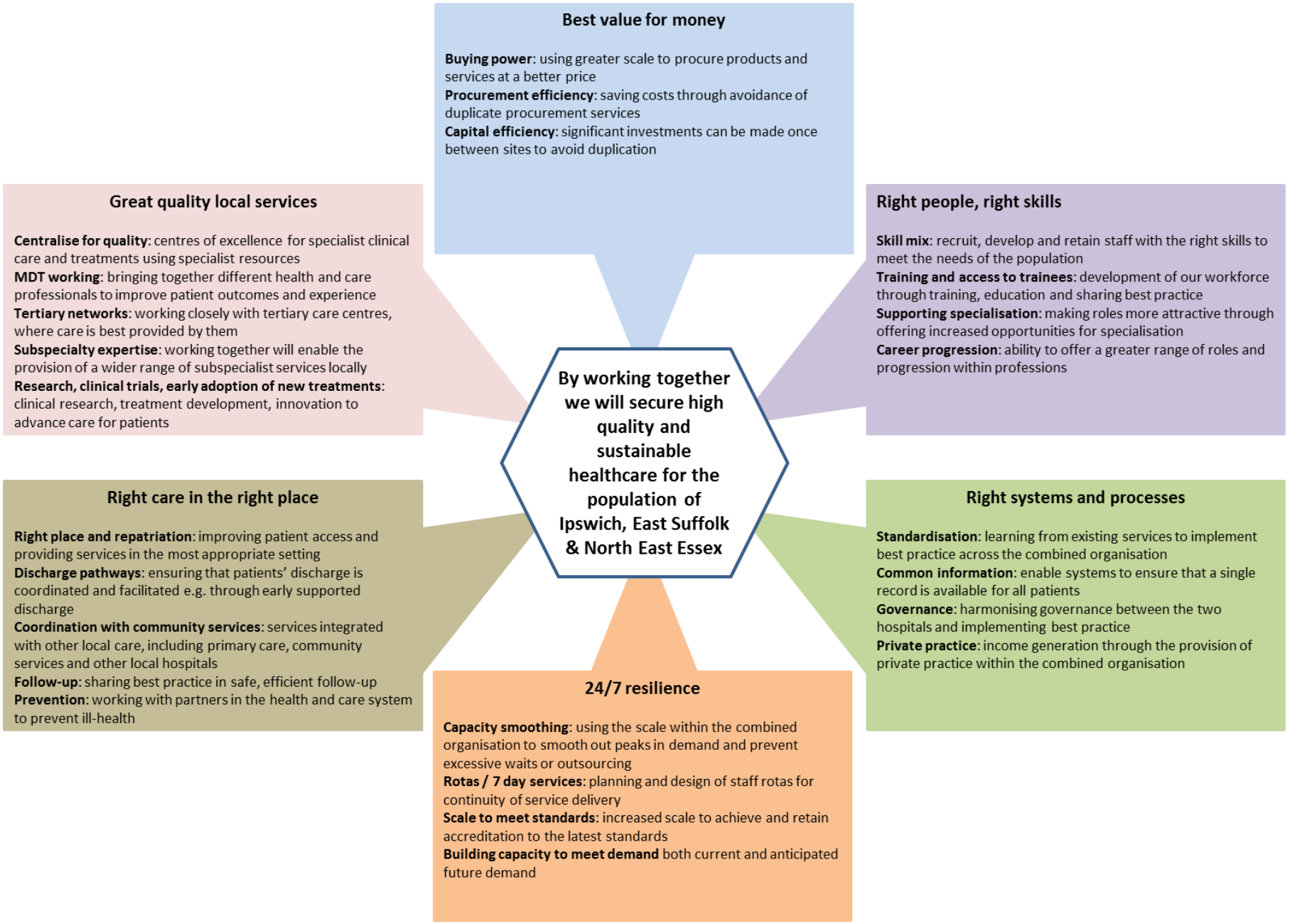


Figure 6.2 Overview of the six strategic themes and sub-themes

Strategic theme	Benefits
Great quality local services	• Joint services across sites enabling better outcomes and reduced errors • Maintain and develop local expertise and skill base through sub-specialty integration, leading to improved quality and patient experience • Improved secondary prevention and lower rates of recurrence by providing greater range of services and sub-specialisms • Care closer to home for patients through integration of sub-specialties or shared sites • Potential to provide innovative treatments more locally thus ensuring a more locally based service
Right people, right skills	• Furthering knowledge and skills at both Trusts resulting in improved quality of service for patients • Equity in service across the two sites by having increased specialist roles • Combined training, education and governance will ensure standardisation of services • Maintaining high-levels of consistency of specialist staff leading to high standards of care, lower mortality and reduced disability • Reduced patient waiting times by having more specialist staff available
24/7 Resilience	• Reduction in patient wait times and service continuity through cross cover between two sites • Improved patient experience by sharing capacity between two sites with shorter wait times and faster diagnostic turnaround • Improved access to specialist input and addressing quality gaps • Seven-day coverage for the wider population from seven-day working across the two sites • Reduction in travel times for patients experience by sharing capacity between two sites
Best value for money	• Standardisation of equipment through joint procurement ensuring safety on cross cover and aiding getting it right first time
Right care in the right place	• Improved patient experience and equity in service from optimised pathways for wider population • Local expertise for improved patient quality and experience for the wider population • More consistent and responsive service leading to better outcomes for patients by increasing admission prevention approach across teams and wider community • Improved continuity of care through standardising discharge and rehab pathways • Improved access for patients through supporting nursing homes, GPs etc.as part of admission prevention approaches • Reduced length of stay and simpler discharge process by standardising discharge pathways • Faster time for diagnosis and discharge through combined diagnostic support • Offer specialised clinics across both sites through pathway reconfiguration
Right systems and processes	• Improved patient experience from sharing best practice on processes and protocols • Improved transfer of patient information to optimise chances of high quality care in the place of their choice • Reduction in duplication of work and time savings that can optimise time for direct patient care • Improved communication between professionals and sites to help optimise patient care

Table 6-2 Summary of the underlying benefits achievable for the six strategic themes

Great quality local services

A wide range of high quality local services will be offered; some aspects of clinical care will be centralised where this is required to maintain or improve standards. Shared delivery of services across the two sites will result in reduced waiting times and improved patient access. Sub-specialty services will be expanded by bringing together clinical expertise from both sites; reducing reliance on tertiary referrals and further improving patient access. There will also be increased opportunity for clinician peer review, allowing for enhanced quality of care and compliance with national standards. In other areas, single site delivery of sub-specialties will enable patients to access more specialist expertise and care. Access to new and innovative treatments will also be increased through shared research and development across a wider patient pool.

What this means for patients

Elsie, 78 years old, had a hip replacement twelve years ago. Unfortunately, this year the replacement hip has become unstable and has dislocated on three occasions, which is painful and needed admission to Hospital A. In discussion with her orthopaedic surgeon, Miss D, she has decided that she wants to have the old hip replacement taken out and a new one put in (which is called "revision arthroplasty"). Hospital A only performs a small number of these procedures each year and so Elsie will have a long wait or will need to be referred to a larger hospital for the procedure.

In the combined organisation, there will be nearly thirty orthopaedic surgeons. It would be possible to organise the service so that more complex procedures, such as revision arthroplasty, are carried out more consistently. This will offer Elsie the best support and the highest level of expertise throughout her care, as close as possible to her home and family.

Right people, right skills

A unified approach to recruitment and retention of clinical and non-clinical staff will enable the development of the required skills and capacity to support sustainable services. Working in larger teams will enable the development of the appropriate roles and skills through combined training and rotations, as well as providing career progression opportunities. The current reliance on temporary staff will be reduced by developing specialty-specific roles, including specialist nursing, and medical roles. This will improve the continuity of care for patients, release clinical capacity and reduce agency costs.

The combined organisation will become an increasingly attractive employer operating at a scale to provide excellent professional and personal development opportunities for staff. It will not be possible for each Trust to deliver these benefits individually as taking a unified approach to recruitment, retention and staff development is dependent on working effectively in larger teams supported by full clinical integration. Equally, developing specialty-specific roles will be far more effective if done within combined specialties that see a greater number of patients.

By making the combined organisation a highly attractive place to work and getting the right mix of skill development and roles for permanent staff, significant savings on agency spend are anticipated.

This saving is forecast to be approximately £10m recurrently by 2021/22. Further information is given in Section 8.

What this means for patients

Joanne is an experienced endoscopy nurse and loves her job. She has studied hard and progressed into a more senior role managing her team. She is keen to train to become a nurse endoscopist, so that she can perform endoscopies independently and help the service at Hospital A to treat their patients quickly and safely. Due to the pressure on the service, it is difficult to provide time with a specialist trainer to offer Joanne the opportunity to develop her skills. As a result, she is considering leaving to take up a role at a teaching hospital in the next county where she could get this training.

In the combined organisation, the endoscopy service will be twice as large. Training lists can be run more frequently at one or other hospital, enabling Joanne to achieve her ambition to become a nurse endoscopist.

24/7 Resilience

Sustainable services will be provided that meet the needs of patients and demands of the modern healthcare system. This will be achieved through integrated working across two sites with more versatile teams to meet patient demand and ensure service continuity. Patients will benefit from improved access, outcomes and safety. Co-ordinating capacity with staff cross-cover, shared rotas and seven-day working in certain areas will reduce delays and cancellations. Combined rotas will also ensure that patients can access specialist care and senior clinical decision-makers when most needed.

In some cases, staff may be required to adapt to new ways of working, with potential travel between sites. It is anticipated that this is likely to impact a small proportion of the workforce and mitigations will be established to minimise potential further impact.

What this means for patients

Twelve months ago, Derek was diagnosed with inoperable lung cancer during an emergency admission to Hospital B, in the neighbouring town. He has been having palliative care since then. Last Saturday Derek's wife was so worried about his cough and laboured breathing that she took him to the emergency department at his local hospital, Hospital A. On arrival, Derek explained his history and was admitted for tests. Ward staff knew he had been treated at Hospital B previously but they had to wait until Monday for his notes to be copied and sent over to Hospital A. Derek was still on the ward at Hospital A two weeks later waiting for support at home.

In the combined organisation because the hospitals use the same electronic patient notes, the team at hospital A will have online access to Derek's records at hospital B and will have a full picture of his treatment and prognosis. An immediate referral is made from the ED team to the on-site Acute Oncology Nurse who in turn makes contact with the on-call consultant for the acute oncology service, who now offers advice to both hospitals. From home, he is able to review Derek's notes and the latest ED assessment online. The acute oncology nurse makes a rapid referral to the palliative care team at Hospital A. Derek spends one night in hospital while a plan is agreed with Derek and his family. He is able to go home with a support package, knowing that everything has been done to get him back home.

Best value for money

There are opportunities to make capital and other investment go further through centralised purchasing and contract management to achieve economies of scale. Efficiencies will be realised through increased buying power in clinical equipment and supplies. The latter will ensure that improved terms can be secured from a wide range of suppliers; this can also support standardisation of practice. Some capital purchases, particularly of the latest equipment technology, become increasingly viable as a combined organisation. In turn, this increases the range of modern services that can be accessed locally.

What this means for patients

Hospital A knows that several of its services, like cardiology and gastroenterology, are updating their clinical pathways to offer non-invasive testing to many more patients, such as MRI and CT scanning. However, the current scanners are fully utilised, running seven days a week at all hours. Hospital A would like to buy an additional scanner, but it hasn't been able to identify quite enough new activity to make this viable, given the multi-million pound cost of this equipment and the staff to run it. Hospital B is also in the same position.

In the combined organisation, there will be more combined activity and therefore a stronger rationale for buying a new scanner which would increase the capacity available to both hospitals. The total scanning capacity can then be organised to make the new clinical pathways available to the patients served by both hospitals, providing fast and painless diagnosis.

Right care in the right place

Patients' access to care will be improved with services provided using optimal pathways combined with the most appropriate settings; this is in line with the aims of the STP and supports the overall health economy. Standardising discharge and rehabilitation pathways by sharing best practices and working with community services will ensure that the patient journey is coordinated with the right care in the most appropriate environment. Additionally, by better integrating services with local providers, there is the opportunity to manage demand at both hospitals more effectively. Further demand control can be achieved by developing referral prevention approaches with local health system partners for the wider population.

What this means for patients

In his Sunday afternoon rugby match, Paul had done some serious damage to his shoulder. In the ED at Hospital A it was quickly agreed that he needed surgery. Paul was admitted to the trauma ward and told he would have his surgery on the 'trauma list'. It had been a busy weekend for the ward, with several urgent frail older patients waiting for hip fracture surgery. What made it worse was that there are only two specialist shoulder surgeons at Hospital A and Paul really needed his surgery done by one of these experts. The next trauma list for the shoulder surgeon was on Thursday, resulting in Paul taking more time off work and experiencing significant pain and inconvenience.

In the combined organisation Paul will still be seen and assessed in his local ED. The trauma lists at both hospitals are now organised to offer an upper-limb trauma list every other day. A decision on surgery can be made at the next day's trauma video-conference to offer Paul surgery with a shoulder specialist. Paul could choose to be transferred to today's upper-limb trauma list at Hospital B or to wait until tomorrow for the dedicated upper-limb list at Hospital A.

Right systems and processes

There will be an increased level of standardisation, aligned to best practice and evidence, across the combined organisation. Standardisation of processes and protocols will provide continuity and best patient care across the wider population. This will be underpinned by unified governance processes and joined-up IT systems. Integrating clinical systems will ensure efficient sharing of patient information, improving safety. Applying standardised auditing, monitoring and assurance tools across both sites will deliver a range of benefits, especially for lower volume services.

What this means for patients

Mary, 56, was seen by the ear, nose and throat (ENT) team at Hospital B complaining of a persistent feeling of a lump in her throat; sadly, after tests, she was diagnosed with a throat cancer. Following surgical removal of the tumour, Mary was due to start chemotherapy and radiotherapy treatment the same week. Dr Z is the consultant oncologist at Hospital B who specialises in head-and-neck cancer patients. Due to the small size of the oncology team Dr Z is the only oncologist who specialises in head and neck cancers and he does not have the capacity to treat all patients with cancers in these parts of the body, meaning that sometimes other oncologists have to treat those patients.

In the combined organisation Dr Z will work as a member of a larger team of oncologists in which more than one oncologist specialises in the same types of cancer. Therefore, when Dr Z takes leave Dr Y at hospital A, who also specialises in head and neck cancer, can support Dr Z's patients. Because the two hospitals both follow the same treatment protocols and have compatible radiotherapy and chemotherapy systems (linked online), Dr Y can safely plan and advise on Mary's treatment and communicate the plan to Dr Z on her return.

Indicative examples from different clinical specialties for what these areas mean in practice are shown in Table 6-3. This is subject to additional verification and planning during the FBC phase.

Table 6-3 Indicative examples of specialty-level benefits within the strategic themes

Theme	Speciality	Opportunity	Benefits
Great quality local services	Stroke Medicine	Develop a level 2 rehabilitation unit in the region or improving access to level 2 rehab beds	Smooth transition between services, improving patient experience, reducing delays More co-ordinated care in-house and in line with standards Reduced hospital length of stay - Community specialist rehab team would be able to take patients earlier, avoiding inpatient waits for patients to get 'ESD' fit Existing staff on both sites already competent to deliver this service Utilise specialist skills across the wider geography
	Cardiology	Provision of complex pacemaker device implantation locally	Repatriation from Papworth & Essex CTC will provide greater local access to implantation and follow up. Local specialist device services will make attracting and retaining highly skilled cardiac physiologists easier
	Cardiology	Provision of elective and non-elective coronary stenting of CHUFT patients at IHT	Repatriation of services from Essex CTC. This has already provided faster access to inpatient primary coronary angioplasty (PCI) for non-ST elevation myocardial infarction and has reduced length of stay. Local elective PCI will reduce waiting times and provide ease of access
	Trauma and Orthopaedic Surgery (T&O)	Larger teams in sub-specialties with some sub-specialities delivered on one site with a combined workforce and dedicated ward facility (e.g. spinal surgery)	Complex patients seen quickly by relevant specialist Patients have access to specialist opinion within 24 hours Shared workload across both teams Reduced length of stay
Right people, right skills	Endoscopy	Training of workforce within Gastroenterology	Increased training opportunity for nurses – increase skill mix, variety and attractiveness of posts Development of nurse endoscopy practitioners to provide additional capacity
	Stroke Medicine and Urology	Develop middle and trust grade roles	Improved on-call provision Addressing challenges in junior medical workforce Improvement in recruitment and retention Release of capacity
	Oncology	Access to training for staff from both sites to develop their skills further Improved peer support and MDT working	Improved opportunities for staff in all disciplines to develop knowledge and skills by working as part of the larger team, ensuring that the right skills are available locally for patient care
	Urology	Develop nursing roles	Develop nurse specialist roles to improve access to services and patient experience

Theme	Speciality	Opportunity	Benefits
24/7 Resilience	Urology	Joint workforce across both sites to improve productivity and reduce waiting times	Reducing patient wait times and allowing for service continuity Reduced errors and better outcomes Improved clinic utilisation to manage increase in activity Reduction in waiting-time breaches
	Oncology	A single integrated service working from two sites	Consistent and increased access to specialist services locally, including for acute oncology patients More resilient sub-specialty multidisciplinary teams and expertise Access to greater participation in clinical trials brining new treatments more quickly to local patients
	Cardiology	Development of non-consultant led clinics and diagnostics	Improved skill mix of workforce Supports development, training and career progression of nurses and physiologists Improves waiting times for patients
Best value for money	Endoscopy	Development of improved facilities for provision of elective services for both sites	Increased training opportunities for nurses allowing for increased experience and skill mix Significant cost savings by developing nurse endoscopy practitioner roles and reducing reliance on outsourcing
	Cardiology	Extension of current IHT cardiovascular information system license to cover both sites	Significant cost saving over original plan to purchase a separate system. The additional licenses result in “infinite license status” so both sites gain access to specialist software from any PC. Shared and unified information systems will allow ease of access to reports on both site
	Oncology	Standardise IT systems for document control and quality management	Free up clinical and technical time Only one contract and one update cycle Small transition to deliver
Right care in the right place	Oncology	Re-design pathways / referral routes including rationalisation of MDT relationships. Focusing on Acute Oncology Service and reviewing MDT team and process	More consistent and responsive care Sharing and exploring pathways to identify gaps and improvements Free up clinical resource time Improve treatment planning

Theme	Speciality	Opportunity	Benefits
	T&O	Combined service for upper limb trauma Fractured neck of femur prioritised based on meeting targets; having one sub speciality list on one site (upper limb and/or lower limb) and single on-call can increase capacity for trauma services	Dedicated on-call for upper limb and lower limb Quicker access to emergency surgery Reduced waiting times for elective surgery On-call rota able to be shared amongst a larger group in a combined workforce Increased theatre throughput
	Cardiology	Share capacity in diagnostic support (CT, MRI and Echocardiograms), with access to technicians and reporting on both sites	Able to comply with the NICE diagnostic guidelines Faster access to treatment Improved patient experience Faster time for diagnosis and discharge
Right systems and processes	T&O	Complete more complex surgery at one or other site (e.g. paediatric orthopaedics)	Better access times Improve throughput Improve patient experience Develop specialist multi-disciplinary skill base
	Urology	Reduce reliance on out-sourcing of activity to manage peaks of demand	Patients can be seen quicker in their local hospitals
	Oncology	Shared best practice and innovation across both sites	Improved patient experience Increased peer review of treatment planning and practice Optimising use of expertise and resources Increased capacity for the management of rarer cancers

6.4.2 Enablers and dependencies

In addition to these strategic themes, a set of enablers and dependencies have been identified that support integration. The enablers and benefits of integration are outlined in Table 6-4.

Table 6-4 Enablers and dependencies of the clinical case

Enablers and dependencies	Description
Estates	Both sites have ageing plant and infrastructure, with some specialties experiencing difficulty meeting the demands of the service within the confines of the currently available estate. A single estates strategy will support efficient investment for the future
HR	Support to develop new healthcare roles required to maintain and improve services, to recruit and train staff efficiently and to allow supporting services to develop innovative workforce models
IT	Integration of IT systems is essential to meet the demands of a modern local healthcare service. Partnership between the organisations would reduce the cost of implementation and the efficiency of procurement
Financing	Financing is vital to delivering change and underpins other enablers and dependencies. Some opportunities are predicated on capital investment
Diagnostics	Ensuring that clinical specialties have access to essential tools, including imaging. The combined organisation offers the opportunity to increase the efficiency of procurement and utilisation
Transport	Managing the needs of patients and staff through a robust patient transport system that supports families and carers as well as those receiving treatment
Inter-dependent specialties	Services which support each other to provide the best possible care to patients
Commissioners	Collaboration between acute trusts and commissioners to ensure patients receive treatment in the most appropriate setting
Governance	Providing essential governance frameworks to embed best practice across clinical areas

6.5 Risks to realising the benefits

The successful delivery of full clinical integration requires the recognition and management of a number of risks. An initial view of these risks and their mitigations is described in Table 6-5; these will be reviewed and managed throughout the FBC phase.

Table 6-5 Risks to realising the benefits of the preferred scenario

Category	Key risks	Detail	Mitigating actions
Clinical	Patient experience and outcomes	Implementing full clinical integration risks destabilising current good service provision and / or the creation of unwarranted clinical variation	• QIA of planned changes • EIA assessment of planned changes • Plan for the transition to the new clinical model so that current good service provision is identified and maintained, and service disruption is minimised • Involve the 'patient voice' in the planning to understand the key areas of focus from a user point of view • Work with clinical teams to identify changes in pathways, protocols and understand how to avoid unwarranted variation • Ensure that clinical interdependencies are recognised and taken into account during planning

Category	Key risks	Detail	Mitigating actions
Operational	Scale of change	Full clinical integration requires implementing a greater scale of change than partial, potentially leading to greater destabilisation	• Ensure clinical leadership of the change and engage regularly with staff to communicate the reasons and timescale for change • Ensure adherence to change management principles • Workforce key performance indicators (KPIs)
Workforce	Workforce capacity and engagement to drive change	Focus on large scale implementation activities results in deterioration in clinical quality / performance of new organisation	• Engage further with staff to build the coalition for change • Review backfill required to support implementation activities • Ensure that staff involvement is planned to minimise the impact on clinical commitments
Engagement	Public support for change	Significant changes to the configuration of services may provoke public concern and reduce support for change	• Continue and extend engagement with patients and carers • Hold public engagement events • Continue and extend the availability of public-facing information • Respond to concerns and adapt plans where required
Regulatory (including commissioner)	Commissioner alignment	Commissioners are not supportive of the clinical model changes required for full clinical integration	• Continue engagement through the Commissioning Reference Group • Involve commissioners in refining the clinical model • Involve commissioners in implementation planning

7 Corporate model and organisation benefits

Section synopsis

- **The Partnership will align corporate services to develop a single operating model, that is digitally enabled to deliver an improved service at a reduced cost**
- The four corporate service functions in scope at the OBC phase are:
  - Estates and facilities management
  - Finance
  - Human resources
  - Information, communication and technology
- The corporate Target Operating Model (TOM) was developed through the consideration of the services currently delivered by the above four corporate functions and how these could be provided in the future to improve services to patients and staff as part of a combined organisation
- The principles and approach identified will be applied to all corporate services during the FBC phase
- Opportunities identified include the establishment of a single corporate function. An operating model has been proposed involving the establishment of 'centres of excellence', an enhanced business partnering approach and a focus on technology-enabled self-service. In addition, further opportunities from economies of scale and alternative models of delivery, are presented
- A high-level financial benefits summary has been developed which estimates the total recurrent gross benefit opportunity of £6.5m at the end of the five-year period. The costs to achieve are included in Section 8

7.1 Introduction to the corporate model

The Partnership presents an opportunity to transform and optimise the way that the Trusts' corporate services are designed, managed and delivered. The nature of these services, and the similarity between the Trusts in terms of scope and scale, means that there is significant potential for aligning corporate service strategies, resources, processes and financial investment. This will also deliver an improved service with reduced costs. The CHUFT and IHT teams have worked together to identify and validate these opportunities and arrive at an agreed corporate TOM. This followed an iterative design process, to:

- Establish a baseline of the range of services and outcomes provided. This includes sub-functions, the core activities performed and their associated processes, the organisational structure and composition of each service, and current cost of these
- Assess areas of current similarity and difference between the Trusts
- Identify optimal working practices that deliver the Partnership vision and objectives and adhere to the design principles
- Evaluate the financial and non-financial benefits
- Estimate the required investment to deliver the change
- Assess the risks in realising the benefits of the corporate TOM

7.1.1 Corporate services scope

At the OBC stage, the scope of the corporate TOM includes Estates and Facilities Management, Finance, Human Resources, and ICT. At the FBC stage other corporate services and administrative areas will also be considered. These four corporate services were considered because they constitute the largest services and present the greatest opportunity for achieving desired benefits.

The components of each corporate function in scope at this stage are shown in Figure 7.1.

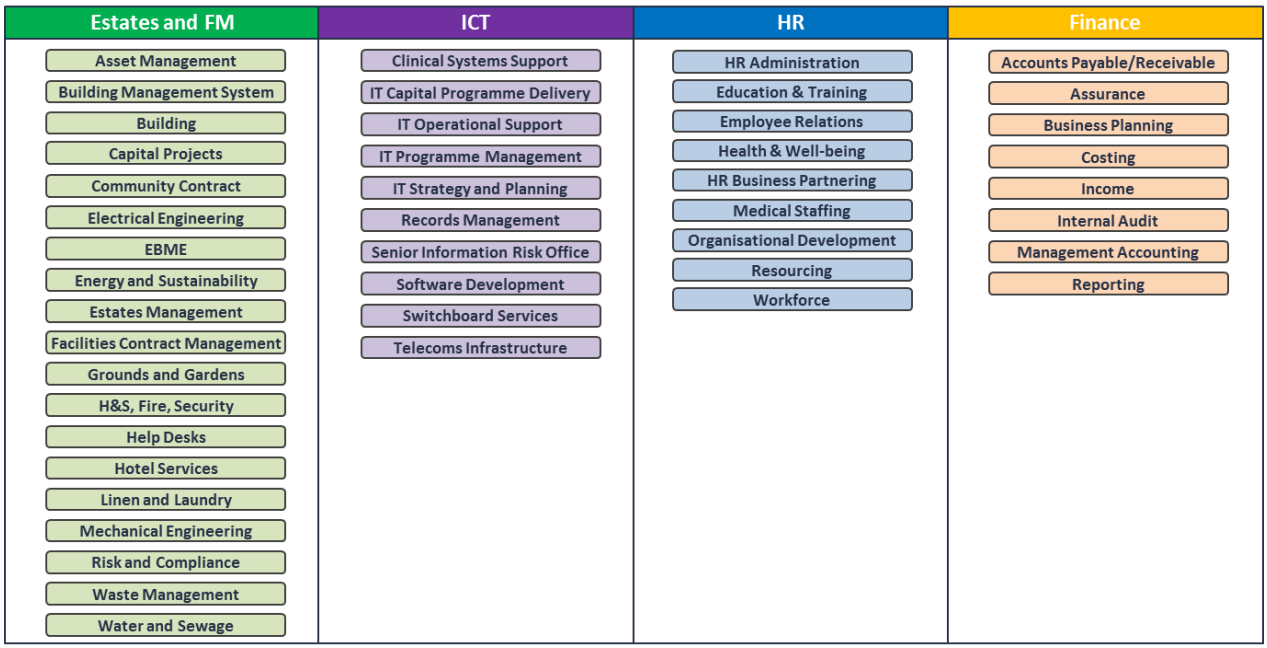


Figure 7.1 Components of corporate services in scope

7.1.2 Corporate TOM objectives

The Partnership vision and objectives seek to improve quality, access to services and value for money. Consequently, the corporate TOM has been designed with focus on customer (patients, staff and partners) and cost (pay and non-pay). The corporate TOM recognises the need for an ambitious level of cost-improvement to direct resources into clinical services.

7.1.3 Corporate TOM design principles

The corporate TOM uses five design principles, developed by the corporate services teams, that align with the Partnership design principles. Each of these is outlined in more detail in Table 7-1.

Table 7-1 Corporate TOM design principles

Design principle	Description
Responsive to customers	• Be clear on who customers are, and what services they are using • New service designs and opportunities should be responsive to these customer needs • Where there are known deficiencies in service levels, these should be addressed as part of the service redesign • The view of service users should inform the design
Technology-enabled	• Opportunities to use technology to increase efficiency are explored, such as automation • Synergies are created by integrating systems and platforms for corporate services, including economies of scale • Synergies are created through shared clinical system functionality • Technology investment is made within agreed parameters
Professional services model where possible	• There should be a focus on value-adding services consistent with the 'professional services' model • Where possible alternative options should be considered for 'routine' or 'transactional' tasks – i.e. through automation or alternative provision
Alternative provision where appropriate	• Opportunities should be assessed to determine which model of provision offers the greatest balance of service and efficiency • One approach should not be assumed more suitable than the other
Cost-releasing and risk managed	• The design of the corporate TOM should deliver reduction in costs • Identifying cost-releasing efficiencies is a priority, but this should be balanced with maintaining service quality • The transition risk and transition cost should be known and manageable

7.2 Overview of the high level corporate TOM

7.2.1 Corporate TOM design components

NHSI recommends assessing corporate services by the level of value they add, grouping these into three categories for high, medium, and low value contribution. This approach has been employed to identify processes which focus more on a professional service or business partnering approach, compared to those which are more transactional in nature and therefore present an opportunity for operational efficiencies. This hierarchy of activity is illustrated in Figure 7.2.

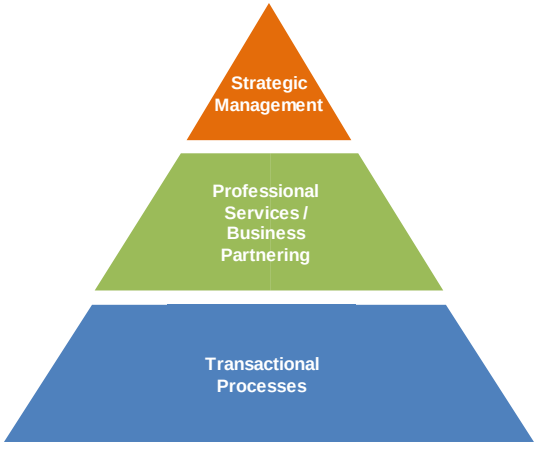


Figure 7.2 Corporate TOM constructs

The corporate TOM will deliver organisational benefits in the following areas:

- Improved service quality to patients and the workforce
- A strengthened financial position through:
    - Attainment of cost efficiencies, by standardisation and alignment of functions and processes, as well as increased economies of scale
    - Income generation opportunities in corporate services
- Improved talent development

The combined organisation will realise these benefits through key initiatives in strategy, structure and operational execution of corporate services. Figure 7.3 shows a high-level summary view of the corporate TOM, indicating how the design elements come together.

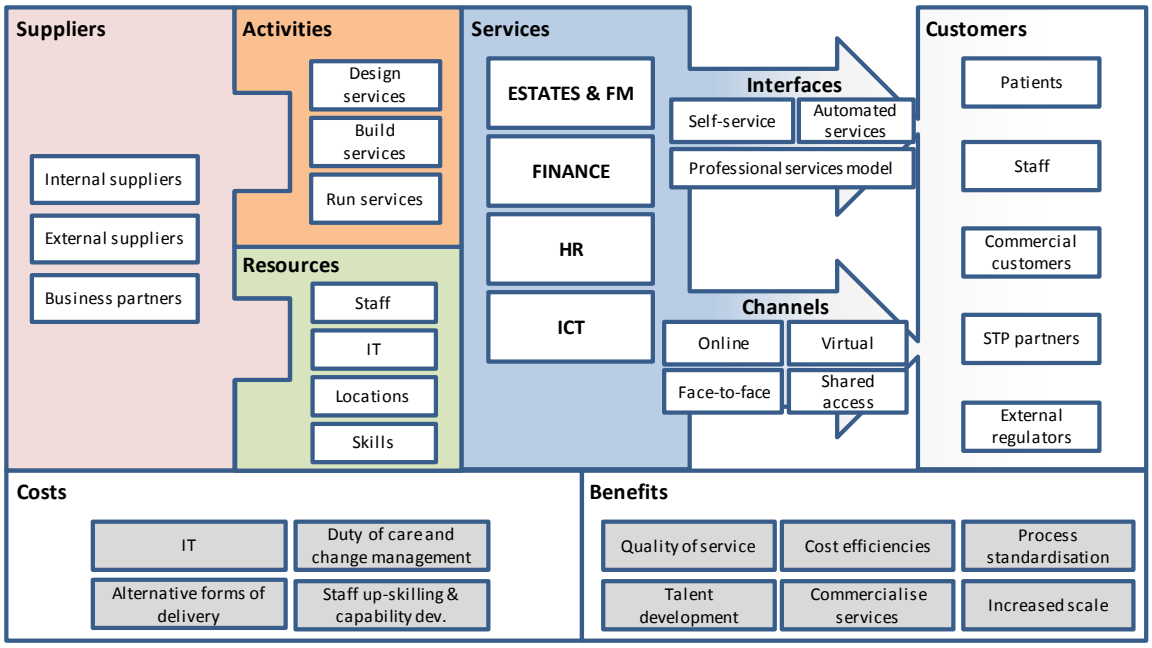


Figure 7.3 Corporate TOM summary

In designing the corporate TOM, the following elements have been considered:

- **Customers:** these include patients, staff, partners and external bodies. The service design and delivery are based on the changing needs and expectations of these different customers. The aim is to deliver improved quality and patient outcomes, support a sustainable, skilled workforce and deliver improved value for money. This will also be achieved by working in conjunction with other partners within the STP and beyond. Some of these changing needs will be met through automation and other technology-based improvements

- **Suppliers, Activities and Resources:** these are the building blocks of the services being provided. They combine to form the sub-functions and processes for each corporate service. As part of the corporate TOM design the combined organisation will:
    - Identify the most efficient (external or internal) suppliers, rationalise these and use the improved negotiating position and economies of scale to deliver cost savings and minimise supply risk exposure
    - Resources (e.g. staff, skills, ICT capability and locations) will be combined where appropriate, enabling cross-cover as needed and enhanced staff development opportunities. Some management roles will be combined to achieve cost efficiencies and higher levels of consistency
    - Activities performed by the corporate services will be harmonised to achieve consistency. Investment in the interfaces and channels below will enable more transactional activities to be automated, releasing capacity which can be used for more value-adding work
- **Interfaces:** these are the way services are performed for customers. These will become more automated and self-service in nature, reducing transactional work and enabling workforce rationalisation over time
- **Channels:** These are routes of communication with customers. These will use technology enabled solutions where possible; this allows for increased flexibility and efficiency of service provision

The corporate TOM will help achieve improved economies of scale in the combined organisation, release costs, and open up the possibility of revenue generating opportunities.

7.2.2 Key benefits of the corporate TOM

This section details how the corporate services will deliver benefits, as summarised in Figure 7.4. The common themes outlined below form the framework of the corporate TOM which will be refined in the FBC phase and will inform the strategic direction of all corporate services.

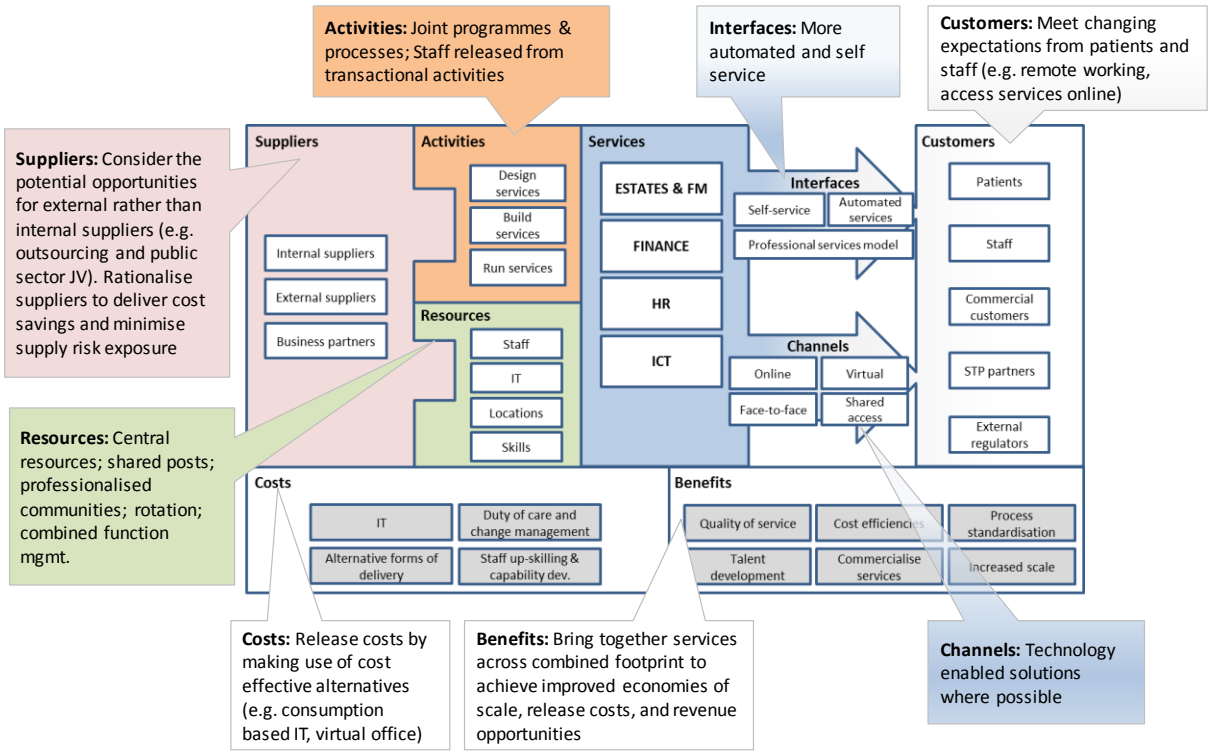


Figure 7.4 Corporate TOM benefits

One corporate service

Across the corporate services, opportunities to align leadership and provide services jointly through combined roles and single service provision have been identified. Services will be unified and integrated across the combined organisation. For example, in Estates and Facilities, critical risk and compliance roles such as fire, emergency planning and local security management, will be combined. The elimination of duplicate roles and provision of a unified service will deliver workforce efficiencies, cost savings and increased consistency in delivery.

Corporate centres of excellence

The establishment of corporate centres of excellence will support the leadership of the combined organisation to establish strategic priorities and objectives. These centres of excellence will set priorities for business partners to deliver this vision working with clinical and support services.

Business partnering

Business partners will be responsible for providing professional support and advice to other teams. They will offer expertise and support development of solutions which are aligned with the combined organisation's strategy. For example, within the HR function, business partners will handle complex employee relations, workforce planning, and organisational change. They will also take an active role in ensuring the corporate TOM is successfully embedded. The implementation of this model will deliver improved consistency in the provision of corporate services throughout the combined organisation.

Self-service

Transactional services will be delivered through a self-service approach wherever practical. This will free up corporate staff to focus on the professional aspects of their work which add greater value,

through the business partnering approach described above. For example, HR will provide a self-service interface which will act as the starting point for contact. This will include an automated self-service help desk solution providing answers to simple questions and routing more complex queries to a call centre agent. These changes will deliver benefit through cost efficiencies and process standardisation.

Digital-enabled future

Other transactional tasks will be automated where possible. The automation of high-volume low-value-added tasks will give staff greater capacity to focus on business partnering and more value-adding activities. The combined organisation will support the shaping of the future workforce by training staff and leaders in digital technologies and processes. It will embed a forward-thinking culture that encourages the use of technology to work efficiently. The combined organisation will also embed technologies such as video conferencing, tele-health, self-care tools, and remote clinical consultations. These approaches will provide both patients and staff with timely access to information by ensuring interoperability between systems and organisations. The technology-enabled approach will deliver higher quality services and improve customer experience as well as workforce and cost efficiencies.

Unified process

Alignment of processes across the combined organisation will reduce inefficiencies which arise from duplication of effort and inconsistent delivery of service. Through standardised systems and processes, the combined organisation can ensure consistent outcomes at a reduced cost.

Examples include the creation of a single finance ledger and the utilisation of a harmonised coding structure. This will enable Finance to deliver consolidated reporting. In HR, by taking a unified approach to talent management, staff will gain access to a greater set of opportunities including the offer of flexible rotations. Likewise, recruitment processes in the combined organisation will have significant economies of scale.

In ICT, a shared front-end to clinical systems will enable a common view of patient information. This will also support work towards the Suffolk and North Essex Health and Social Care Record (a shared health and care record), improving the seamlessness of service delivered.

Joint procurement and supplier rationalisation

Opportunities exist to rationalise suppliers where the two Trusts are currently sourcing the same products or services. The combined organisation will benefit from a stronger negotiating position and greater opportunity to realise economies of scale. The benefits from this approach include cost savings, more consistent delivery of service and, particularly in the case of ICT, a smaller portfolio of systems to manage, support and maintain.

Alternative models of delivery

In carefully selected corporate sub-functions, working with a third-party provider or through an established or newly created public sector joint venture could realise efficiency benefits. These include reduced procurement costs, best practice service provision and the possibility of generating revenue from external sources. At this stage, Estates and Facilities have identified alternative models of delivery as a strategic initiative within their vision for the corporate TOM.

7.3 Financial benefits summary

An initial assessment has been carried out on the financial benefits in the corporate TOM. These are estimated by the corporate services with support from the Trusts' financial modelling teams. These benefits are included in the financial evaluation in Section 8.

The financial benefits are outlined in Table 7-2, grouped by common themes. It is important to note that at the OBC phase the financial benefits identified are at a high level and will be assessed in greater detail at the FBC stage.

Table 7-2 Corporate TOM benefits by year

Common themes All in £m	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Combined corporate function	0.6	1.3	1.6	1.8
Digital enabled future	0.1	0.2	0.8	1.4
Improved operating model	0.1	0.2	0.3	0.3
Joint procurement & rationalisation of suppliers	0.5	0.5	0.7	0.8
Working with Third-party supplier	0.2	0.2	0.2	0.2
Unified process	0.0	0.5	1.0	1.9
Total	**1.4**	**2.9**	**4.6**	**6.5**

The high-level financial benefits were identified through a top-down exercise carried out with the four main corporate services. The full benefits of the corporate TOM will be assessed in greater detail at the FBC stage. It is expected that the benefits will increase on the basis that all corporate services will be in scope and further ambition will be applied to the themes identified above.

Assumptions

The costs/benefits associated with the potential rationalisation of the estate (an initiative explored within the Estates and Facilities function) are not included in the financial summary provided above. This potential scheme will be validated further at the FBC stage. The savings presented above do not include the impact of price inflation, and the values have not been risk adjusted. Operating costs such as duty of care, organisational development, and IT infrastructure, have been included in transition costs and separately delineated in Section 8.4.5 of this document. Additional capital expenditure required to deliver the corporate TOM is included in the overall capital expenditure modelling, detailed in Section 8.4.6.

7.4 Risks to realising the benefits

The successful delivery of the corporate TOM requires the recognition and management of a number of risks. An initial view of these risks and their mitigations is described in Table 7-3; these will be reviewed and managed throughout the FBC phase.

Table 7-3 Corporate TOM risks to realisation of benefits

Category	Risk	Description	Mitigating actions
Financial	Realising benefits from third-party provision arrangement	The option for the most efficient alternative delivery model(s) is still to be fully assessed. There is a risk that benefits to be derived through this model will not be fully realised if a suitable partner is not found and/or if the cost to set-up and operate such a model prove to be cost-prohibitive	Careful planning is recommended to ensure services are scoped correctly, with thorough due diligence carried out on prospective partners
Workforce	Insufficient skills or availability	A lack of staff expertise or the availability of the required resources will impede the combined organisation's ability to deliver a major change programme at the pace required	Manager roles should be reviewed to ensure focus is on management and leadership tasks, with adequate resourcing provided to devolve operational tasks. Additional skill sets and capacity to be brought in as required
Engagement	Lack of staff engagement	A lack of staff engagement with the change programme has potential to adversely affect workforce KPIs causing disruption to change delivery. In particular, there are a number of areas within the corporate services where process automation is being considered which can bring a risk of staff uncertainty if they are not fully involved in opportunities throughout the programme	Culture change associated with self-service and automation should receive adequate funding and be supported by the right messaging from management in conjunction with a wider communication and engagement plan
Operational	Disruption to operational delivery	A focus of resources on change delivery will lead to reduced attention being placed on operational delivery, resulting in disruption to operations	Demands of operational delivery and changes to resource availability should be taken into account when planning the detailed phasing of the initiatives in the FBC stage. Plans and proposals should be peer reviewed and subject to QIA
Operational	Inadequate readiness for change	Insufficient progress in aligning corporate services to the required timeline, and/or failure to provide levels of funding needed to deliver identified change initiatives will result in identified benefits not being fully realised	Sufficient funds and resources should be allocated to confirm readiness; stakeholder engagement should include change support training
Engagement	Insufficient corporate communications	Insufficient levels of high quality centralised communications will impact levels of staff involvement and culture change that are needed for the overall success of the change programme	Timely and effective decision making and communications, as part of a wider change management and communications strategy
Operational	Prioritisation of corporate transformation	Corporate services will not be able to fully support the clinical change programme at the same time as meeting the demands within the corporate transformation programme	Prioritisation of corporate TOM implementation may be required to establish the capacity and technology requirements to support the rest of the change programme

Category	Risk	Description	Mitigating actions
Financial	Quality of business case data	The quality of data input to the FBC will result in reduced levels of realised benefits	Further time and resources to be allocated in the FBC phase to validate assumptions and confirm or refine estimates

8 Financial Case

Section synopsis

- **The financial case demonstrates that full clinical integration delivers the greatest financial benefit. Gross financial savings are £22m before transitional costs and increased capital charges. This is in line with STP assumptions, and includes capital investment of £70m to enhance infrastructure, modernise corporate services, and reduce reliance on expensive temporary staff in the combined organisation's clinical services. The latter will be a recurrent benefit of approximately £10m**

Key Financial Information - all figures show position in-year in 2021/22		
Financial element	Financial baseline (£m)*	Full clinical integration (£m)*
EBITDA	(13.9)	6.5
Capital charges	(30.5)	(39.2)
Recurrent I&E position	(44.5)	(32.7)
Gross financial saving		22.0
Transitional costs		(1.5)
Post EBITDA changes inc capital charges		(8.7)
Net saving		11.8

*Surplus / (Deficit)

- The financial case gives a more detailed analysis of the preferred scenario of full clinical integration. The assumptions for the financial modelling are broadly in line with those made by the STP
- The financial case for full clinical integration is based upon evidence and agreed assumptions available at the time of writing. It is a cautious position, especially for corporate areas, and it is expected that financial improvement will be enhanced at the FBC stage once further analysis has been completed
- The baseline 'do nothing' financial modelling incorporates STP assumptions that demand management and internal efficiencies at IHT and CHUFT will individually deliver 2% cost improvement plans (CIP). The preferred scenario assumes delivery of these CIPs plus the gross benefits of £22m by year five. This means that, at year five, the combined organisation will generate positive earnings before interest, tax, depreciation and amortisation (EBITDA)
- The preferred scenario assumes capital expenditure (capex) in addition to depreciation and pre-committed schemes of approximately £70m over the five years. This will allow for reconfiguration of the combined organisation's facilities to deliver the greatest clinical and financial benefits. It will also allow for the investment needed to modernise corporate services. The capex is assumed to be funded by public dividend capital (PDC). Although the EBITDA is positive, the increased capital charges for full clinical integration result in a deficit at year five
- As local providers and commissioners come together to manage the collective resources available for NHS services for their local population, it is anticipated that the combined organisation will meet its control total in line with STP expectations

8.1 Overarching assumptions and principles

A detailed review of historic finances for the two trusts was the starting point for the development of a financial baseline from which projected financials were estimated for each of the given scenarios.

To ensure consistency of approach, the assumptions underpinning the programme of work and modelling related to the STP plans have been used to develop and assess scenarios where appropriate. The detail of these assumptions can be found in Appendix G, but are summarised in Table 8-1.

Table 8-1 Overarching assumptions

Assumption	Comment
Patient contacts	Underlying growth in patient contacts, driven by demographic change, is based on Indicative Hospital Activity Model (IHAM) projections, aligned to the STP plan. Also considered are activity reductions related to demand management schemes proposed by the STP plan
National tariff and efficiency requirement	NHSI published cost inflation and efficiency requirements (see Appendix G), which then allow expected changes in tariff inflation to be derived, have been used. NHSI advised that Trusts should assume efficiency requirements of 2% for the purposes of long-term modelling
Cost inflation and CNST	The only change to the generic NHSI cost inflation assumptions is a further uplift for clinical negligence costs (CNST) as included in the STP plan
Cost improvement programme targets	All models assume that recurrent CIPs targets will be realised in each year, and that the total efficiency to be delivered is the 2% expected national requirement
Sustainability and transformation funding (STF)	For a combined organisation, STF is assumed to be combined and remain at the same level that each Trust has been individually advised. Although arrangements beyond 2018/19 are not confirmed it is assumed that funding will continue
Commissioner impact of additional activity	Income beyond the baseline activity assumptions is not an additional cost to commissioners. It is assumed to come from repatriation of activity currently undertaken in settings outside of the Trusts
Expenditure changes	Only material changes[37] to expenditure (increases or reductions) have been modelled, including those costs incurred to enable the corporate TOM and relevant clinical strategy. Small value efficiency schemes have been assumed to help deliver the inherent savings targets built into tariff

8.2 Historical financial performance

The baseline for the financial evaluation is the 'do nothing' scenario. This assumes that both Trusts continue with their current structures and do not share any clinical or corporate efficiencies. To help explain the respective position of each organisation their historical income and expenditure (I&E) performance is detailed in Table 8-2 and Table 8-3.

[37] Material changes are defined as a financial movement exceeding £100k

Table 8-2 Historical Trust I&E performance CHUFT

Income and Expenditure All in £m	2014/15 Actual	2015/16 Actual	2016/17 Actual
Income	268.0	269.9	301.6
Operating Expenses	(284.4)	(302.5)	(316.3)
Non-Operating Expenses	(5.9)	(5.6)	(4.3)
Net (Deficit)/Surplus for the year	**(22.3)**	**(38.1)**	**(18.9)**
Control Total issued by NHSI	n/a	n/a	(31.7)

Table 8-3 Historical Trust I&E performance IHT

Income and Expenditure All in £m	2014/15 Actual	2015/16 Actual	2016/17 Actual
Income	250.6	266.3	296.5
Operating Expenses	(256.7)	(283.7)	(314.5)
Non-Operating Expenses	(5.8)	(4.8)	0.5
Net (Deficit)/Surplus for the year	**(11.9)**	**(22.1)**	**(17.6)**
Control Total issued by NHSI	n/a	n/a	(20.1)

Further detail on historical financial performance is shown in Appendix H. This includes past CIP performance and the capital expenditure of both Trusts.

8.3 Baseline position

Baseline forecasts produced for each Trust using the assumptions shown in Table 8-4 in addition to the core assumptions above have been produced. Key assumptions to note are the 2% efficiency achievement each year, and STP demand management assumptions.

Table 8-4 Baseline assumptions

Assumption	Comment
Starting year	The initial year of modelling is 2017/18 and matches planned submissions to NHSI
NHSI control totals	Financial targets (control totals) have been advised by NHSI and agreed by both Boards for 2017/18. These totals have been reflected in the baseline modelling for this year. However, since the targets which have also been notified for 2018/19 are still to be formally agreed, these have not been used and deficits have been projected from 2017/18
Cash	The Trusts will continue to rely on cash funding support from the Department of Health (DH) for the foreseeable future
Financing	Broad assumptions are included for the cost of servicing the Trusts' interim support and other debt. Depreciation has been modelled on the five-year capital plans produced by each organisation
Strategic change and service developments	The impacts from currently known strategic business cases and service developments are included
Service reconfigurations and organisational changes	The modelling does not include any further service reconfigurations or organisational changes other than those already mentioned
Inflation and efficiency	Inflation and efficiency targets are as previously stated in the core assumptions

Assumption	Comment
Workforce	Changes in activity within the LTFMs will adjust workforce costs; these are calculated using average salary costs. However, whilst the financial effect of such changes has been considered, the actual workforce implications have not formed part of the financial analysis.

Further detail on the assumptions is shown in Appendix I.

8.3.1 Income and expenditure

The individual Trust baseline forecasts, along with an aggregated position, are shown in Table 8-5, Table 8-6 and Table 8-7. Further detail is shown in Appendix I.

Table 8-5 I&E summary of future years plan and projections - CHUFT

Income and Expenditure All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Income	291.2	296.0	299.6	305.7	315.0
Operating expenses	(299.1)	(303.0)	(306.9)	(313.0)	(322.4)
EBITDA	**(7.9)**	**(7.0)**	**(7.2)**	**(7.2)**	**(7.4)**
Non-operating expenses	(14.2)	(14.9)	(15.2)	(15.3)	(15.3)
Net (Deficit)/Surplus	**(22.1)**	**(21.9)**	**(22.4)**	**(22.5)**	**(22.7)**

Table 8-6 I&E summary of future years plan and projections - IHT

Income and Expenditure All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Income	292.8	292.9	291.0	290.6	300.1
Operating expenses	(296.6)	(298.7)	(294.5)	(295.9)	(306.7)
EBITDA	**(3.8)**	**(5.8)**	**(3.5)**	**(5.3)**	**(6.6)**
Non-operating expenses	(14.0)	(13.7)	(14.0)	(14.8)	(15.2)
Net (Deficit)/Surplus	**(17.8)**	**(19.5)**	**(17.5)**	**(20.1)**	**(21.8)**

Table 8-7 I&E summary of future years plan and projections - Aggregate

Income and Expenditure All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Income	584.0	588.9	590.6	596.3	615.2
Operating expenses	(595.7)	(601.7)	(601.3)	(608.8)	(629.1)
EBITDA	**(11.7)**	**(12.8)**	**(10.7)**	**(12.5)**	**(13.9)**
Non-operating expenses	(28.2)	(28.6)	(29.2)	(30.1)	(30.5)
Net (Deficit)/Surplus	**(39.9)**	**(41.4)**	**(39.8)**	**(42.5)**	**(44.5)**

8.3.2 Capital expenditure

Capital investment is limited to depreciation and pre-approved externally financed projects; each Trust's current capital plan and aggregated position are shown in Table 8-8, Table 8-9 and Table 8-10. Further detail is shown in Appendix I.

Table 8-8 Forecast of capital investment - CHUFT

Capital All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Capital Investment	15.8	12.3	13.8	10.8	9.9
Total Capital	**15.8**	**12.3**	**13.8**	**10.8**	**9.9**

Table 8-9 Forecast of capital investment - IHT

Capital All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Capital Investment	9.9	9.8	9.6	9.6	9.6
Total Capital	**9.9**	**9.8**	**9.6**	**9.6**	**9.6**

Table 8-10 Forecast of capital investment - Aggregate

Capital All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Capital Investment	25.7	22.1	23.4	20.4	19.5
Total Capital	**25.7**	**22.1**	**23.4**	**20.4**	**19.5**

8.3.3 Conclusions for the baseline forecast

Under the 'do nothing' scenario the overall revenue position of both Trusts worsens over the period of assessment, with each organisation remaining with significant deficit. This is despite the achievement of the expected national 2% efficiency requirement. The total aggregated revenue position goes from a deficit position of (£39.9m) in 2017/18 to a deficit of (£44.5m) by 2021/22, with the 2018/19 position not meeting indicative NHSI control totals notified for that year.

Even to achieve this position, the Trusts will still need to deliver 2% efficiency savings and achieve a net £4.0m saving through STP demand management schemes. This position also assumes that capital will remain constrained and opportunities for the improvement of estate will be limited.

8.4 Modelling the preferred scenario

This section provides an overview of the financial impact of the preferred scenario, full clinical integration. The financial modelling incorporates an assessment of the corporate TOM, and the six strategic themes described in the clinical case. It includes assumptions for cost avoidance, additional income and activity, transition and enabling costs and capital expenditure.

For the delivery of the clinical strategy and corporate TOM, additional income or savings that will result from these changes have been included along with costs that will need to be incurred to enable their achievement (capital or revenue).

8.4.1 Modelling the corporate TOM

A number of savings initiatives were identified for the corporate TOM and were grouped into common themes. The potential financial impact of these has been applied to all corporate areas based on the detailed analysis produced by the four major corporate functions. Costs incurred to deliver these savings have also been factored in (see Section 8.4.5 on transition costs). The anticipated net savings, allowing for the recurrent costs expected by the departments to change to the new models of delivery, are shown in Table 8-11.

Table 8-11 I&E impact of future years projections for corporate TOM by theme

Income and Expenditure	2018/19	2019/20	2020/21	2021/22
All in £m	Projection	Projection	Projection	Projection
Combined corporate function	0.6	1.3	1.6	1.8
Digital enabled future	0.1	0.2	0.8	1.4
Improved operating model	0.1	0.2	0.3	0.3
Joint procurement & rationalisation of suppliers	0.5	0.5	0.7	0.8
Outsourcing	0.2	0.2	0.2	0.2
Unified process	0.0	0.5	1.0	1.9
Total	**1.4**	**2.9**	**4.6**	**6.5**

Detailed efficiency plans for the other corporate functions and administrative areas will be worked up and considered at the FBC phase. Whilst not actually part of the corporate TOM review, partnership working will lead to a single board structure. It is assumed that this will result in a saving of 50% from the current board costs incurred by each individual organisation.

The corporate TOM produces a savings benefit to the I&E position; an expected recurrent annual revenue improvement of £6.5m by 2021/22 prior to the costs required to enable delivery of these schemes.

8.4.2 Modelling the impact of full clinical integration

The six strategic themes described in the clinical case (see Section 6) were assessed to identify the associated financial benefits or costs. The assumptions for modelling the impact of the themes are described in Table 8-12.

Table 8-12 Strategic themes

Strategic theme	Assumptions
Best value for money	A number of specialties described procurement efficiencies as an obvious benefit from the larger buying capability of a combined organisation. The integration of procurement non-pay spend particularly in the medical and surgical portfolio will enable further efficiencies through a product standardisation and rationalisation programme. This will need to be reviewed in the context of existing cost improvement projects but this will be maximised by clinically-led agreement to review the full range of products in use. Changes to the national procurement system (starting in October 2018) may affect the combined organisation's ability to influence price. This was taken into account in the financial modelling. By focussing on high spend specialties, with a key objective of reducing range to maximise volume and pricing and aligning medical equipment replacement programmes, it is considered that the combined organisation could generate additional savings of £400k beyond any national opportunity or 'regular' savings programme.
Right systems and processes	Standardisation and the establishment of common information platforms will lead to quality improvements. However, there is insufficient information presently to allow these to be reliably quantified and therefore they have not been included in the financial evaluation. There may be greater scope to offer more private patient activity. However, this is not currently viewed as a key strategic priority, so no financial impact has been incorporated into any of the scenarios.
Right people, right skills	Significant savings on agency spend are anticipated due to changes to clinical skill mix. This will include the appointment of nurse specialists and physician associates. Enhanced training and increasing sub-specialisation will also contribute. The financial modelling assumes that a third of current agency spend is saved over the period of the OBC (after allowing for the cost of appointing to the required new roles). Based on the current spend of approximately £30m (CHUFT £20m and Ipswich £10m) this equates to ca. £10m recurrently. This has been profiled as 20% deliverable in year 1 (2018/19), 20% in year 2, 40% in year 3 and the final 20% in year 4. There will also be additional training costs to support the new teams and structures. It is assumed that the centralisation of training and utilisation of apprenticeship levy monies will mean that this is cost neutral.
Great quality local services	A number of potential schemes have been identified within this theme, such as the centralisation of services, MDT working opportunities and reconfigured tertiary network links. From a revenue perspective, such schemes are likely to necessitate additional cost and investment as they reflect quality initiatives. However, it is not possible at this stage to reliably estimate such costs and these will need to be considered in the FBC phase. This strategic theme highlighted the areas and schemes where capital expenditure is likely to be incurred.

Strategic theme	Assumptions
24/7 resilience	Capacity smoothing will be possible between the two fully integrated clinical teams. This will enable the combined organisation to significantly reduce outsourcing with only marginal additional non-pay costs incurred to undertake this work. Income is assumed to be neutral (both Trusts are already receiving the income) and pay costs absorbed. This does not include existing strategic partnerships with third party providers. This has been profiled as 20% deliverable in year 1 (2018/19), 20% in year 2, 40% in year 3 and the final 20% in year 4. Seven-day service requirements were reviewed. This is an overarching ambition of the NHS; it has been assumed that this would affect all models equally and so has been excluded on that basis. Rota reviews and changes were considered. There is insufficient information to model this impact and this will be explored further in the FBC phase. In all scenarios, it is assumed that additional activity and income is matched by equivalent cost.
Right care in the right place	By aligning pathways, along with skill mix enhancements and investment, capacity will be available to repatriate activity currently performed by other providers (NHS or private) therefore generating additional revenue. An assessment of the potential activity has been included. Work with other healthcare providers (such as primary and community care) is recognised as an opportunity for acute providers to engage in preventative measures that limit the demand placed on them. Such integrated approaches already form the basis of the regional STP plan and is therefore considered to apply to all options.

Summary tables of the I&E impact by year for each of the strategic themes are shown in Table 8-13.

Table 8-13 I&E impact of clinical strategies - full clinical integration

Income and Expenditure All in £m	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Recruitment and Retention	2.0	4.0	8.0	10.0
Centres of Excellence	0.0	0.0	0.0	0.0
Resilience	0.4	0.7	1.5	1.9
Economies of Scale	0.4	0.4	0.4	0.4
Pathways	0.0	0.1	0.1	0.1
Cross cutting opportunities	0.0	0.0	0.0	0.0
Total	**2.8**	**5.2**	**10.0**	**12.4**

8.4.3 Cost avoidance

Cost avoidance schemes identified have been reflected in the clinical integration or corporate TOM modelling where explicitly detailed. National developments such as seven-day working are not sufficiently defined to be built into the base model.

Further schemes would be expected to develop through the FBC phase and then be included when the detail is known.

8.4.4 Additional income

Additional income arises from the repatriation of clinical activity from either outside the area or other providers. It has been assumed that full clinical integration will create additional flexibility that enables more activity to be performed than in the other scenarios. Through this, clinical teams have proposed that it would be possible for activity currently sent to other providers to be repatriated.

The opportunity to undertake additional patient choice or private patient activity will be considered in the FBC phase.

8.4.5 Transition costs

Transition costs are primarily linked to investment in automation or the redeployment of staff to support transition arrangements on a time-limited basis. Enabling costs in IT have also been incorporated. These have been included in all scenarios apart from 'do nothing'.

To support the delivery of two fully clinically integrated hospitals, transport links and provision for staff flexibility between sites is a key consideration. Additional costs incurred by staff travelling between sites have been included for the some and full clinical integration scenarios.

A summary of the transition costs for each scenario is shown in Table 8-14.

Table 8-14 I&E impact of transition costs - full clinical integration

Income and Expenditure All in £m	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Transport	(0.4)	(0.8)	(0.8)	(0.8)
Transition Costs – General	(0.8)	(0.8)	0.0	0.0
Transition Costs – IT	(0.5)	(0.6)	(0.6)	(0.4)
Transition Costs – Finance	(0.2)	(0.3)	(0.2)	(0.3)
Transition Costs – HR	(0.3)	(0.3)	0.0	0.0
Duty Of Care	(0.3)	(0.3)	0.0	0.0
Total	**(2.3)**	**(2.9)**	**(1.5)**	**(1.5)**

8.4.6 Capital

The work by specialties on clinical integration has highlighted significant capital investment as a key enabler of change. A number of potential schemes have been proposed, and these will be considered in more detail in the FBC phase. Capital expenditure is therefore based on high level assumptions for the OBC phase.

An initial application has been made for capital funding for approximately £70m to support estates reconfiguration for clinical and corporate integration. A total anticipated capital spend consistent with this application is assumed.

Table 8-15 Capital expenditure and associated revenue impact – full clinical integration

Expenditure Type (£m)	2018/19	2019/20	2020/21	2021/22
Capital expenditure – Total	**(4.0)**	**(14.0)**	**(22.0)**	**(29.3)**
I&E expenditure – Capital charges	(0.1)	(0.2)	(0.5)	(1.7)
I&E expenditure – Depreciation	(0.1)	(0.8)	(2.5)	(5.6)
I&E expenditure – Total	**(0.2)**	**(1.1)**	**(3.0)**	**(7.3)**

8.5 Cash requirements

Table 8-16 highlights the cash impact and requirements for the full clinical integration scenario.

Table 8-16 Cash requirements

	2017/18	2018/19	2019/20	2020/21	2021/22
Opening cash balance	**6,113**	**3,694**	**4,043**	**4,072**	**4,029**
Operating cash flows before movements in working capital	(12,425)	(10,335)	(4,083)	2,639	6,338
Increase/(decrease) in working capital	584	(2,714)	(467)	(4,775)	465
Net cash inflow/(outflow) from operating activities	(11,841)	(13,049)	(4,550)	(2,136)	6,804
Net cash inflow/(outflow) from investing activities	(24,987)	(26,821)	(39,558)	(46,332)	(54,982)
CF before Financing	**(36,828)**	**(39,870)**	**(44,108)**	**(48,468)**	**(48,178)**
Financing					
Public Dividend Capital received	0	4,000	14,000	22,000	29,258
Public Dividend Capital repaid	0	0	0	0	0
Dividends paid	(4,014)	(3,758)	(4,106)	(4,744)	(6,381)
Interest (paid) on loans and leases	(2,963)	(3,721)	(4,357)	(5,145)	(5,606)
Interest element of PFI Unitary Charge	(1,538)	(1,563)	(1,669)	(1,669)	(1,669)
Interest received on cash and cash equivalents	184	223	241	100	100
Drawdown and repayment of loans and leases	42,739	45,037	40,028	37,883	32,491
Movement in Other grants/Capital received	0	0	0	0	0
Net cash inflow/(outflow) from financing	**34,409**	**40,218**	**44,137**	**48,426**	**48,193**
Net cash (outflow) / inflow	**(2,419)**	**349**	**28**	**(42)**	**15**
Closing cash balance	**3,694**	**4,043**	**4,072**	**4,029**	**4,045**

The key points to note are:

- It is assumed that capital funding is via Public Dividend Capital as opposed to capital interim loans

- Deficit positions are assumed to be funded by cash loans from the Department of Health to maintain appropriate working capital. The expectation is that this funding will be agreed from local sources once the STP position is finalised
- As operating cash flows and EBITDA improve, the level of loans that need to be drawn down reduces
- It is recognised that working capital is currently modelled to fluctuate across the period of assessment. Ideally, working capital levels will be held at relatively stable levels and this will be explored in the FBC

8.6 Sensitivity analysis

Sensitivity analysis was undertaken for the full clinical integration scenario to assess the level of risk and opportunity that changes to underlying assumptions would present. Only those factors that impact on the delivery of the scenario were considered:

- Costs and savings to deliver the corporate TOM
- Costs and savings to deliver full clinical integration
- Transition costs

8.6.1 Corporate TOM sensitivity analysis

The corporate TOM has an assumed level of savings building up to £6.5m in 2021/22. The initiatives could fail to deliver, or slip in timeframe adding further costs. Conversely there is an opportunity for these to deliver additional savings above the themes that were identified.

Due to the process of developing the corporate initiatives and the level of detail supporting the plans that have been produced, there is not expected to be a major risk of deviation from the opportunities that have already been identified. The scenario was therefore tested to assess the impact of 25% over-delivery of savings and 25% under-delivery.

Relative to the base value of (£32.7m) deficit in 2021/22, the range of outcomes of testing for the Corporate TOM is (£30.8m) upside – (£34.5m) downside.

8.6.2 Full clinical integration sensitivity analysis

Full clinical integration has an assumed level of savings of £12.4m in 2021/22. These may not deliver the expected staffing efficiencies due to the inability to hire or train staff, which is a current issue with the clinical workforce.

Although the clinical workshops and reviews identified a number of ideas from which it has been possible to derive the strategic themes associated with the clinical vision, there is insufficient detail to quantify them. A top-down approach was used to derive the potential financial consequences of these changes. This approach has a higher level of risk and the scenario was therefore tested to assess the impact of 50% over-delivery of savings associated with clinical integration and 50% under-delivery.

Relative to the base value of (£32.7m) deficit in 2021/22, the range of outcomes of testing for clinical savings is (£25.8m) upside – (£39.6m) downside.

8.6.3 Transition cost sensitivity analysis

Finally, transition costs could increase if there was a delay in decision making or implementation of the plans. These are currently estimated at £1.5m for 2021/22 in the full clinical integration scenario. Equally the transition costs could significantly reduce, for example if the future cost of technology reduces as it becomes more widely used.

Relative to the base value of (£32.7m) deficit in 2021/22, the range of outcomes of testing for transition costs is (£31.8m) upside – (£33.6m) downside.

8.6.4 Sensitivity analysis conclusion

The largest risk can be seen on the clinical strategy, and during the FBC period this strategy will need to be refined further and plans developed to mitigate and minimise this exposure. However, even if all three risks were to materialise, the testing has shown that full clinical integration would have a deficit position of (£42.3m) which is still better than the 'do nothing' scenario.

9 Workforce case and staff benefits

Section synopsis

- **The preferred scenario of full clinical integration will deliver benefits to staff and will be underpinned by a refreshed workforce strategy and organisational development approach. The latter will support the establishment of a single culture for the combined organisation**
- Staff benefits include: greater access to education; training and development opportunities; improved career pathways; and increased organisational resilience. These benefits are derived from the clinical case and corporate TOM. These benefits will be harnessed to make the combined organisation an attractive employer
- A workforce strategy for the combined organisation will be developed during the FBC phase. This will ensure that the right people with the right skills are in place to deliver the ambition and objectives of the Partnership. In particular, there is a commitment to implementing meaningful training and development programmes that equip staff with the skills that they need now and in the future
- Cultural alignment is highlighted by NHSI as a critical success factor in organisations coming together. Although there are similarities in the cultures at both CHUFT and IHT, there are also recognisable differences. Work will be undertaken during the FBC phase to understand these existing cultures in more detail and develop plans to move to a combined organisation with a single culture
- An organisational development plan will be created during the FBC phase. This will contain a number of initiatives to support the development of a strong, patient-focused culture for the combined organisation
- Both Trusts bring elements of best practice. Therefore, the emphasis and approach to transition will be based on the principle of bringing two equal organisations together
- Implementation planning for staff moving into the combined organisation will be developed in the FBC phase. These will ensure that disruption is minimised and that business continues as usual during the changes to the organisational form. Early opportunities to harmonise policies and procedures and terms and conditions will be identified in preparation for the combined organisation

9.1 Benefits to the workforce

The Partnership will result in a range of benefits for both the current workforce within the Trusts as well as for the future workforce of the combined organisation. This assumption has been tested throughout the development of the clinical case and the corporate TOM.

9.1.1 Summary of benefits

Identified workforce benefits include:

- Offering staff a viable future: the Partnership will be able to meet the personal and professional ambition of staff within a single organisation that has greater scale to create alternative roles and career pathways
- Right people, right skills: improved workforce resilience will be achieved through a unified approach to recruitment and retention of clinical and non-clinical staff. This will enable the development of the required skills mix and capacity to support sustainable services and, as a result, reduce reliance on agency and temporary staff
- Enhanced peer review and professional support: combined teams will be able to increase learning and the spread of best practice and innovation
- Greater use of technology and automation: reducing the administrative and transactional activity burden, especially on clinical staff, will allow them to focus on using their skills for more value-adding tasks that improve patient care and experience
- Better career progression: increased emergent talent, paired with targeted leadership development, will ensure succession planning from a 'home grown' pool of staff

This is not an exhaustive list, but provides an overview of the types of benefits that will be delivered for staff within the combined organisation.

9.2 Workforce strategy

9.2.1 Overview of the current workforce

Together CHUFT and IHT employ over 8,000 individuals; this workforce will form the basis of the combined organisation. An overview of staff numbers is shown in Table 9-1.

Table 9-1 Workforce by Trust headcount and WTE, as at 30 June 2017

	CHUFT		IHT	
	Headcount	WTE	Headcount	WTE
Medical & Dental				
Consultants	217	191.33	223	207.75
Junior & other grades	357	248.76	276	262.27
Nursing & Midwifery				
Registered	1,331	1,126.47	1,349	1,136.59
Not Registered	616	495.98	636	527.8
Allied Health Professionals				
Registered	292	224.05	290	232.87
Not Registered	92	62.9	108	81.28
Scientific & Professional	611	509.74	260	221.25
Admin & Clerical	1,006	774.24	981	827.35
Board & Senior managerial	47	37.84	51	50.37
Other Staff Groups	392	308.26	156	148.61
Total	**4,961**	**3,979.57**	**4,330**	**3,696.14**

9.2.2 Developing a workforce strategy for the new organisation

IHT has recently undertaken a programme of work to refresh and renew the Trust's People, Organisation and Development (POD) strategy. This refreshed strategy and delivery plan will feed

into and inform the workforce strategy for the combined organisation, which will one of the key work streams of the FBC phase.

The workforce strategy will set out the combined organisation's commitment to training and development of its workforce. This will seek to ensure that staff have the required skills in both the short- and long-term. As the different elements of the clinical and corporate model are implemented this offer will evolve to ensure that it remains relevant to the staff of the combined organisation.

9.2.3 Implementation planning

Irrespective of the form of the transaction, it is recognised that both Trusts bring elements of best practice. Therefore, throughout the transition the emphasis and approach will be based on the principle of bringing two equal organisations together.

Transition of staff into the combined organisation

Clear and open engagement with all stakeholders (see Section 11) has been a principle of the Partnership programme. This includes staff reference groups and discussion of the Partnership as a regular agenda item at staff partnership forums (including staff representatives). This work will be extended for the FBC phase, as transition planning is undertaken.

Implementation planning will be based on the principles of open and transparent engagement with strong governance and leadership. This will ensure the continuity of operations and delivery of services during the transition. The workforce transition to the combined organisation will operate within the bounds of the process defined by the legal form of the transaction.

Employment policies and procedures and terms and conditions

Both Trusts are undertaking a review of core employment policies and procedures. This aims to identify those that can be aligned to ensure a smooth transition to the combined organisation. It will also identify policies where further work will be required to move to one set of policies.

In addition, a detailed review of the terms and conditions of service embodied within contracts of employment will be undertaken to identify differences between equivalent roles and, where relevant, to enable the reconciliation of these differences. This work will be completed working in partnership with staff representatives.

Transition metrics and controls

The importance of maintaining 'business as usual' across the entire organisation during transition is recognised. Implementation planning will be undertaken in the FBC phase, and is likely to include:

- Recruitment and selection of staff
- Identification of new opportunities within the combined organisation
- Retaining key skills and talent
- Minimising redundancies and associated costs

9.3 Organisational development plan

9.3.1 Introduction

Enabling an effective transition and transformation to a combined organisation is essential. The operating structure and culture of the combined organisation are fundamental components of this.

Developing the new culture will be based on understanding the motivations and ambitions of staff. The approach to organisational development will be built on role modelling, clear communication and engagement.

9.3.2 Leadership principles

The emerging culture of an organisation is shaped by interactions by every leader at every level. The combined organisation will require strong and effective leadership that builds on the best from both Trusts.

To successfully deliver the size and scale of change required, the combined organisation will adopt the principles of collective leadership[38]. Where leaders create a positive, supportive, performance-led environment for staff, those staff will then in turn create caring, supportive environments for patients which will deliver higher quality care:

> *"Collective leadership means everyone taking responsibility for the success of the organisation as a whole … characterised by staff focusing on continual learning and through this on the improvement of patient care."*[39]

9.3.3 Cultural alignment

Cultural alignment is highlighted by NHSI as a critical success factor in organisations coming together[40]. Although there are similarities in the cultures at both CHUFT and IHT, there are also recognisable differences.

Approach to cultural alignment during the development of the OBC

Initial scoping of the requirements for a cultural alignment programme of work has been completed. This considered the key activities that would make up the cultural assessment, as shown in Figure 9.1.

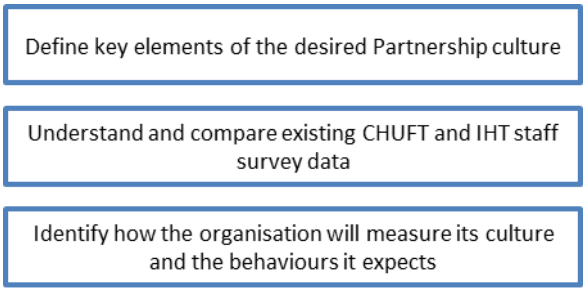


Figure 9.1 Key activities scoped for the cultural assessment

Considerable engagement is required from both Trusts, in particular executive sponsorship and leadership from the outset.

Future plans for cultural development

Work will be undertaken as part of the FBC phase to understand these cultures in more detail and ensure that the transition to the combined organisation is a success. This work will align with the key activities shown above. Crucially, future plans will include the design and implementation of

[38] *Developing Collective Leadership for Healthcare*, West M, Eckert R, Steward K & Pasmore W, Kings Fund (2014)
[39] Ibid.
[40] *Making mergers work: factors affecting the success of NHS mergers*, NHS Improvement May (2016)

interventions to achieve and embed the desired culture. These strategic interventions will form the basis of the organisational development plan.

Although there are likely to be differences between the two sites, the shared culture will be part of what binds the combined organisation together. This will support the consistent delivery of high quality services, both clinical and corporate, and is a key enabler to delivering the ambition of the Partnership.

9.3.4 Values and behaviours

A new set of values and expected behaviours will be developed for the combined organisation. These will be an enabler for embedding the desired culture. They will describe how all staff will work together to ensure that the combined organisation delivers high quality, patient-focused, efficient and consistent service.

10 Programme governance, timelines and risks

Section synopsis

- **The OBC phase, including the development of the draft clinical strategy and corporate TOM, has been underpinned by robust programme governance with the identification and management of risks, and developed plans for future phases of work**
- The Partnership between CHUFT and IHT has been developed within a jointly agreed programme governance framework that is accountable to both Trust Boards. The work to develop the three-stage Business Case has been overseen by this governance framework
- The Trusts are developing plans for the FBC and Implementation Plan (IP) phase of work, with wide stakeholder engagement, including regulatory authorities
- The Partnership has carried out a high level due diligence exercise for both Trusts in the OBC phase, across a number of areas. This exercise did not uncover any new areas of risk that were new to the Board of either organisation
- Risks to delivering the Partnership vision and objectives have been identified, controlled and mitigated within the agreed governance structure. Risk management and control will continue to be maintained throughout the FBC phase
- The risks of adverse impact on either the quality of services or the equality of access to services of any future changes in the ways services are delivered will be assessed using established Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) methodologies. The QIA and EIA process will be shared with the Partnership's engagement groups throughout the FBC phase

10.1 Programme overview

This programme of work is to develop the preferred scenario for the combined organisation form for the Partnership and to produce the supporting business case through all its stages.

10.2 Programme governance

The programme governance arrangements to develop the OBC have been designed to ensure robust internal governance and accountability to both Trust Boards, supported by appropriate engagement with patients and carers, staff, clinicians, commissioners and wider stakeholders. The governance arrangements are shown in Figure 10.1.

It is proposed that in developing the governance arrangements for the FBC phase of work, the Trusts will continue to work broadly within the current governance framework; this may need to be adjusted as required to address emerging issues as work on the FBC progresses.

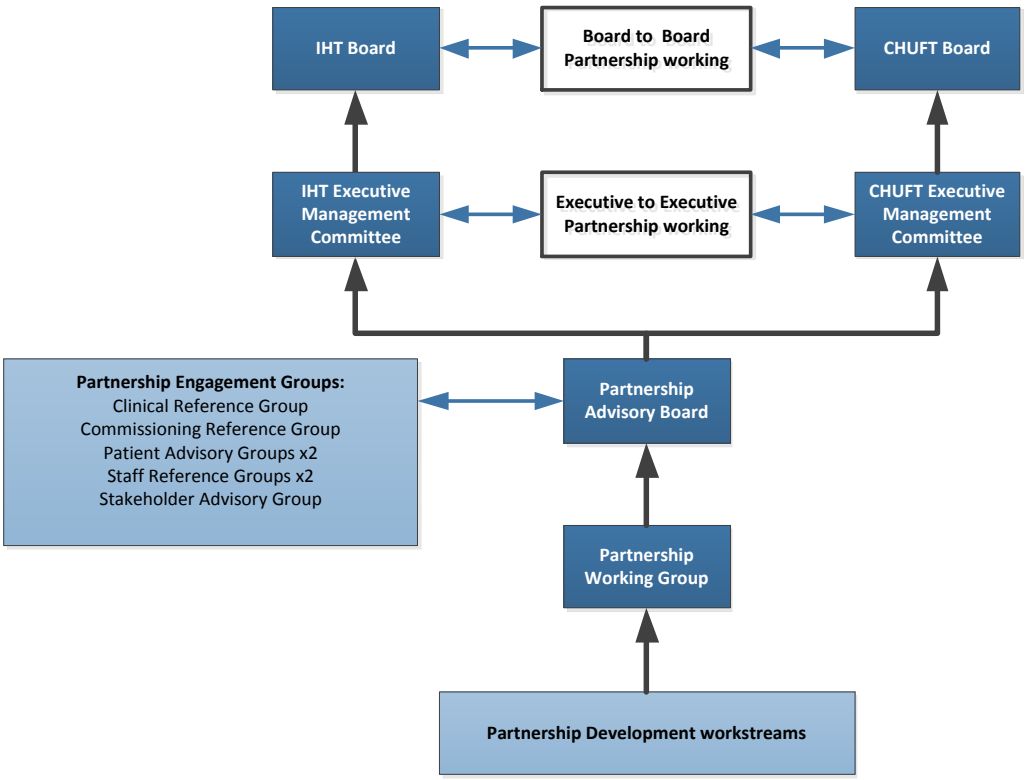


Figure 10.1 Programme governance structure

10.2.1 Roles and responsibilities within the governance structure

Trust Boards

The Trust Board is the body responsible for the management and governance in both an NHS Trust[41] and an NHS Foundation Trust[42]. The Trust Boards of CHUFT and IHT have led the process of partnership and have set the overall direction under which the business case has been developed.

The Boards have met informally on a number of occasions since the commitment to the Partnership to develop shared understanding of the challenges facing both Trusts and a wider strategic view on potential arrangements.

The Boards are individually responsible for considering and if supportive, approving, the business case.

Executive management committees of both Trusts

The day-to-day responsibility for the management and leadership of each Trust is vested in the chief executive and a team of executive directors. Executive directors together with senior clinical and operational leaders (divisional directors and heads of operations) meet formally as the executive management committee (EMC) of the Trust. The EMC structural model is mirrored in both Trusts and the EMCs of each Trust report formally to their respective Trust Boards.

Executive directors from CHUFT and IHT meet together frequently in briefing and discussion sessions to help shape the Partnership's ambition and emerging models of working.

[41] Established under the *National Health Service and Community Care Act 1990* (as amended)
[42] Established under the *Health and Social Care (Community Health and Standards) Act 2003* (as amended)

Partnership advisory board

The partnership advisory board (PAB) was established by the Trust Boards to support the Trusts in developing the Partnership. It is made up of executive and non-executive directors of both Boards. PAB reports to both Trust EMCs. PAB meets monthly and has four main aims:

1. Developing a framework for the Partnership
2. Supporting progress towards optimising the Partnership in a safe and timely way
3. Overseeing and co-ordinating Partnership plans and activity to keep the Trust Boards and executives aware of progress
4. Agreeing recommendations to the Trust Boards on issues that have an impact on the Partnership

Partnership working group

The partnership working group (PWG) includes directors, clinical leaders and senior managers from CHUFT and IHT together with external support. PWG meets weekly and has six aims:

1. Develop, present for approval and communicate a vision for the Trusts over the next six months to three years
2. Track, co-ordinate and communicate integration plans and activity to keep the Trust Boards and Executives abreast of progress
3. Create a framework for collaboration to allow services and departments to progress their own integration within a framework and towards the vision
4. Provide advice to executives, specialties and departments
5. Encourage integration efforts where these are slower than anticipated
6. Prioritise and manage a programme of more complex integration projects

PWG outputs, subject to regulatory approval, include supporting the Partnership by:

- Developing the vision for integration
- Overseeing the Partnership communication plan and materials
- Supporting managers in both Trusts
- Providing progress update reports for the PAB
- Ensuring appropriate programme plan and project documents (including the SOC, OBC and FBC) are produced as required

Reference and advisory groups

The programme is supported by a number of reference and advisory groups established to ensure broad engagement in discussions regarding the development of the Partnership. The outcomes of the group deliberations are considered by the PAB. Details of these groups are shown in Section 11.3.

10.3 Developing the full business case

10.3.1 Plan to approval

The next stage of the Partnership programme will follow approval of the OBC by the Boards of both Trusts and NHSI.

Following this approval, the Trusts with support from NHSI, will consider formal notification to the CMA. The decision and timing will be agreed via further discussions with NHSI and the Trusts' legal and competition advisors. This may initiate a formal review of the potential impact on competition. As part of this review, the Trusts (with NHSI) would provide advice to the CMA on the patient benefits of the combined organisation.

In parallel, the Trusts' legal advisors, working with CHUFT and IHT Trust Boards, will draft Heads of Terms for the development of a Business Transfer Agreement (BTA) which will set out the nature of the transaction, the combined organisational form, details of assets, liabilities and staff to transfer and a proposed constitution for the combined organisation. This will reflect proposed changes to the membership, governors, Board and governance structures for the combined organisation.

Once a robust draft of the FBC is developed, a due diligence exercise to assure the Trust Boards and the regulatory bodies, will be completed. The issues identified during the due diligence exercise will be reflected in the final FBC and implementation planning.

Further Trust Board decision points are:

- FBC Approval
- Reporting accountant opinion (each of the statements and supporting Board memoranda or plans will be the subject of a review by an independent accountant or expert, to be selected and appointed by CHUFT and IHT. On conclusion of their reviews the reporting accountant or expert will issue a report and a formal opinion)
- Board Transaction Approval by both CHUFT and IHT Boards

Following submission of the FBC, NHSI will review the FBC and implementation plan, and issue a transaction risk rating. The Trust Boards will then need to approve the transaction agreement and make the decision to proceed with a transaction. Approval of the CHUFT Council of Governors will also be required. Depending on the statutory route, the Trusts will make the required application to NHSI, who will then make the required statutory orders.

10.3.2 Plan to implementation

Development and approval of the implementation plan (IP) runs in parallel with the plan to FBC approval. This period will commence on anticipated agreement of the final OBC by CHUFT and IHT Boards in early August 2017 and the IP will be completed with the FBC in early 2018.

The detailed IP covers three areas:

- Describes how the combined organisation will work, including the management structure, governance arrangements and the proposed structure of clinical groups
- The project management arrangements for integration and a description of how the IP will be delivered including the governance systems and processes which will be put in place to ensure safe 'day one' operation of the combined organisation and the subsequent integration plans. It will also focus on how the benefits of the Partnership will be measured and delivered
- The programme work streams and implementation plans will document Partnership

objectives, milestones, risks and mitigations as well as all activities to be undertaken before and after the transaction

In order to bring CHUFT and IHT together as a combined organisation there are a number of legal and regulatory processes which are required. These are described below.

10.3.3 Competition

Combining NHS organisations can benefit patients by helping providers improve the efficiency and quality of their services. At the same time, choice and competition also have a role in encouraging providers to deliver better services. The Competition and Markets Authority (CMA) has a statutory role in assessing the competition effects and the benefits of mergers to be taken into account in order to determine what is in the overall best interests of patients.

> *"NHSI (previously Monitor [also comprising NHS Trust Development Authority]) and the CMA work together to ensure that the interests of patients are always at the heart of the merger review process. We want to ensure that the merger review process is well understood and operates as quickly and predictably as possible, both to serve the patient interest and to preserve public resources."*[43]

NHSI provides advice and guidance to Trusts on the regulatory framework governing transactions in the NHS. It also has a statutory role on advising the CMA on patient benefits and any other matters it considers appropriate relating to a merger. NHSI will also be the regulator of any new organisation.

Competition Markets Authority

The CMA is an independent non-ministerial government department with responsibility for carrying out investigations into mergers, markets and the regulated industries and enforcing competition and consumer law. NHS organisational transactions which may impact on patient choice and competition between NHS providers may be subject to review by the CMA.

There are three phases to the CMA evaluation:

- Pre-notification
- Phase 1
- Phase 2 (only required if the evidence supplied at phase 1 is not sufficient to eliminate any competition concerns)

The CMA would consider, as part of pre-notification and Phase 1, whether the impact of reducing competition in the above services, is likely to significantly affect patients.

CHUFT and IHT have already engaged with NHSI's Competition and Co-operation Directorate, and with expert advisers who have been appointed by the Trusts. They will help understand the likely level of interest from CMA in the proposed combined organisation, and provide support to the Trusts in working with the CMA.

In the event of a merger review, the Trusts have an opportunity to provide evidence to the CMA to support the case in terms of patient benefits of the proposed combined organisation, and measures

[43] *Competition review of NHS mergers: A short guide for managers of NHS providers*, Monitor and CMA (2014)

that might be put in place to ensure that patients would not be disadvantaged by a reduction in choice.

Competition - early steps

CHUFT and IHT are working to identify the possible impact for individual services. This is being done in collaboration with NHSI's Competition and Co-operation Directorate.

If the OBC is approved by both CHUFT and IHT Boards, the next step will be to agree with NHSI the approach to competition issues and potential CMA engagement which might lead to phase 1 review.

10.3.4 Confidentiality and information barrier agreement

CHUFT and IHT have taken legal advice on their approach to a possible transaction. This has identified the need for a Confidentiality and Information Barrier Agreement (CIBA) for the duration of the period of working in partnership. The CIBA allows the Trusts to undertake 'business as usual' activities but places restrictions on activities that seek to integrate the Trusts' businesses prior to the transaction. This is necessary to ensure that the Trusts comply with the requirements of the CMA and the legislative framework relating to mergers (and other forms of corporate transactions).

Some commercially sensitive information will need to be shared between CHUFT and IHT in order for due diligence to take place and for the Trusts to take decisions about proceeding with the transaction. The CIBA provides that this information can only be shared with a limited 'clean team' within each Trust. This team is normally made up of individuals who do not have strategic decision-making functions such that they could influence the competitive behaviour of their trust as a result of seeing this commercially sensitive information so the clean team usually excludes directors of strategy and finance. It should be noted that information that is not confidential information can be shared and therefore due to the high levels of transparency in the NHS much of this information will be available in any event.

The Trusts currently have a shared Chief Executive and Chair, as well as other joint appointments. As a result, these individuals will have access to confidential information by virtue of holding these shared positions. This situation is unusual in merger reviews and will need to be managed in line with the requirements of the CIBA.

10.3.5 Due diligence – prior to Board FBC approval and regulatory review

The areas of due diligence (assurance that the FBC is comprehensive and robust and all key risks have been identified and taken into account in the FBC) required as assurance for approval of the FBC by the Boards and progress to regulatory review, are listed below:

- Clinical
- Operational Management (HR, Pensions, IT, Estates and Environmental)
- Financial
- Legal (including Health and Safety)
- Commercial and Contracting

10.3.6 Quality Impact Assessment

A detailed QIA of the preferred scenario will be undertaken during the FBC development, using the process shown in Figure 10.2.

Stage 1	Medical and Nursing Directors of both Trusts will develop the QIA framework for the Partnership
Stage 2	QIA assessment of the preferred scenario to be undertaken by a multidisciplinary clinical team from both organisations, including an assessment of mitigation actions
Stage 3	QIA and mitigation actions reviewed by Reference Groups and commissioners
Stage 4	QIA and mitigation actions reviewed by Partnership Advisory Board
Stage 5	QIA and mitigation actions signed off by both Boards as part of the FBC

Figure 10.2 Stages of the QIA process

10.3.7 Equality Impact Assessment

CHUFT and IHT will engage specialist support to undertake an EIA including a travel impact assessment as part of the development of the FBC. These assessments will be tested with the reference and advisory groups (see Section 11.3) as part of the engagement in developing the FBC.

10.3.8 FBC programme delivery

The oversight of the development of the FBC and detailed implementation plans will be through the PAB. The next stage of the programme will be delivered through a number of work streams that will operate to drive activities within specialist areas. A programme team will be required to develop the FBC and this team will need to be supplemented with additional dedicated resources to deliver the more detailed outputs required.

For example, there will need to be significant focus on staff and public involvement, and an implementation plan developed to cover every corporate and clinical service across CHUFT and IHT, as well as ensuring that the necessary assurance is in place to support regulatory review and approval at each stage. Feedback from other similar NHS transactions is that it is imperative that there is dedicated programme management and implementation planning resource to support this work. The work streams are outlined in Table 10-1.

Table 10-1 FBC development work streams

Area	Work streams
Communications and Stakeholder Management	1. Communications and engagement 2. Impact assessments
HR, OD, clinical and corporate strategies	3. HR & OD strategies/Organisational design/Governance 4. Clinical strategy and integration planning 5. Corporate strategy and integration/transformation planning
Transaction process	6. Programme and project management arrangements and programme governance 7. FBC and IP development 8. Financial analysis (LTFM) 9. Due Diligence 10. Legal services (transaction structure)

Area	Work streams
Regulatory process	11. Reporting Accountant 12. Competition analysis 13. Regulatory engagement (NHSI approvals process)

10.3.9 FBC timeline

The timeline to complete the FBC is subject to a number of factors which cannot be estimated precisely at this stage including regulatory approval processes (NHSI, CMA), the extent of public involvement required and due diligence. However, if no significant delay is encountered, it is anticipated that the transaction would take place in financial Quarter 1 2018.

10.4 Due diligence in the OBC phase

10.4.1 Scope of the OBC phase due diligence

The Partnership has carried out a high level due diligence exercise across both Trusts in the OBC phase, with the expectation that full due diligence will be carried out in the FBC phase. The transactions guidance issued by Monitor (now NHSI) sets out in some detail the requirements for due diligence in the FBC phase. However, for the OBC phase it only states that preliminary, high-level due diligence is required. The scope of the OBC phase due diligence was therefore limited.

10.4.2 Key results from the OBC phase due diligence

The OBC phase due diligence did not expose any risks of which the Boards were unaware. In particular, the clinical and financial information was well known to both Boards. The key areas information arising from the due diligence exercise is summarised in Table 10-2.

Table 10-2 Areas of due diligence

Area of due diligence	Description	CHUFT key messages	IHT key messages
Clinical	• High-level review of potential clinical issues based on current CQC concerns and Board papers	CQC rating (2015): "Inadequate" Mortality indicators May 2017: • HSMR: 112.8 • SHMI 12-months: 108.6 Performance May 2017: • ED 4 hour: 79.9% (95%) • 62-day cancer GP referred: 74.9% (85%) • 62-day cancer screening: 82.6% (90%) • Diagnostics over 6 weeks: 1.7% (1%)	CQC rating (2015): "Good" Mortality indicators May 2017: • HSMR 12-months to Feb 17: 108.7 • SHMI 12-months to Sept 16: 98.3 Performance Apr 2017: • ED 4 hour: 93.6% (95%) • 62-day cancer GP referred: 84.6% (85%) • 62-day cancer screening: 100% (90%) • Diagnostics over 6 weeks: 2.9% (1%)
HR and Pensions	• High-level analysis of HR key performance indicators (KPIs)	• Staff turnover May 2017: 14.7% • Employee related litigation: 11 cases open • Staff survey 2017: bottom quintile • Ongoing employment tribunals: 1 scheduled • Ongoing pension liabilities: none identified	• Staff turnover May 2017: 6.8% • Employee related litigation: 7 • Staff survey 2017: bottom quartile • Ongoing employment tribunals: 1 • Ongoing pension liabilities: none identified
Financial	• High-level financial review	• Financial position 2016/17: Deficit of £18.9m • Run rate 2017/18: For Month 3 the Trust incurred a deficit of £0.5m • Financial plans 2017/18 including status of CIP planning and commissioner contracts: Deficit of £22.1m • Current cash position: At the end of Month 3 the Trust held cash of £14.7m which was higher than plan by £11.3m • 3-year forecast: See Finance Section	• Financial position 2016/17: Deficit of £17.6m • Run rate 2017/18: Month 3 YTD I&E position is £450k adverse against profile. • Financial plans 2017/18 including status of CIP planning and commissioner contracts: Deficit of £17.8m • Current cash position: The Trust Cash balance is £0.3m at the end of Month 3 • 3-year forecast: See Finance Section

Area of due diligence	Description	CHUFT key messages	IHT key messages
Contracts	• High-level review of contracts	Key contracts (over £100k) • NHS North East Essex CCG: £189.9m • NHS England Specialised: £35.8m • NHS Mid Essex CCG: £21.0m • NHSE Local Area Team: £5.7m • NHS Ipswich & East Suffolk CCG: £3.8m • NHS West Suffolk CCG: £1.5m • NHS England Armed Forces: £0.5m • NHS West Essex CCG: £3.8m • NHS Basildon & Brentwood CCG: £0.3m • NHS Castle Point & Rochford CCG: £0.2m	Key contracts (over £100k) • NHS Ipswich & East CCG: £190.0m • NHS England Specialised: £37.1m • NHS North East Essex CCG: £5.4m • NHS England Dental: £3.9m • NHS West Suffolk CCG: £2.8m • NHS England Local Area Team: £1.0m • NHS Great Yarmouth & Waveney CCG: £1.0m • NHS Mid Essex CCG: £0.6m • NHS South Norfolk CCG: £0.4m • NHS England Armed Forces: £0.4m • NHS England Health & Justice: £0.2m
Legal	• High-level review	• None identified	• None identified
Commercial	• High-level overview of the services and geography covered by the trust	• Initial assessment of competition issues undertaken with support from NHSI	• Initial assessment of competition issues undertaken • support from NHSI
Estates	• High-level review	• Backlog maintenance value of works: £49/sq.m • Anticipated capital expenditure: £15.8m • LIFT contracts capital investment: £2.5m • PFI contracts: Nil • Pathology services managing organisation • Privately managed service provision of Diagnostic centre • Disputes: Nil	• Backlog maintenance value of works: £148/sq.m • Anticipated capital expenditure: £11.4m • LIFT contracts: Nil • PFI contracts: A&E building • Pathology services partner organisation • Third party supply of procurement and transactional financial services • Disputes: Nil

Area of due diligence	Description	CHUFT key messages	IHT key messages
IT	• High-level review of core IT systems, both clinical and non-clinical	• Immediate IT problems	• Immediate IT problems

As described in Section 10.3.5, more detailed due diligence will be undertaken during the FBC phase. This exercise will be based on the relevant NHSI guidance, and use a combination of internal and third party due diligence.

10.5 Risks and issues

10.5.1 Programme risks

The risks to achieving a preferred scenario for the Partnership that is jointly agreed by both Trust Boards have been identified, documented, and tracked throughout the development of the OBC. These risks and mitigations have been reviewed by the PWG and the PAB and are reported to the Trust Boards.

Risks have been identified and rated by the programme team assessing the combination of impact and likelihood[44] to arrive at an overall risk score. This approach is consistent with NHS standards. Key programme risks with a combined 'Impact' and 'Likelihood' rating of 15 and above (High or Extreme Risks) are shown in Table 10-3.

Table 10-3 'High' and 'Extreme' rated risks to the delivery of the programme

Risks	Risk Description	Controls & Mitigation
Engagement of Stakeholders	Failure to ensure that all stakeholders (commissioners, partner public bodies and third sector bodies, patients, carers and staff) are engaged and able to influence the development of the partnership, leading to lack of preparedness of stakeholders. Therefore, the business case falls short of the required stakeholder support, creates potential hostility to the proposed partnership arrangement, and the potential for legal challenge, resulting in a failure to obtain regulatory approval to proceed	Engagement of communications consultants to support Detailed Communications Strategy/Plan Professionally supported structure of engagement advisory/reference groups in place Clinical engagement through the Clinical Strategy work Engagement of consultation/engagement consultants to establish a baseline and advise/support programme Check back with commissioners through the reference groups and involvement in clinical strategy Regular contact with NHSI provider appraisal team. Regular dialogue and briefings with Essex and Suffolk HOSCs and HWBs Discussions with other leaders of current or recent change processes – lessons learned Dialogue with CMA, NHSE Regular Exec-to-exec and Board to Board discussions. *In Partnership* Newsletter and communication incl. Q&A document Intranet and microsite development
Financial Costs of Partnership project work	Failure to recognise and provide for the cost of the work to reach a completed FBC will result in an insufficiently prepared case for change resulting in failure to reach approval	Ensure fullest understanding of all costs and contingencies in relation to FBC work Understanding of costs and risks to costs from other similar transactions Secure early NHSI support and approval for costs

[44] Risks are measured using a five by five matrix assessment of Impact and Likelihood; Impact is assessed on the scale: 1 = Negligible, 2 = Minor, 3 = Moderate, 4 = Major, 5 = Catastrophic; Likelihood is assessed on the scale: 1 = rare, 2 = Unlikely, 3 = Possible, 4 = Likely, 5 = Almost Certain

Risks	Risk Description	Controls & Mitigation
Public Involvement	Failure to involve the public in planning during the Partnership business case development process, in accordance with legislation and guidance is likely to lead to legal challenge to the process (judicial review) or referral to the Independent Reconfiguration Panel for the NHS. This may result in failure of the Partnership programme or significant delay and significant costs (c. £300k) to defend these challenges.	Communications consultants engaged to provide support and capacity for public involvement at an early stage A substantial engagement programme with clear identification of stakeholders and required levels of involvement. A series of reference and advisory groups have been established Consultation/engagement consultants engaged early at OBC stage to advise on the future approach to public involvement, undertake a baseline review of work to date Recognised need for a detailed risk management approach for public involvement, to be developed with support from consultation/engagement consultants
Long-Term Sustainability	If we are unable to present a balanced LTFM for the partnership Regulators may not be able to approve the transaction leading to delay or project failure	Work to align the financial strategies of the Trusts that articulate how sustainability can be achieved Early discussion with senior leaders at NHSI regarding their expectations of LFTM and approach to possible transaction
Executive and wider Trust leadership engagement	Failure to gain the commitment (and time) of senior leaders in the Trusts to the partnership work against the pressures of the 'day job' leading to inadequate development of ideas in relation to the clinical strategy, corporate Target Operating Model (TOM) and long-term relationships, resulting in delays and a lack of leadership commitment from both Trusts to the OBC	Strong Chair/CEO leadership of programme. EMCs regular agenda time for Partnership matters. PAB oversight Executive leadership of TOM work and involvement with Clinical Strategy work streams

10.5.2 Partnership risks

This section highlights the key risks to delivering the preferred scenario, focussing on how the identified risks will be managed as the Partnership progresses from OBC to FBC and from FBC to implementation of the preferred scenario through the IP, including risks to delivering its stated benefits.

The top risks to delivering the Partnership, together with the key controls and mitigation are summarised in Table 10-4.

Table 10-4 Partnership risks

Risks	Risk Description	Controls & Mitigation
Organisational Performance	Failure to deliver on key organisational performance targets and high quality accessible care, whilst focussed on developing the formal collaboration arrangements	Established Accountability Framework in both Trusts supported e.g. by Every Patient Every Day Strong and experienced operational delivery teams

Risks	Risk Description	Controls & Mitigation
Partner Support	Failure to secure support of partners in development of the formal collaboration. (Partners include governors, CCGs, STP partners, local MPs, the CQC, local scrutiny committees, trade union representatives and the wider public.)	Programme is under the auspices of the agreed STP framework NHSI & CQC recognition of the partnership model to support CHUFT sustainability. Robust Programme governance with clear roles and mandate for multi-faceted stakeholder engagement (see Chapter 11)
Staff Support	Failure to (a) sustain staffing levels given anxiety that may arise from the potential change of organisational form; and (b) convince staff that the Partnership is in the best interests of future sustainability for both hospitals	Robust Communication Plan including staff briefing and engagement with trade unions focussing on clear messages and support Engagement of staff in developing the clinical strategy and corporate operating model Developing a strong vision for the future organisation and the benefits arising
Delivering Clinical Sustainability	Failure to deliver the clinical benefits identified by teams in developing the clinical strategy	Continued engagement with clinical specialties through the FBC and implementation planning
Delivering Financial Sustainability	Failure, in the FBC, to achieve financial benefits outlined in the SOC and in the OBC	Rigorous risk-assessed evaluation of financial benefits arising from the operating model and clinical strategy Work to align the financial strategies of the two trusts which articulate how sustainability could be achieved Early discussion with senior leaders at NHSI regarding their expectations of LFTM and approach to possible transaction
Delivering the planned Timescale	Failure to achieve FBC and IP deadlines outlined in OBC. This may be due to a number of factors including CMA Phase 2 review, lack of appropriate resources to undertake FBC and IP work, time taken for regulatory approvals, potential for Judicial Review, or referral by HOSC / JHOSC to the Secretary of State	Appointment of specialist technical advisors to support close liaison with NHSI team to ensure appropriate engagement and information sharing with CMA at the right time Budget provision for an appropriately skilled and resourced programme team fit to undertake the requirements of the FBC and IP work
CQC regulatory risks	CHUFT fails to achieve the required level of improvement at the CQC inspection in Summer 2017 to satisfy the requirements to be removed from 'Special Measures' IHT fails to maintain its current 'Good' CQC rating at the CQC inspection in Summer 2017	Robust implementation of Every Patient Every Day programme at CHUFT to deliver sustainable improvement overseen by partners/regulators Robust preparation for CQC inspection at both Trusts

10.5.3 Risk of not proceeding with the Partnership

The long-term risks of not proceeding with the Partnership are similar for both CHUFT and IHT are summarised in Table 10-5, with the likely outcome for the future of acute care locally, and the wider STP system, if the risk materialises.

Table 10-5 Risks of not proceeding with the Partnership

Risks	Risk Description	Likely long-term Outcome
Clinical Sustainability	Short, or longer-term clinical unsustainability of some services at either or both CHUFT and IHT, due to issues with recruitment and retaining specialist staff and an inability to fill rotas and provide safe models of specialty services for patients	Increasing stagnation of services and transfer of activity to sustainable providers at a greater distance for patient travel
Quality variation	Inability to improve quality by reducing variability in patient outcomes and experience	Failure in accreditation of services, patient safety concerns and patient experience. Resulting in diminution of services and regulatory concerns
Financial Sustainability	Inability to improve CHUFT and IT financial positions and deliver CIP targets, not making best use of tax-payers money	Failure to deliver affordable high-quality care within the NHS resources available, resulting in increased regulatory intervention and reduced ability to invest in service transformation and quality improvement
'Isolation'	Inability of either CHUFT or IHT to find another suitable partner to collaborate with due to worsening clinical and financial position and reputation	Progressively unsustainable Trusts will in the longer-term be unattractive for partnering arrangements with successful NHS providers. As a consequence, services will be unsustainable and lost to local provision
Whole system stagnation	Inability to contribute effectively to the STP, both because of the points above and because senior staff within the organisations will need to spend increasing amounts of time managing the worsening internal pressures	The STP will fail to deliver its planned outcomes. The ability to deliver other STP plan components is dependent, in part, on the partnership

Risks in all of the categories above will be reviewed and tracked during the FBC phase. In addition, a further risk assessment will be undertaken related to both regulatory and reputational risks. As plans progress, these will become individual risk categories, as the likely risks and issues become more apparent. At this stage, they have been tracked as part of the Programme and Partnership risks, shown above

11 Communications and engagement

Section synopsis

- **Stakeholder engagement has supported the development of the OBC; the outputs of engagement has been reported through the programme governance and influenced plans**
- A communications and engagement plan was established for the OBC phase and this was shared with key stakeholders including commissioners and the HOSCs for Essex and Suffolk.
- Stakeholders included patients, carers, clinical and non-clinical staff in the hospitals and other NHS organisations, foundation trust governors, local government and other public-sector stakeholders
- Engagement activity used range of approaches including joining existing meetings, reference groups established for the Partnership, newsletters, briefings and responses to enquiries
- Views from the stakeholders were communicated to the PAB, which responded to them
- A number of themes have emerged and actions were taken in response to these. These included implications for patients, carers and staff, travel concerns and the form of a combined organisation
- The engagement plan for the FBC phase will extend the engagement in the OBC phase and will address specific issues arising from stakeholder views

11.1 Background

Following the publication of the SOC in February 2017, a further communications and engagement plan was developed to support the development of the OBC for the Partnership. This communications and engagement plan was developed jointly by CHUFT and IHT and this has been shared with external stakeholders. Its aim is to ensure meaningful engagement with patients, NHS staff, public service partners and the wider public as the Partnership develops. It seeks to ensure that any significant change to the ways in which the Partnership will deliver services is developed with key stakeholders and is responsive to their views and needs.

Engagement activity for the Partnership began in October 2016, though the views of staff and patients and their families have been captured previously as part of routine channels of feedback already in place at both Trusts.

The Partnership is aligned to the engagement work undertaken by the STP.

11.2 Engagement activity and responses

Engagement is the informative and conversational stage during which the NHS gathers information, listens to peoples' ideas and views and uses these to adapt plans for service transformation.

The Partnership has used two main forms of engagement in the OBC phase. These are as follows:

- Engagement with clinical and corporate staff to develop a draft clinical strategy and corporate TOM. This is summarised in Sections 6 and 7
- A targeted programme of communications and engagement activity for other stakeholders. These include staff, patients, carers, and representatives of specific communities. They have been updated on the work of the Partnership and their views captured and fed back to the clinical and executive teams for consideration when developing proposals

The communication and engagement programme for the OBC phase of the Partnership has gathered views from people through a number of activities including:

- 13 stakeholder meetings (including workshops)
- Eight reference and advisory group meetings
- Staff drop-ins and briefing meetings
- Five staff newsletters
- Seven written or verbal responses

11.3 Engagement with stakeholder groups

In order to engage effectively with specific groups of stakeholders, the Partnership has adopted three approaches:

- Joining pre-existing groups to give updates about the Partnership and hear the views of members
- Establishing a number of stakeholder reference and advisory groups specifically for the Partnership. These provide an opportunity for stakeholders to directly influence the process
- Providing regular written or verbal briefings at meetings of other key external stakeholders

11.3.1 Joining pre-existing groups

The Partnership has either formally joined or secured a regular agenda item at meetings of existing groups that engage with key stakeholders (see Table 11-1). These groups include patients, carers, external health organisations (NHS and voluntary sector), staff and trade union representatives as well as local authority representation. Briefings and updates about the progress of the Partnership were provided and questions from groups' members answered. Ideas, thoughts or concerns raised in these meetings have been communicated in writing to the PAB for consideration. Joint meetings of some groups have been held to discuss common opportunities and challenges.

Table 11-1 Pre-existing groups involved in Partnership Engagement

Group	Membership	Contribution
Colchester Hospital University NHS Foundation Trust Council of Governors	The Council of Governors includes elected public governors, elected staff governors, and nominated stakeholder governors from within the community	Under the Foundation Trust Constitution, the Council of Governors works closely with the Trust Board to influence decision-making and strategic planning. The Council influences and signs off strategies while monitoring performance and holding the Trust Board to account
Ipswich Hospital User Group	Membership includes representatives of patients, carers and external health organisations, as well as senior trust staff and board members	The group's key responsibilities are: • To maintain an overview of patient and public involvement in the Trust • To contribute towards the development of Trust policies and procedures that affect patients and public • To work with the Trust in seeking views from patients and the public and in developing links with patient/public/community groups
Colchester Hospital University NHS Foundation Trust (i) Staff Partnership Forum and (ii) Joint Local Negotiating Committee **Ipswich Hospital NHS Trust Joint Consultative & Negotiation Group**	Members of these groups are accredited staff trade union representatives acting for and on behalf of colleagues	• To represent the employment interests of groups of staff or individual employees • To consider the operational and strategic plans of the Trusts and any impact this may have on the jobs and roles of employees

11.3.2 Establishing stakeholder reference and advisory groups

A number of Partnership advisory and reference groups were established, as shown in Table 11-2.

The purpose of the groups is to involve key stakeholders including patients, staff and local organisations involved in health and social care. This includes providing information about the Partnership and giving the opportunity to influence its direction, development and potential scenarios for change through the Partnership process.

The groups offered views and suggestions on appropriate and effective communications and engagement activities for patients and the public. They also advised on any additional groups, including those with protected characteristics, who should be engaged in the process.

These groups included staff representatives from the CHUFT and IHT (including clinical, non-clinical and senior management), representatives of communities of interest and place, and key partners in health, local government and social care from across Suffolk and North East Essex.

Table 11-2 Reference and advisory groups established to support Partnership engagement

Group	Membership	Contribution
Colchester Patient & Carer Advisory Group **Ipswich Patient & Carer Advisory Group**	These groups include representatives of community interest and place from across North East Essex and Ipswich & East Suffolk Members have expertise and knowledge of organisations involved with patients, carers and service users	Offers views and advice on: • Potential implications and impacts of scenarios for change on patients, service users and carers • What values should underpin the planning of specific service changes (e.g. best use of skills; time and money; highest quality medical skills and technical expertise) • Appropriate and effective communication and engagement activities for patients and the public as the Partnership progresses • Which seldom-heard groups should be consulted and what forms of engagement would be most appropriate for these groups
Colchester Hospitals Staff Reference Group **Ipswich Hospital Staff Reference Group**	These groups include representatives of staff from across the respective Trusts	Offers views and advice on: • Appropriate and effective communication and engagement activities for staff as the Partnership progresses • The language, tone and style of communication materials including, for example, the *In Partnership* staff e-newsletter • What values should underpin the planning of specific service changes (e.g. best use of skills; time and money; highest quality medical skills and technical expertise) • Potential implications and impacts of scenarios for change on staff, patients, service users and carers
Clinical Reference Group	Membership includes: senior clinical staff of both Trusts; medical and nursing leaders from NHS North East Essex and NHS Ipswich & East Suffolk; together with clinical representatives from the East of England Ambulance Services NHS Trust, Anglian Community Enterprise, Essex CC, Suffolk CC and Healthwatch	Offers views and advice on: • Identification of clinical services opportunities and benefits for the long-term partnership • The shortlisting of high priority clinical services to develop future specialty-level clinical strategies • Putting together specialty-level strategies to create an overarching clinical strategy (bearing in mind clinical adjacencies and interrelationships) • The process to provide clinical evaluation of the shortlisted scenarios • Quality impact assessment for proposed changes, including risk assessment
Commissioning Reference Group	Membership includes the Chair, Chief Officer and commissioning leads from NEECCG and IESCCG, together with executives from both Trusts	Offers views and advice on: • Potential scenarios for the shape and delivery of the Partnership • The process for evaluating the four scenarios identified in the SOC phase • The potential preferred scenario for the partnership, along with the clinical and patient benefits • The vision and design of clinical and corporate services as part of the Partnership

Group	Membership	Contribution
Stakeholder Advisory Group	Membership comprises representatives from key partners in health, local government and social care across northeast Essex and Suffolk. This is not a closed group. Where it is evident that a particular viewpoint or set of expertise is missing, the membership may flex accordingly	Offers views and advice on: • What values should underpin the planning of specific service changes (e.g. best use of skills; time and money; highest quality medical skills and technical expertise) • Appropriate and effective communication and engagement activities for stakeholders and elected members as the Partnership progresses • How to ensure the Partnership is responsive to the views and needs of partner organisations in the North East Essex and Suffolk health and social care system • How to ensure the Partnership aligns effectively with local commissioning, health, social care and well-being strategies • Potential implications and impacts of scenarios for change on patients, service users and carers

Governance

Reference groups offered their views and advice, including recommendations, which were considered by the PAB. Each meeting is minuted and a written response from the PAB is provided to the groups after each meeting. Representatives from the Partnership then feed back to the groups the progress on the recommendations made.

11.3.3 Briefing other external stakeholders

A number of other key external stakeholders have been engaged during the OBC phase.

A written briefing paper, along with the communications and engagement plan, was shared with both the Suffolk County Council and Essex County Council HOSCs. A Joint HOSC (JHOSC) has been established to carry out scrutiny functions on behalf of both councils, as required by the *Health and Social Care Act 2012*. As a statutory consultee in the event of any proposed substantial variation, the Partnership has conducted early engagement with the committee to ensure it is able to carry out its functions fully.

On 10 March 2017, the JHOSC met to gather information on the STP plan, which included evidence from representatives of the Partnership. Recommendations from the committee have influenced the direction of engagement for the Partnership, most notably their emphasis on the key role that staff should play, as well the importance of engaging with vulnerable and seldom-heard from communities.

In addition to the scrutiny committees, the Partnership has engaged with both Essex and Suffolk Health and Wellbeing Boards (HWB). A written briefing was provided to HWB members and briefings are scheduled at subsequent HWB meetings.

Healthwatch Essex and Healthwatch Suffolk have also contributed to the communications and engagement plan to ensure that patient representatives and patients are adequately involved. The Chief Executives of both organisations either chair or sit on the respective patient advisory groups for Essex and Suffolk, as well as the wider stakeholder advisory group and the CRG.

11.4 Key engagement themes

A wide spectrum of views has been expressed and four key themes have emerged, detailed in table 11-3.

Table 11-3 Key Themes from Engagement

Theme	Views of stakeholders
Patients and the public	• Patient representatives have been broadly supportive of the principles and direction of the Partnership • Some members of the public expressed the view that other engagement exercises (not related to the Partnership) have been carried out after key decisions have been made • There was consensus that simple, jargon-free language and concise information is the best way to articulate the Partnership and the process for change to patients and the public • The important role that carers play in the healthcare system should not be overlooked, and their views and needs should be taken into consideration in developing any proposals for change • Seldom-heard groups should play a key part in any engagement going forward. Their views will be important to the success of public confidence. These groups represent vulnerable people and members of smaller communities • Polling of members before and after meetings indicated that, on average, support for and knowledge of the Partnership increased during engagement programme
Travel and rurality	• There are concerns about the impact any services changes may have on the travel and transport arrangements for patients and carers, as well as for staff • Rurality is a worry for patients in outlying areas, especially in those areas where deprivation is high and car ownership is low • Concerns that an elderly population may have to travel further • The possible impact on relatives and relations visiting inpatients
Staff	• Members of staff who have been actively engaged in the process (either through developing their clinical strategy or as a member of a staff reference group) are predominately positive about the benefits and opportunities that the Partnership can offer • It would be helpful for departmental teams – both clinical and non-clinical – to meet one another regularly and share ideas and ways of working • Updates and information provided so far have been helpful. However, some staff expressed the view that it is hard not to think of the worst-case scenarios and the overriding question that is on everyone's mind throughout the whole process is: 'what does this mean for me and my job?' • Members of staff at both Trusts have expressed the view that they are keen to play their part in helping demystify the Partnership for colleagues and ensure that the process are grounded in the realities of everyday practice • Staff members are less concerned about the form of the combined organisation but more the impact that it will have on their working life • All staff have been keen to stress that patients should be involved in any change going forward and in the development of any potential clinical scenarios
Organisational form	• Some people have expressed concerns that the Partnership will amount to no more than a takeover of one hospital by the other • A number of people have questioned how a Partnership, merger or otherwise, between a Foundation Trust and non-Foundation Trust would work in practice • Some people considered that timescales proposed for delivery of the Partnership's plans are too short to realise all its benefits

11.5 How engagement has influenced thinking

The programme of engagement will extend into the FBC phase. CHUFT and IHT will continue to listen to and consider all views presented. During the OBC phase a number of changes were made to the plans and activities on the basis of the views and suggestions of stakeholders.

11.5.1 Reporting

To ensure views are being fed back into the Partnership, there are a number of established reporting lines. These included updates on engagement activity and stakeholder feedback. The frequency of this is feedback shown in Table 11-4.

Table 11-4 Governance bodies that received feedback on engagement

Committee or working group	Update frequency
Updates to the OBC working group	Weekly
Updates to the partnership working group (PWG)	Weekly
Updates to the partnership advisory board (PAB)	Monthly
Updates at CHUFT and IHT Board-to-Board meetings	Monthly
Updates to Trust Board meetings (CHUFT and IHT)	Monthly

11.5.2 Stakeholders initial views and the Partnership's response

As a result of the feedback from the engagement programme so far, CHUFT and IHT have been able to adapt and refine thinking in a number of areas. These areas are set out below.

- **The implications for travel and transport for patients.** The Partnership is planning a Transport Summit with the STP. From this a transport reference group will be formed involving local stakeholders. A travel impact assessment will be carried out on any specific proposals for change
- **Encourage collaboration through meetings between sites, particularly in non-clinical services**. CHUFT and IHT have implemented access to each other's email lists. Skype for business is in pilot testing. Joint meetings have been arranged between the staff (and patient) reference and advisory groups at both hospitals. Clinical workshops have already been held with over 200 clinicians from both sites
- **Guidance on collaboration of services**. A collaboration framework is being produced for services
- **Patients and the public should be involved in any potential clinical changes**. The Partnership is producing public-facing documents to outline the vision, opportunities and challenges associated with the Partnership. This will aid public involvement in the coming months. The reference groups will continue in the FBC phase and be expanded as required to ensure broad public and patient involvement

11.6 Future communications and engagement plans

The FBC phase of the Partnership will include the further development of the clinical strategy and will involve patients and carers in this process.

The engagement programme is ongoing and will ensure that stakeholders are informed and given opportunities to express their views; these will be considered by the Partnership as plans develop.

These activities are likely to include, but not necessarily be limited to:

- Briefings with key external stakeholders
- The production of public-facing documents to support public involvement
- Publication of the OBC document in full
- Update meetings for all external stakeholders to share their views
- A Partnership website hosting a number of informative documents and with a 'have your say' form to share views electronically
- *In Partnership* newsletters to update staff
- Reference groups with key stakeholders, including seldom-heard groups
- EIA to allow all future clinical proposals to be assessed against the current state

The timeline for this programme will be determined by the nature and extent of service change proposed by the Partnership.

12 Conclusions and recommendations

Section synopsis

- **The preferred scenario of full clinical integration best meets the objectives of the Partnership by delivering benefits to patients and staff and demonstrating the greatest financial benefit.** Delivery of this scenario is more complex and therefore carries a greater degree of risk which must be mitigated during planning for implementation
- The recommendations to the Boards are:
  - Approve the preferred scenario of full clinical integration
  - Approve work on the next phase of the Partnership, including a full business case, implementation plan, and development of an operating structure and culture for the combined organisation
  - Adopt the eight corporate TOM strategic themes in planning a unified corporate service model for the combined organisation
  - Adopt the six clinical strategic themes in planning a unified clinical service model for the combined organisation
- The next steps include:
  - Development of a full business case
  - Planning for implementation
  - Agreement with NHSI on the preferred legal form of the transaction
  - Obtain regulatory approvals

12.1 Partnership ambition and objectives

The Trust boards have agreed an ambition and objectives for the Partnership, consistent with the STP plan.

Partnership Ambition

By working together CHUFT and IHT will secure sustainable and high-quality healthcare for Ipswich, East Suffolk and North East Essex

Objectives

- Improved quality and patient outcomes
- Better value for money
- Sustained and improved access to services that meet the needs of the population
- A sustainable, skilled workforce

12.2 Conclusions from the OBC

The OBC has identified full clinical integration as the preferred scenario. This includes the formation of a combined organisation with integration of corporate services and clinical teams. The benefits address the ambitions and objectives of the Partnership. This scenario is recommended due to its higher level of patient benefits, and higher contributions to workforce and financial sustainability. Delivery of this scenario is more complex than the others and therefore carries a greater degree of risk which must be mitigated during planning for implementation.

The patient, staff and system benefits have been identified by clinical and corporate services from both Trusts using a 'bottom-up', rather than a 'top-down', approach. As a result, there is confidence that the identified benefits are genuine and can be realised. However, this does mean that whilst the benefits included in this document are realistic at this stage, there is the potential that further benefits (some of which could be material) may be identified through the development of the FBC as further 'bottom up' analysis is carried out. Through the development of implementation plans, the balance between benefit and risk will be achieved, ensuring that benefits are realised by the greatest number of people. These benefits are only attainable as a single combined organisation.

The legal form of the transaction to create the combined organisation will be agreed with regulators, principally NHSI, and the necessary processes started.

12.2.1 Benefits of the preferred scenario

Full clinical integration will require the formation of a combined organisation. This will have a single governance structure and process across the two sites, unified corporate services and the formation of unified clinical teams working across the two sites. This enables greater flexibility in the use of estates and capital investment, development of staff and roles as well as the increased opportunities for specialisation within a larger team. The scale of the combined clinical services also offers the opportunity to meet current or future national standards (which would not be possible as separate Trusts) and will offer better opportunities to participate in clinical trials and research.

Table 12-1 details examples of where full clinical integration, supported by the implementation of the corporate TOM delivers benefits against the agreed Partnership objectives.

Table 12-1 Delivery of Partnership objectives in the preferred scenario

Partnership objective	Examples of how full clinical integration will deliver the objective
Improved quality and patient outcomes	Working in a larger team will improve senior decision-maker cover in some specialties (e.g. oncology tumour sites) delivering improved safety, experience and patient outcomes.
	By reshaping services locally, and planning for the larger catchment population, some patients currently travelling out of the area for care will be able to have the equivalent care at one of their local hospitals (e.g. planned cardiac angioplasty)
	By pooling resources, service models will be developed to support some front-line services 24/7 across both sites
	Clinical governance systems operating across wider specialty community will establish consistent standards and deliver consistency of services and outcomes

Partnership objective	Examples of how full clinical integration will deliver the objective
Better value for money	Improved support and opportunities for staff development will in turn improve recruitment and retention of skilled staff, reducing reliance on agency staff and the associated cost. The clinical case plans to deliver cumulative saving of £10m (one-third of the current temporary staff pay bill) for the combined organisation by 2021/22
	By working as a single purchaser, the combined organisation will benefit from volume and pricing discounts with suppliers of clinical equipment
	The corporate TOM will reduce the annual cost of the combined organisation's corporate services by at least £4.5m by 2021/22
Sustained and improved access to services that meet the needs of the population	Working with a larger population base will ensure that the Partnership sustains the clinical critical mass of demand, skills and experience to support some smaller or specialist clinical services locally (e.g. arterial vascular surgery)
	Working across two sites will give flexibility to align resources and clinical work patterns to more effectively meet peaks of demand within local NHS facilities reducing the reliance on outsourcing and the risks of exceeding access time standards
A sustainable, skilled workforce	Full clinical integration will strengthen the clinical workforce and improve opportunities for development training and for developing different roles
	A larger clinical base opens up opportunities for greater participation in innovation and research, and for strengthening links to academic medicine, creating development opportunities for professional staff

12.3 Recommendation to the Boards

The Boards of the two Trusts are recommended to:

1. Approve the preferred scenario of full clinical integration
2. Approve work on the next phase of the Partnership, including a full business case, implementation plan, and development of an operating structure and culture for the combined organisation
3. Adopt the eight corporate TOM strategic themes in planning a unified corporate service model for the combined organisation. These themes are:
    - One corporate service
    - Corporate centres of excellence
    - Business partnering
    - Self-service
    - Digital-enabled future
    - Unified process
    - Joint procurement and supplier rationalisation
    - Alternative models of delivery
4. Adopt the six clinical strategic themes in planning a unified clinical service model for the combined organisation. These themes are:
    - Right people, right skills
    - Great quality local services
    - 24/7 resilience
    - Best value for money
    - Right care in the right place
    - Right systems and processes

12.4 Next steps

The next stage of the Partnership programme will follow agreement of the OBC by both Trust Boards, and will be fully activated when NHSI approval is secured for the OBC. Following OBC approval and decision to proceed to FBC the Trusts, with support from NHSI, will consider formal notification to the CMA which could initiate a formal review of the potential impact on competition. The legal form of the transaction to create the combined organisation will be agreed with regulators, principally NHSI and the necessary processes started.

During the FBC the model for the combined organisation will be developed into implementation plans. This will include:

- The organisational design, governance structures and processes
- Workforce and organisational development plans
- The clinical and corporate models
- The long-term financial model
- Equality impact assessment (and travel impact assessment)
- Quality impact assessment
- Due diligence

Appendices

A. Organisational Forms Considered in the Strategic Outline Case

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Do minimal / nothing	Compulsory scenario	No change to current state	No change to current state	Draft SOC suggests combined deficit approaching £200m by 2020/21	N/A
Federation	Dependent on whether clinical services were included within the federation agreement; could extend to joint delivery of services subject to MoU	Back office services often jointly delivered or commissioned	Each organisation retains individual sovereignty Typically, one trust would take lead on governance, quality and finance as set out in MoU	Relatively minimal Required for infrastructure to allow joint working, i.e. technology Associated procurement costs	UCL Partners in London has a central team that allows best practice to be shared across 40 organisations, with support for implementation; has used model to support changes to stroke care in London Critical success factor: Independent coordinating and support function
Buddying	Input and advice from buddy trust workforce to improve performance, though of a more informal nature than a management contract Will result in changes to operating procedures and ways of working	Input and advice from buddy trust workforce to improve performance, though of a more informal nature than a management contract Will result in changes to operating procedures and ways of working	Clinical and corporate governance would initially remain unchanged, though there would be the opportunity to update governance based on buddy trust experience Accountability for performance and quality remains with the host trust	Minimal investment, though buddy trust will require additional resource to provide assistance Some financial assistance from regulators may be available	Current situation between IHT and CHUFT Introduced into the NHS as a result of the Keogh Review and the subsequent Special Measures regime; intended to enable a two-way learning relationship between trusts Critical success factor: Openness to learn from each trust

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Clinical and strategic networks	Sharing of best practice between clinicians, changing procedures and sharing evidence-base	Minimal impact	No change to governance as likely to be based on informal sharing agreements, individual services remain accountable for performance and quality	Minimal impact	Regional Strategic Clinical Networks in areas such as maternity, paediatrics, mental health, dementia and neurological conditions Critical success factor: Support from local Clinical Senate and clinical input
Joint venture (JV) – Contractual	Only services that are included within the JV would be affected; not all services have to be included Potentially minimal change to services, especially where services are offered by a subcontractor to a prime provider Prime contractor may define new or different service standards and ways of working, holding subcontractors to account	JV can also be used to provide back office and corporate functions into 'owner' trusts (and others)	Contractual JVs are based on existing contractual structures and do not result in the creation of a new separate entity Contractual forms include: prime contractor, lead contractor, subcontracting, alliance contracting Clinical governance: accountability ultimately lies with contract holder (exception is alliance contracting)	Required for the development of the legal entity or the	Acute care collaboration (ACC) vanguard – One NHS in Dorset South West London Elective Orthopaedic Centre (SWLEOC) is a contractual joint venture between St George's, Epsom and St Helier, Croydon and Kingston. Located on Epsom site, carries out elective orthopaedic surgery only with high levels of efficiency, surplus shared between 'owner' trusts. Critical success factor: Development of appropriate contractual vehicle

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Corporate joint venture	Only services that are included within the JV would be affected; not all services have to be included Included services would be provided by the JV, this could result in workforce transfers; pooled staffing can enable clinical standards to be met JV may set standardised operating procedure across sites where services are provided	As with a contractual joint venture, back office services can be provided into 'owner' and other trusts	Core difference is that a corporate joint venture always results in the creation of a separate entity – either a company limited by shares or a limited liability partnership (LLP) FTs taking part in a corporate joint venture remain accountable for the decisions they take under their provider licence	Requires legal and professional advice to select and implement the appropriate organisational form Additional costs incurred, for example corporate JVs would be treated differently for tax purposes compared with NHS vehicles	ACC vanguards – some of the Foundation Groups are exploring this as an enabling organisational form There are few examples of implementation within the NHS, though NHSI is developing further guidance Balances freedoms not available to NHS Trusts / FTs against losing some benefits (i.e. tax treatment) Critical success factor: Selection of the most appropriate legal entity type

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Service-level chain type 1 – outsourced	Service or specialty is offered by an entirely new provider, and is directly accountable for performance 'Host' trust provides the physical space for the service and sometime clinical support services At the time of change of provider workforce may transfer into new provider (TUPE), or provider may bring in their own workforce Operating procedures and policies are those of the new provider	Full outsource of back office functions into a separate legal entity (or offered by an existing entity) Corporate services related to the clinical service are the responsibility of that provider Requires a 'landlord' contract between host trust and provider	Full governance and accountability for the service sits with the provider, and is transferred from the host trust Host trust assumes role of landlord, renting physical space (not necessarily income generating) to provider Agreements required to ensure governance, data gathering, performance reporting and quality inspections are undertaken correctly	For host trust: relatively low investment, though will require additional expertise to develop and manage landlord contracts, and a procurement may need to be run For provider: Investment required to respond to a procurement, and costs associated with implementing service onto a new site, including for technology and training	ACC vanguard – Moorfields Eye Hospital Moorfields @ model, where Moorfields run the entire ophthalmology unit at St Geroge's, London as a satellite to the main site. Service is outsourced to Moorfields in its entirety, who 'take' the activity, employ workforce and own equipment Critical success factors: Suitable specialism selection, appropriate contractual expertise of both parties

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Service-level chain type 2 – provision	Service or specialty is offered by an alternative provider, and is accountable to the host trust for the quality and performance of the service 'Host' trust provides the physical space for the service and sometime clinical support services At the time of change of provider workforce may transfer into new provider (TUPE), or provider may bring in their own workforce Operating procedures and policies are those of the new provider	Most common organisational form for outsourced back office functions, where the host trust remains ultimately accountable for the performance of these and, in turn, holds them to account Can take the form of shared service centres	Key difference to 'type 1' is that accountability for the service is to the host trust, not directly to the regulator; in this respect this is similar to a subcontracting agreement For a Foundation Trust, the host trust remains ultimately accountable for the service as per the terms of the licence conditions Agreements required to ensure governance, data gathering, performance reporting and quality inspections are undertaken correctly	As above	ACC vanguard – Moorfields Eye Hospital (additionally provide visiting services) ACC vanguard – The Neuro Network: The Walton Centre, Liverpool, provides Consultant Neurologists into a large number of surrounding hospitals, spreading best practice and providing outpatient reviews. Also applicable for back office services; Northumbria Healthcare NHS FT provides payroll services across the NHS Critical success factors: Capacity to 'sell' services and develop an appropriate price
Service-level chain type 3 – policies and protocols	Trust 'buys in' and implements the procedures and policies from another provider Existing workforce is required to operate in a new and different way, though workforce may not change	Introduction of alternative providers standard operating procedures and policies Provision of the service is still by the original team, though job roles and skill mix may be altered	No transfer or accountability to the provider of policies and protocols, though they may provide inspection and oversight	Policies and procedures may need to be purchased from the provider under a franchise agreement, the cost of this can vary considerably There will be additional cost associated with training	ACC vanguard – National Orthopaedic Alliance is developing a 'kite mark' for services, based on the opportunity identified in Getting it Right First Time Critical success factors: Suitable specialism selection, appropriate target market

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Management contract – Single service	Service in question moves to be managed in its entirety to a new provider under contract, for a time-limited period Workforce is likely to be retained in original form, though would report into management contract owner	Standardised practices could be brought across wholesale from the organisation that is managing the contract. Allows sharing of back office functions to a greater degree including procurement practices and operational and clinical policies and procedures	Accountability of the service in its entirety moves to the contract manager Often used in the case of significant service failure Host trust holds contract provider to account; regulator holds host trust to account for service	Minimal from the perspective of the host trust, though dependent on the management contract financial agreement income from the operated service may be forfeited	Extended form of buddying arrangement, where an alternative provider manages an entire service on behalf of a host trust (not outsourced) Critical success factors: Clearly articulated replicable operating model, clarity on service changes required (back office and clinical), leadership capacity
Management contract – Whole organisation	Clinical services come under the management of the contacted organisation; potential to have significant change Could result in changes to policies and procedures for frontline workforce	Standardised practices could be brought across wholesale from the organisation that is managing the contract. Allows sharing of back office functions to a greater degree including procurement practices and operational and clinical policies and procedures	Accountability for the performance of the organisation under contract moves to the contract holder Often used in the case of serious organisational failure Regulator holds the contract owner to account	Potentially significant for the managing organisation, in terms of implementing new operating procedures, which will require additional resource and external support Deficit support may be required from national bodies at the outset of the contract	ACC vanguard – Foundation Healthcare Group: Examining how a trust that is not viable can be supported through pooling organisational sovereignty on the route to development into a Foundation Group Hinchingbrooke is an example of the risks associated Critical success factors: Clearly articulated replicable operating model, clarity on service changes required (back office and clinical), leadership capacity

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Joining an existing foundation group (four currently accredited)	Dependent on membership option chosen (range being developed); some of these include wholesale adoption of clinical operating procedures and standardisation of practices At the 'least integrated' level of the spectrum similar to buddying, at the most integrated end similar to merger	Dependent on membership option chosen (range being developed); some of these include wholesale adoption of clinical operating procedures and standardisation of practices For many options there are likely to be significant back office synergies sought, moving to shared back office functions	Dependent on membership option chosen, but in most cases individual organisations retain accountability for quality and performance NHS Improvement is developing a regulatory approach to foundation group members	Dependent on membership option chosen, but under all there is investment required from the trust becoming the centre of the foundation group to codify operating model and procedures Dedicated resource required to pass through the NHSI accreditation process	Four foundation groups have now been accredited by NHS Improvement - all of which have had to identify initial partners; they are now in a position to open discussions with other potential partners Critical success factors: Aligned strategic visions, identification of a suitable Foundation Group to join, capacity of Foundation Group
Forming a foundation group	Requires codification of clinical services and the development of a clinical standard operating procedures by the trust forming the foundation group May involve the reassessment of current procedures and policies and any required updating	Corporate services may undergo significant transformation, including the organisation of services into 'headquarters' and 'site-level' functions Range of services provided and capabilities will have to increase to provide group level functions	New group level governance arrangements will be required, for the spectrum of different group membership options Accountability for performance and quality at 'owned' sites are the responsibility of the foundation group organisation	Potentially significant investment to prepare the organisation to pass through the NHSI accreditation process Legal and professional support required to develop new organisational forms	Four foundation groups have now been accredited by NHS Improvement - passing through the newly developed accreditation process (which includes desktop review of organisational performance and Board to Board meeting) NHSI has recently encouraged South Warwick to form a foundation group to support Wye Valley Critical success factors: Clearly articulated replicable operating model, clarity on service changes required (back office and clinical), leadership capacity

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Organisational merger, focus on back office	Some shared clinical services, but relatively little impact on frontline services	Full back office consolidation, including movement to shared services and functions	Governance remains separate and the individual sites are accountable for quality and performance Regulators would consider merged trust as one organisation	Significant investment required for any merger, with additional resource dedicated to developing business cases and implementing integration Potentially some transitional funding available – though likely to be extremely limited	Historical mergers often took this form, for example Epsom and St Helier, which retains a Medical Director on both sites and services are not highly integrated Critical success factors: Aligned organisational visions and strategies, complementary services
Organisational merger, focus on back office plus some clinical integration	Some clinical consolidation and harmonisation of practices and standardisation across sites May retain separate Medical Directors	Full back office consolidation, including movement to shared services and functions	Single set of governance arrangements for the merged organisation, accountable for performance and quality Regulators consider merged organisation as a single entity	Significant investment required for any merger, with additional resource dedicated to developing business cases and implementing integration Potentially some transitional funding available – though likely to be extremely limited	Chelsea and Westminster's acquisition of West Middlesex: Here there was no reconfiguration of services and only a limited level of integration Critical success factors: Complimentary services, sufficient levels of back office efficiencies to make merger worthwhile
Organisational merger, focus on back office plus full clinical integration	Full clinical services consolidation, including a reconfiguration of service and centralisation where appropriate Services and specialties are fully integrated and offered across sites from a single rota Single Medical Director	Full back office consolidation, including movement to shared services and functions	Single set of governance arrangements for the merged organisation, accountable for performance and quality Regulators consider merged organisation as a single entity	Significant investment required for any merger, with additional resource dedicated to developing business cases and implementing integration Potentially some transitional funding available – likely to be somewhat limited	Royal Free's acquisition of Barnet and Chase Farm included a reconfiguration of services between sites and full integration of front line clinical services and back office functions, based on the 'Royal Free way' standardised approach Critical success factors: Clearly articulated replicable operating model, clarity on service changes required (back office and clinical), leadership capacity, organisational development

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Acquisition (full)	As above	As above	As above Under certain circumstances it is possible for NHS Trusts to acquire NHS Foundation Trusts	As above	Frimley Park's acquisition of Heatherwood and Wexham Park involved an 'outstanding' rated trust acquiring a distressed neighbour, stabilising the services and significantly increasing quality Critical success factors: Strong case for change and organisational track record, regulatory approval, strategic rationale for approach
Vertical integration	Relatively minor change to front line acute services, but would allow for more effective integration between acute and community services	Brings together the acute and community corporate functions Some consolidation of services and functions possible, with a move to shared services and functions	Single set of governance arrangements for the merged organisation, accountable for performance and quality Regulators consider merged organisation as a single entity	Investment required to bring organisations together and standardise policies and procedures	Symphony (South Somerset) PACS vanguard is a collaboration between Yeovil District Hospital NHS Foundation Trust, south Somerset Healthcare GP Federation, Somerset CCG, and Somerset County Council, it seeks to integrate services for patients, and move towards a whole population budget Critical success factors: Suitable forum for provider collaboration within the area, development of whole population budget

B. Population analysis

Population growth

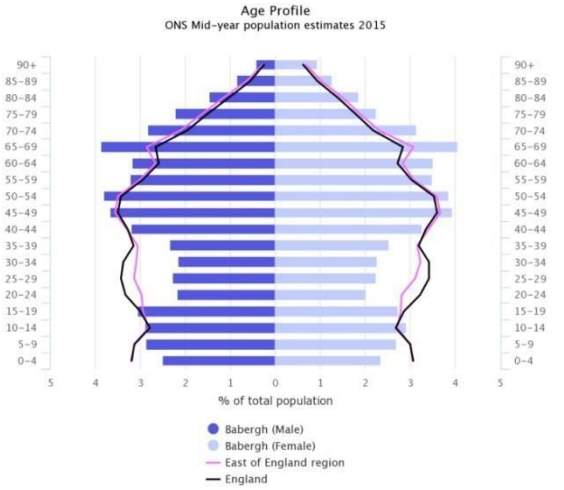
Projected population growth is shown by District / Borough Council in Table B-1.

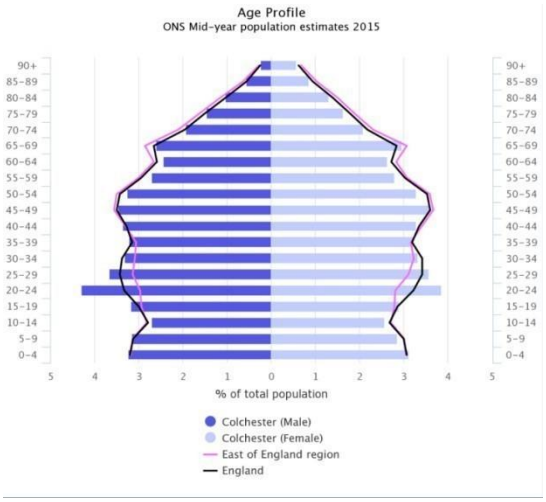
Table B-1 Predicted population growth by council

Local Authority	Total Population			Population aged 70 and over		
	2016 Estimate [45]	**2021 projected** [46]	**Change (%)**	**2016 Estimate**	**2021 projected**	**Change (%)**
Essex						
Braintree DC	151,000	158,000	+4.6%	19,900	25,000	+25.6%
Colchester BC	186,640	195,000	+4.5%	21,900	27,000	+23.3%
Tendring DC	142,600	146,000	+2.4%	29,780	34,000	+14.2%
Suffolk						
Babergh DC	89,500	91,000	+1.7%	15,820	20,000	+26.4%
Ipswich BC	135,910	140,000	+3.0%	15,380	18,000	+17.0%
Mid Suffolk DC	100,010	104,000	+4.0%	16,170	20,000	+23.7%
Suffolk Coastal DC	125,960	127,000	+0.8%	23,120	29,000	+25.4%

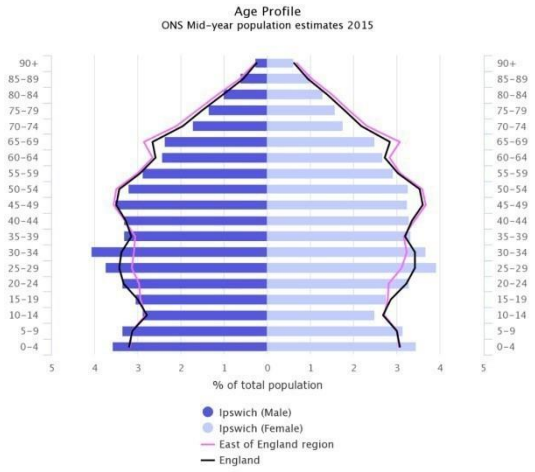
Local area age profiles

The charts below show the population characteristics for the relevant local authority areas.





[45] ONS 2016 Mid-year estimates, published June 2017
[46] ONS 2014 based sub-national population Projections 2016


Age Profile
ONS Mid-year population estimates 2015
90+
85-89
80-84
75-79
70-74
65-69
60-64
55-59
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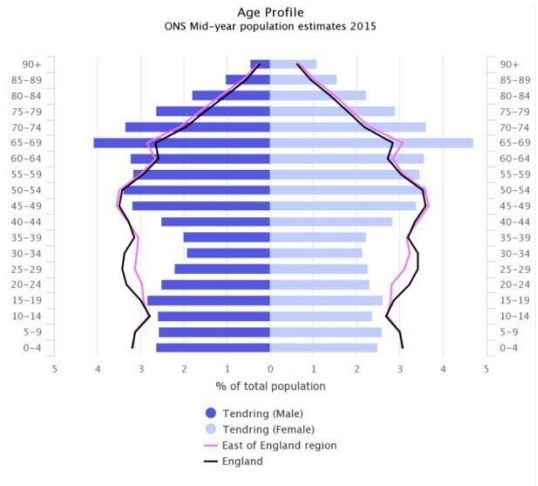
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
5 4 3 2 1 0 1 2 3 4 5
% of total population
Ipswich (Male)
Ipswich (Female)
East of England region
England


Age Profile
ONS Mid-year population estimates 2015
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20-24
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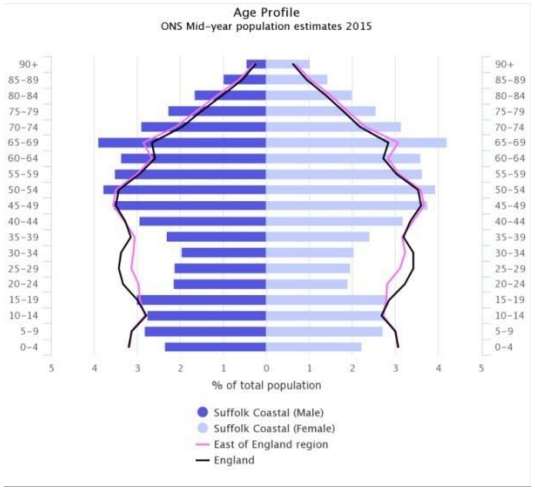
5 4 3 2 1 0 1 2 3 4 5
% of total population
Tendring (Male)
Tendring (Female)
East of England region
England


Age Profile
ONS Mid-year population estimates 2015
90+
85-89
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30-34
25-29
20-24
15-19
10-14
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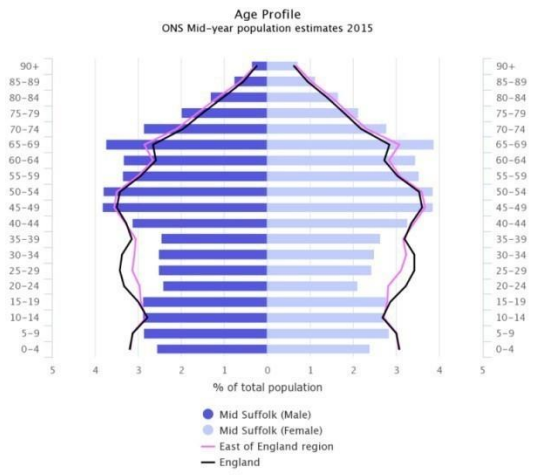
0-4
5 4 3 2 1 0 1 2 3 4 5
% of total population
Suffolk Coastal (Male)
Suffolk Coastal (Female)
East of England region
England


Age Profile
ONS Mid-year population estimates 2015
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75-79
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40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
5 4 3 2 1 0 1 2 3 4 5
% of total population
Mid Suffolk (Male)
Mid Suffolk (Female)
East of England region
England

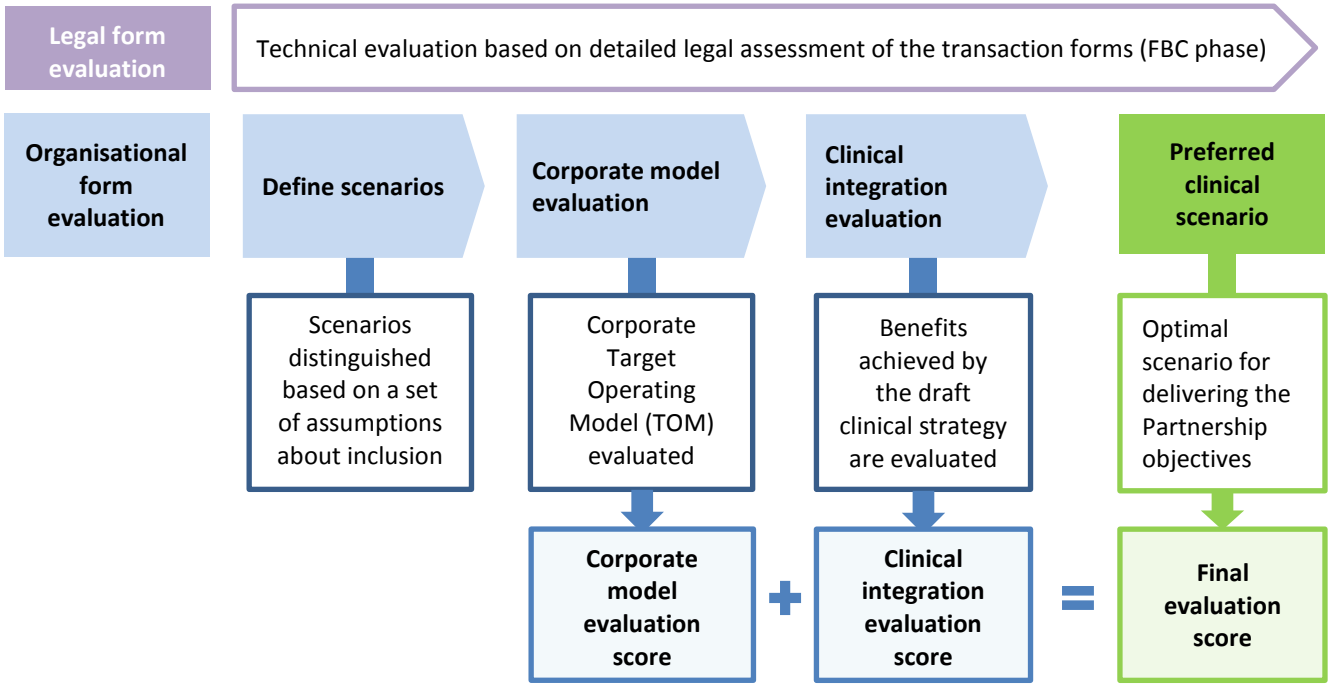
C. Scenario evaluation detailed approach

Approach to the scenario evaluation

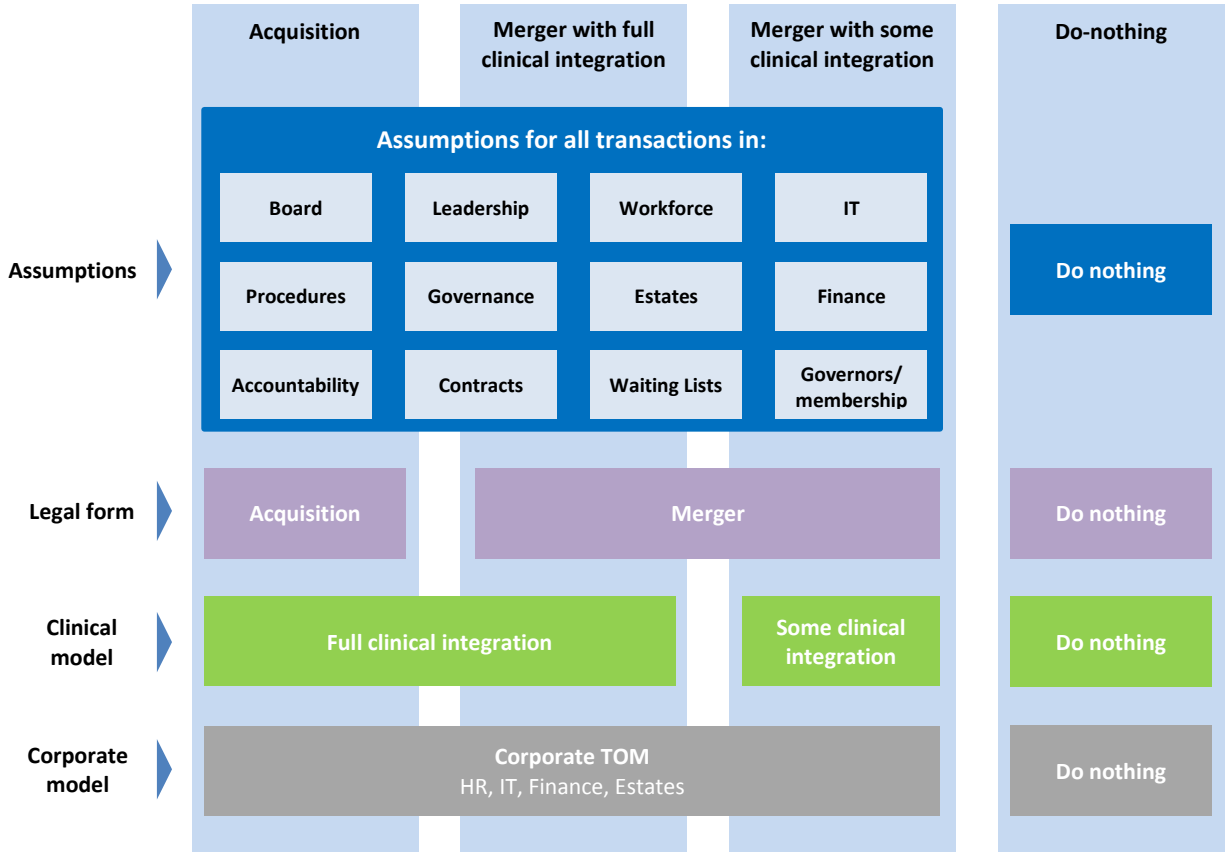
The high-level process for carrying out the scenario evaluation is outlined in the diagram below. The evaluation consists of two parallel elements:

A. Transaction legal form: Understanding the legal options for the organisational form resulting from the transaction (merger or acquisition)

B. Organisational form: Evaluating the clinical and corporate models underpinning the scenarios



The first step in the organisational form evaluation was to redefine the four scenarios based on their individual corporate and clinical models using the framework shown in the diagram below.



The resulting three scenarios, 'do nothing', 'some clinical integration' and 'full clinical integration' were evaluated in two parts with separate assessments of the corporate and clinical service models.

The clinical and corporate models were assessed against the five evaluation criteria (quality, access, workforce sustainability, financial sustainability and deliverability). The scores obtained for the clinical and corporate models were used to determine the final evaluation scores for the three scenarios by combining the results as shown below:

- *Do-nothing* = 'Do-nothing' (corporate) score + 'Do-nothing' (clinical) score
- *Some Clinical Integration* = 'Corporate TOM' score + 'Some clinical integration' score
- *Full Clinical Integration* = 'Corporate TOM' score + 'Full clinical integration' score

The individual final evaluation scores for the scenarios were used to identify the preferred scenario for the organisational form of the Partnership.

Evaluation criteria definitions

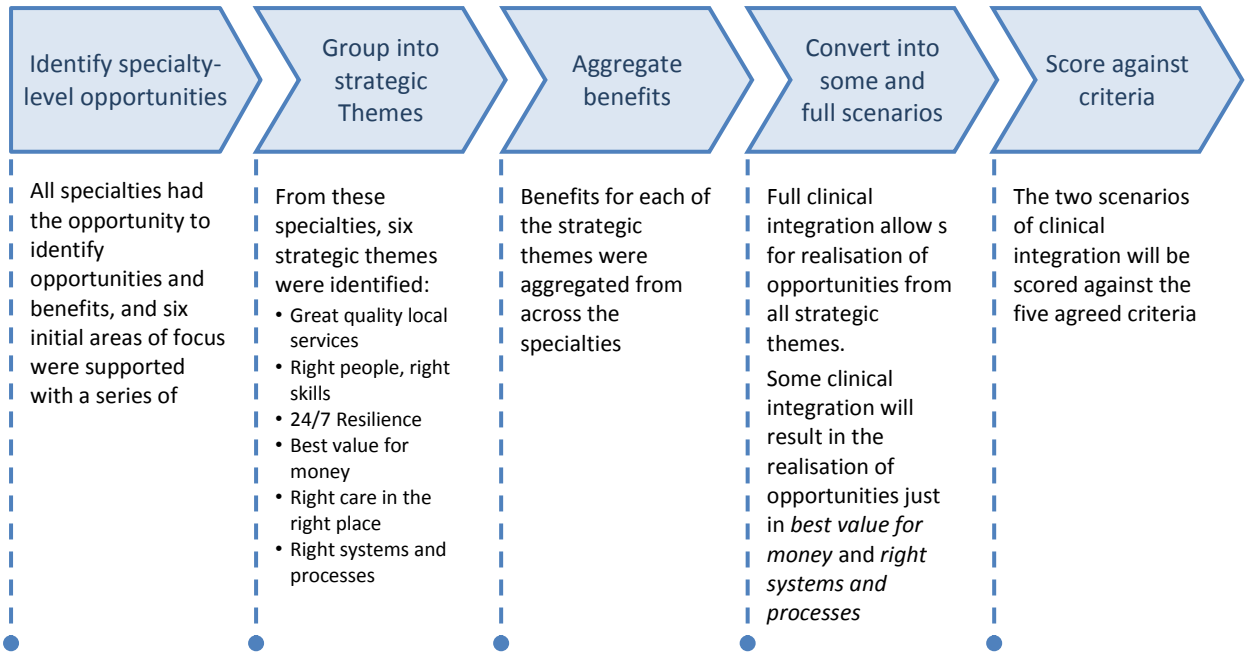
Detailed definitions of the five criteria used to evaluate the three scenarios are provided along with their weightings in the table below.

Criteria	Definition	Weighting
Quality: outcomes, safety and patient experience	The extent to which a scenario enables the improvement of quality and safety in a consistent way and improves or maintains patient experience across the area covered by the Partnership, and the wider system. Key considerations are: • The potential of a scenario to improve quality and safety and the extent to which it supports the spread of best practice and standardisation, where appropriate • Whether the scenario is likely to enable services to meet appropriate clinical standards, such as the Royal College (or equivalent) standards and NICE guidelines – especially through achieving recommended levels of senior decision-makers in services • The impact on interdependent and co-dependent services should be assessed, especially in light of the fixed points • A positive patient experience may correlate with better healthcare facilities, including a better quality of equipment, estates and environment – is the scenario able to deliver this? • For people requiring both health and social care provision, there should be co-ordination between these two services to provide a seamless pathway and better information-sharing; equally the scenario should consider the entrance to and exit from the acute pathway	29%
Access	The extent to which the scenario enables equitable access to high quality services within the catchment area for all population groups. Key considerations are: • Whether services are provided when and where people need them, and the extent to which this would be enabled by the scenario and considerations on how travel will be impacted • Different types of services may be offered from different sites, but all people should be able to access the service that is most likely to give them the best clinical outcome, particularly for those groups with the greatest health needs • The extent to which the scenario can maintain and improve access to acute (and specialist) services within the catchment area, at a time and place that is convenient for the local population	15%

Criteria	Definition	Weighting
Workforce sustainability	Assess whether the scenario will allow the Partnership to attract, develop and retain the staff needed to provide high quality healthcare in the local area. Key considerations are: • The extent to which the workforce, comprising both clinical and non-clinical staff, will be better developed as a result of the proposed scenario • The impact of the scenario on the ability for the Partnership to attract and retain the highest quality workforce • Assessment of the extent to which the scenario will enable staff to access appropriate training and development, opportunities to advance, particularly for those with specialist skills	20%
Financial sustainability	The scenario's ability to contribute to the short-term and longer-term financial sustainability for the Partnership as well as the wider system. Key considerations are: • The estimated cost to implement the scenario • The estimated financial benefits of the scenario • Assessment of whether the scenario makes best use of scarce resources, such as staff and equipment, and offers the potential to take advantage of efficiencies	19%
Deliverability	The extent to which the scenario enables sustainable change to be delivered by the dates that have been set out, including assessing the risks associated with the implementation, and the potential level of difficulty that this involves. Key considerations are: • The extent to which key stakeholders are likely to be supportive of the scenario and the political acceptability of the proposal • Understanding what can be accommodated on any given site and the high level capital investment associated with this as a measure of the likelihood of being able to achieve it • Whether the relevant workforce capacity and expertise exists to implement the scenario, within the local system or more widely, and any cost implications of this	17%

Defining some and full clinical integration

The process shown below was used to convert the specialty outputs for the clinical case into the full and some clinical integration scenarios.



The benefits identified from the specialty opportunities were aggregated for each of the six strategic themes as shown in the table below. As a result, full and some clinical integration could be differentiated based on their underlying strategic themes and corresponding benefits; allowing the evaluators to make an informed judgement when assessing the scenarios.

Strategic theme	Benefits				
	Quality	Access	Workforce sustainability	Financial sustainability	Deliverability
Great quality local services (Part of *Full* Integration)	• Single site delivery of sub-specialties allowing complex patients to be seen by relevant specialist • Joint services across sites enabling better outcomes and reduced errors • Maintain and develop local expertise and skill base through sub-specialty integration, leading to improved quality and patient experience • Meet national standards on pathways through shared services and units and MDT working • Increased pool of patients to allow for shared audit and research opportunities • Improved secondary prevention and lower rates of recurrence by providing greater range of services and sub-specialisms	• Improved patient access to specialist care through single site delivery of sub-specialties • Care closer to home for patients through integration of sub-specialties or shared sites • Able to offer more complex procedures through centralisation • Access to new treatments for more patients by being able to carry out larger R&D studies • Potential to provide innovative treatments more locally thus ensuring a more locally based service	• Staff development through training and rotation through shared sites • Improved recruitment and retention by doing more specialist work • Shared workload and cross cover across both teams through MDT working • Wider pool to share experiences and develop staff through sub-specialty activity • Attract skilled staff and funding by expanding R&D across two sites	• Potential to repatriate from the independent provider through centralisation and sub-specialty integration • Financial opportunities for centralisation from inpatient procedures and complex higher gain procedures • Reduced length of stay from centralisation and single site delivery of sub-specialties • Reducing duplicated service fixed costs • Share R&D funding requirements across both sites • Potential for limiting capital costs from centralisation by using existing bed base • Generating new income from centralised rehab services	• Utilise specialist skills across the wider geography • Existing staff on both sites equipped to deliver centralised rehab services • Integrating sub-specialties allows cross cover for service and mitigates risks associated with services provided by a sole provider • Potential to and open up shared rehab units to West Suffolk or bordering CCG • There is enough activity within both trusts
Right people, right skills (Part of *Full* Integration)	• Furthering knowledge and skills at both Trusts resulting in improved quality of service for patients • Equity in service across the two sites by having increased specialist roles • Combined training, education and governance will ensure standardisation of services and sharing of best practice • High standards of care and compliance with guidelines through more and improved training • Maintaining high-levels of consistency of specialist staff leading to high	• Reduced patient waiting times by having more specialist staff available • Releasing medical staff resource by developing role scope of nurses to deliver routine procedures • Releasing capacity by having high-levels of specialist staff	• Consistent development and training opportunities to wider group of staff • Offer more attractive roles through opportunities for development; improving recruitment and retention • Addressing challenges of junior staff capacity by developing middle and trust grade roles • Providing leadership and management experience opportunities through shared training and rotation • Increased training opportunities for	• Having the right specialist staff leads to the reduction in locum reliance; reduced agency costs • Reduced training costs by having shared training in-house • Reduced length of stay through increased availability of specialist staff resulting in reduced staff costs • Development of nursing specialists to lead clinics instead of medical workforce • Provision of training to external (NHS/non-NHS) staff to generate an income stream	• Shared clinical experience & knowledge to improve strategic developments • Combining education packages can increase number of staff trained at any one time • Sharing best practices across sites to further improve efficiency of services • Training delivery easier for trainers through combined training days

Strategic theme	Benefits				
	Quality	Access	Workforce sustainability	Financial sustainability	Deliverability
Right people, right skills (Part of *Full* Integration)	standards of care, lower mortality and reduced disability		nurses to increase skill mix • Better support and career development for staff leading to better retention	• Combined recruitment reducing recruitment costs	
24/7 Resilience (Part of *Full* Integration)	• Reduction in patient wait times and service continuity through cross cover between two sites • Utilising spare capacity across sites to reduce cancellations • Meeting national guidance by working as one team • Meeting recommendations for seven day working • Improved patient experience by sharing capacity between two sites with shorter wait times and faster diagnostic turnaround • Improved access to specialist input and addressing quality gaps by sharing on rota	• Faster decision-making for assessments by two teams sharing one rota • Seven day coverage for the wider population from seven-day working across the two sites • Reduction in travel times for patients experience by sharing capacity between two sites • Equity of access to specialist opinion for the whole population through seven day coverage across two sites	• Address capacity issues at both sites by two teams sharing one rota; releasing workforce capacity • More consistent rota through sharing without dependence on locums • Improved skill mix and sub specialisation across both sites • Improve staff experience and retention with more development opportunities and variation from rotations • Consolidation of rota and use of Telemedicine may allow individuals to contribute to other specialty demands e.g. Internal Medicine/Elderly Care • Development of non-consultant led clinics allowing for training and career progression of nurses and physiologists	• Improved clinic utilisation and less reliance on agency staff/locums by sharing rotas • Improve RTT through non-consultant led clinics and potentially reduce associated fines	• Use of existing technology and shared IT systems • Increased productivity of support services through cross-site working of clinicians • Utilise dropped sessions through joint workforces across sites
Best value for money (Part of *Full* and *Some* Integration)	• Standardisation of equipment through joint procurement ensuring safety on cross cover and aiding getting it right first time		• Increased training opportunity for nurses to develop experience and skill mix by developing dedicated units • Free up clinical and technical time by developing systems for document control and quality management together	• Savings on purchase volumes through joint procurement • Sharing nursing staff across two sites, improving staff utilisation • Larger buying power from joint procurement • Potential savings from shared technology utilised across both sites	

Strategic theme	Benefits				
	Quality	Access	Workforce sustainability	Financial sustainability	Deliverability
Right care in the right place (Part of *Full* Integration)	• Improved patient experience and equity in service from optimised pathways for wider population • Reduced risk of complications by streamlining pathways across the two sites • Comply with NICE guidelines by having combined diagnostic support • Local expertise for improved patient quality and experience for the wider population • More consistent and responsive service leading to better outcomes for patients by increasing admission prevention approach across teams and wider community (primary care) • Improved continuity of care through standardising discharge and rehab pathways	• Improved access for patients through supporting nursing homes, GPs etc.as part of admission prevention approaches • Reduced length of stay and simpler discharge process by standardising discharge pathways • Standardised discharge service available to the wider geography • Faster time for diagnosis and discharge through combined diagnostic support • Offer specialised clinics across both sites through pathway reconfiguration	• Developing staff with sharing of experiences and skills through pathway standardisation; more attractive roles and increased retention	• Increased throughput /productivity from optimising pathways • Savings on the health and social care costs of prevention, through expanded admission prevention approach • Reduced length of stay for low dependency patients by streamlining discharge pathways • Potential cost saving from weekend work sharing by standardising discharge pathways • Repatriation of specialist work from other providers through joint interventional procedures	• Improved utilisation of equipment by combining diagnostic support
Right systems and processes (Part of *Full* and *Some* Integration)	• Improved patient experience from sharing best practice on processes and protocols • Improved transfer of patient information to optimise chances of high quality care in the place of their choice by integrating clinical systems • Improved communication between professionals and sites to help optimise patient care • Information given to patient will align across both sites by merging information folders, avoiding confusion and concern	• Improved transfer or availability of information for patients if they have cross-site care	• Optimising use of expertise and resources by sharing best practice	• Potential to increase income from private patients through job planning within expanded service	• Shared IT enabling calls to be shared across both locations and supporting more robust disaster recovery plans • Greater ability to optimise policy, guidance and strategy at each site via shared working where possible and this could help free up more clinical time • Potential saving in time needed for policy development and strategy if integrated across both sites

Strategic theme	Benefits				
	Quality	Access	Workforce sustainability	Financial sustainability	Deliverability
Right systems and processes (Part of *Full* and *Some* Integration)	• Reduction in duplication of work and time savings that can optimise time for direct patient care • Continuity and provision of best patient care across two trusts and wider local health economy by developing shared protocols				

D. Scenario evaluation sub-group analysis

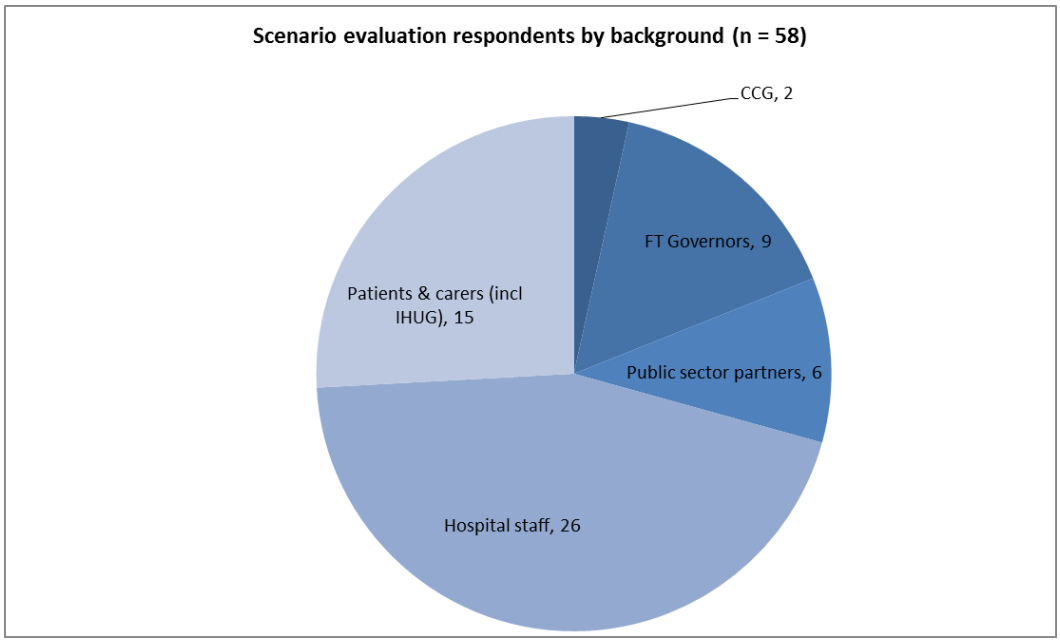
58 stakeholders completed the evaluation of the scenarios. This section looks at the distribution of evaluators and their responses. A small number of evaluators (eight) did not respond to some or all of the evaluation questions. Two evaluators sent comments separately by email.

Evaluators by organisation, reference groups and background

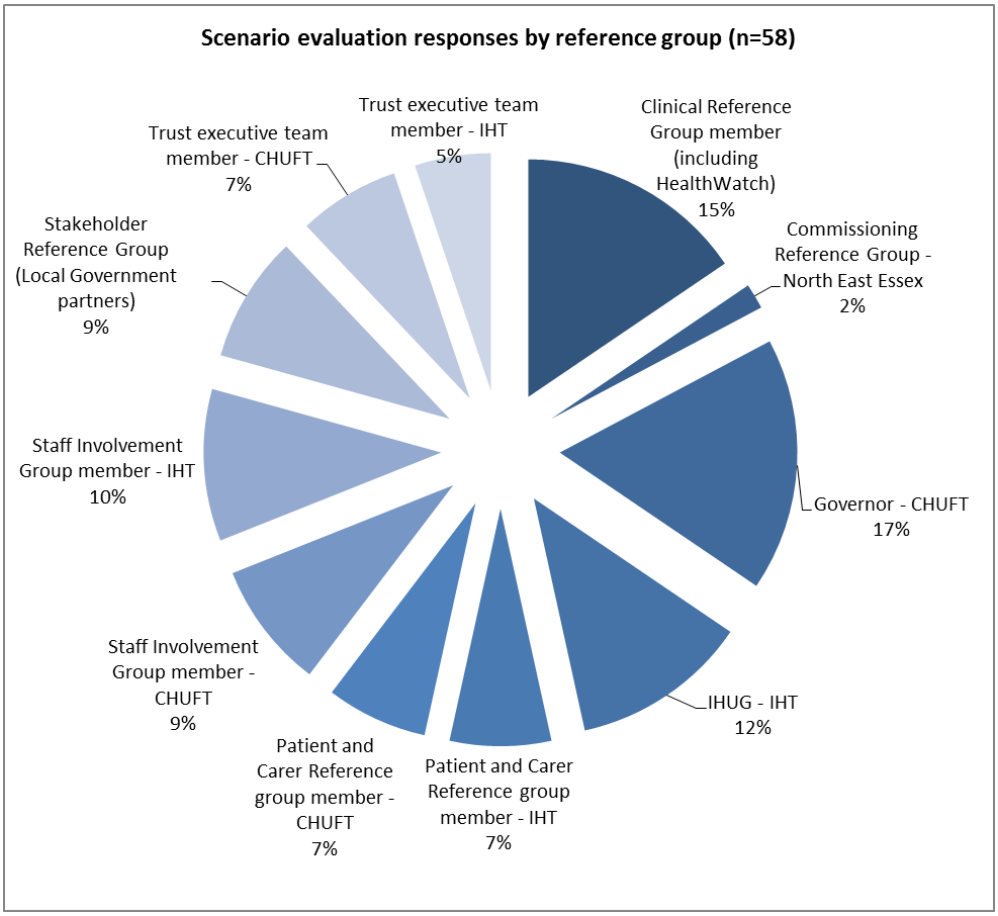
In total, representatives of 20 organisations participated in the evaluation:

- Action for Family Carers
- CHUFT
- CHUFT and IHT
- Colchester Borough Council
- Essex Sight
- Healthwatch Suffolk
- IESCCG
- IHT
- IHUG
- Ipswich Borough Council
- Ipswich Locality Homelessness Partnership
- NEECCG
- Public Health Suffolk
- Stroke Association
- Sue Ryder
- Suffolk County Council
- Tendring District Council
- University of Essex
- North Colchester Health Centre PPG
- Suffolk Family Carers

These stakeholders represented a number of different backgrounds. Overall, less than half were hospital employees. This is set out below:



There was representation from all the stakeholder reference groups. This is set out below:



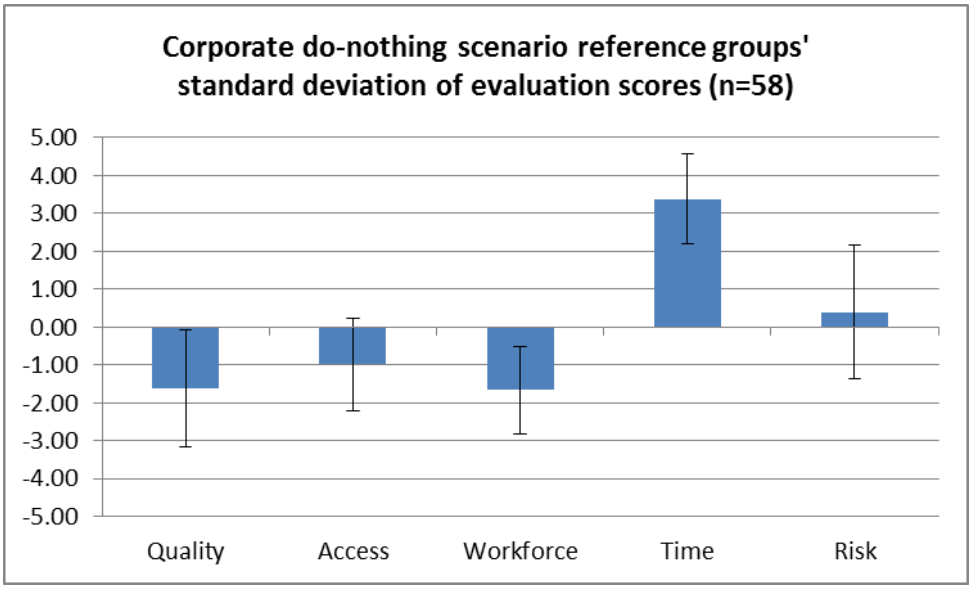
Distribution of evaluation results

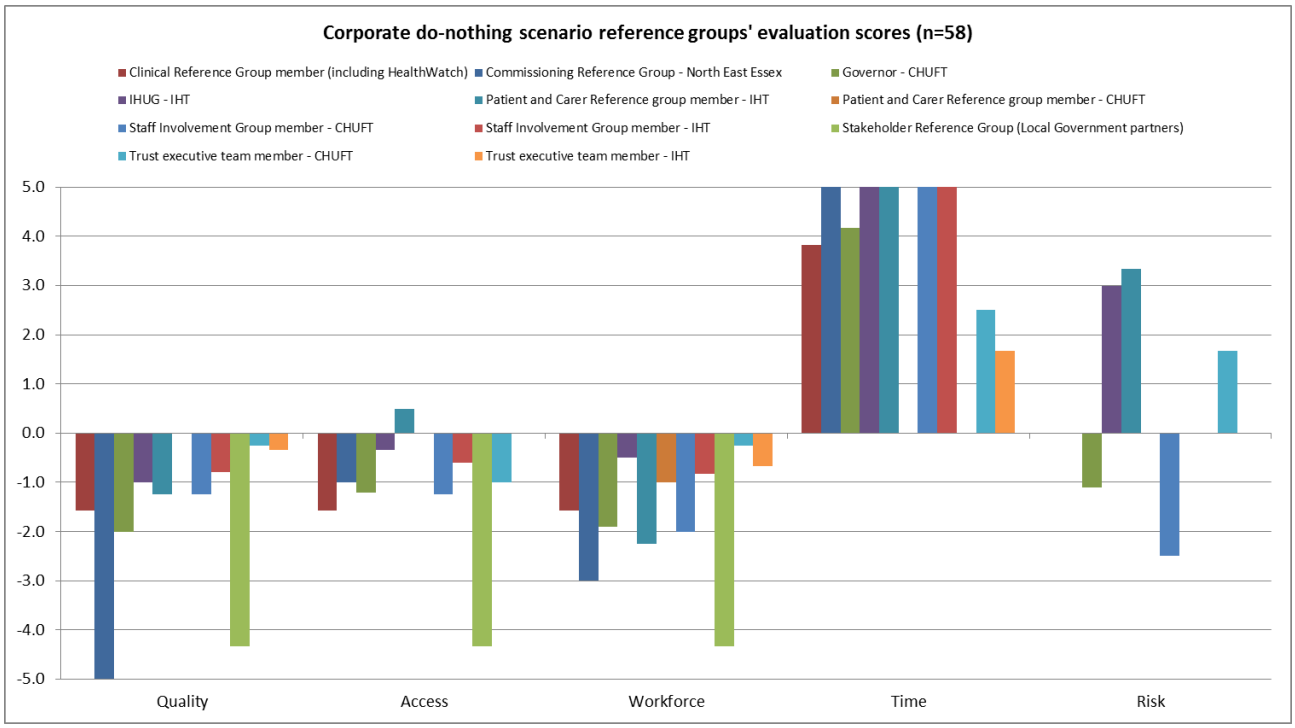
The distribution of evaluation results is set out by reference group for the corporate and clinical integration models. In all the models there was the least agreement in the evaluation of the risk. The comments in Section 0 suggest that this may represent different views of the risk of change, the risk of lack of transformation in a challenging environment or insufficient information at the OBC stage to make a satisfactory judgement.

Corporate model

Corporate 'do nothing'

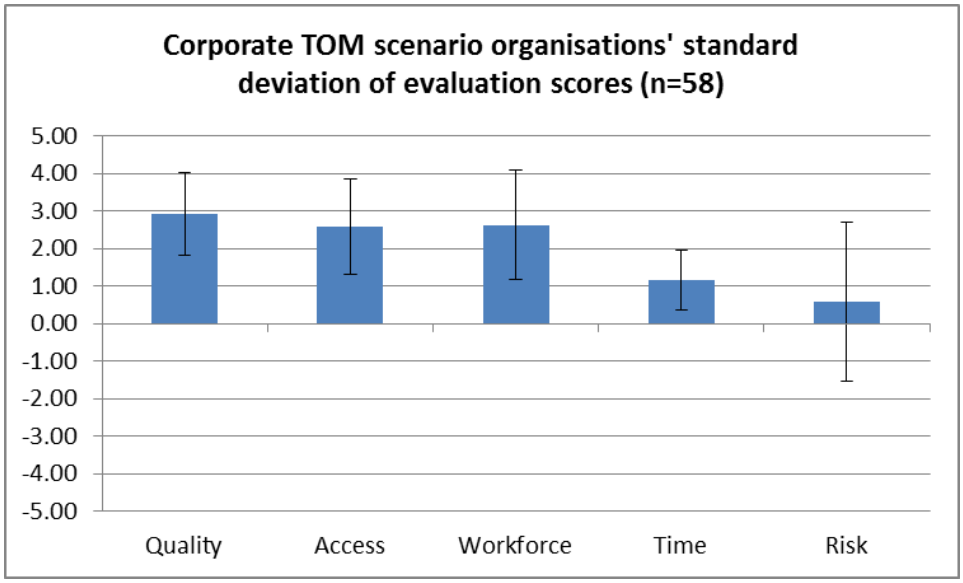
The range of evaluation for the corporate 'do nothing' scenario showed most variation in the evaluation of risk. The distribution is set out below:

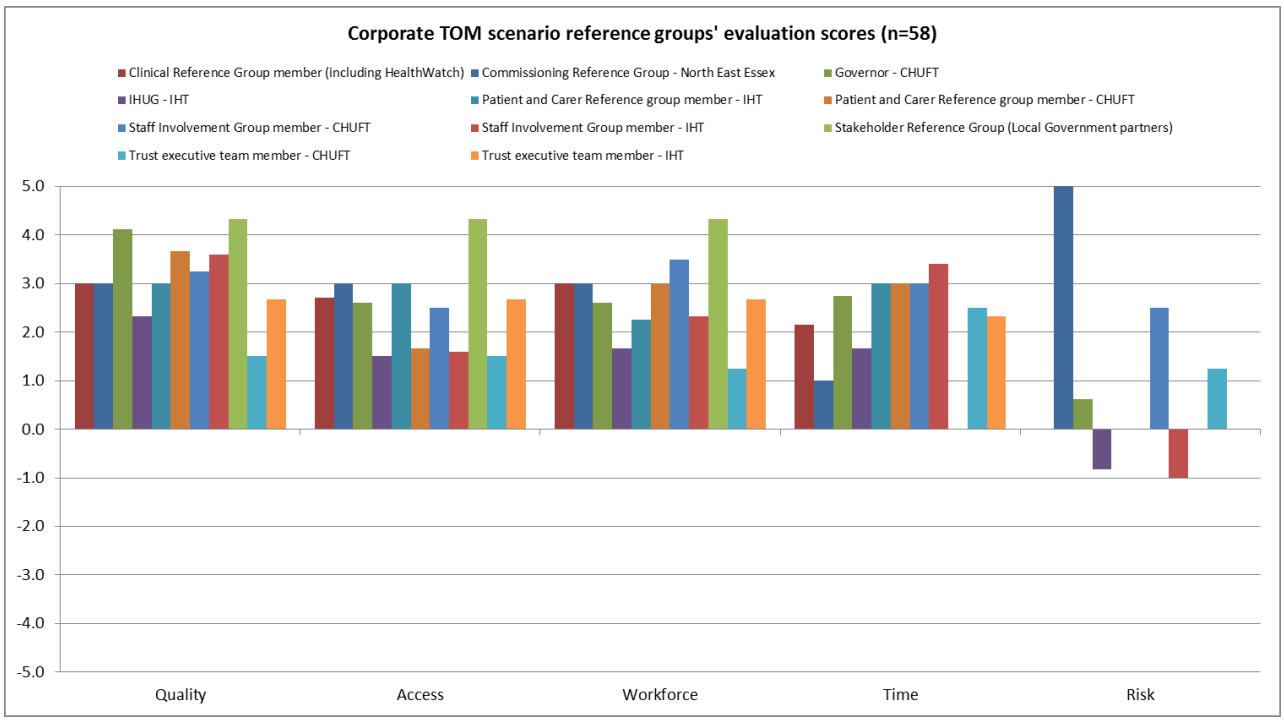




Corporate TOM

There was greater consensus on the quality benefits (quality, access and workforce sustainability) of the corporate TOM. There was the most variation in evaluation of risk. The distribution is set out below:

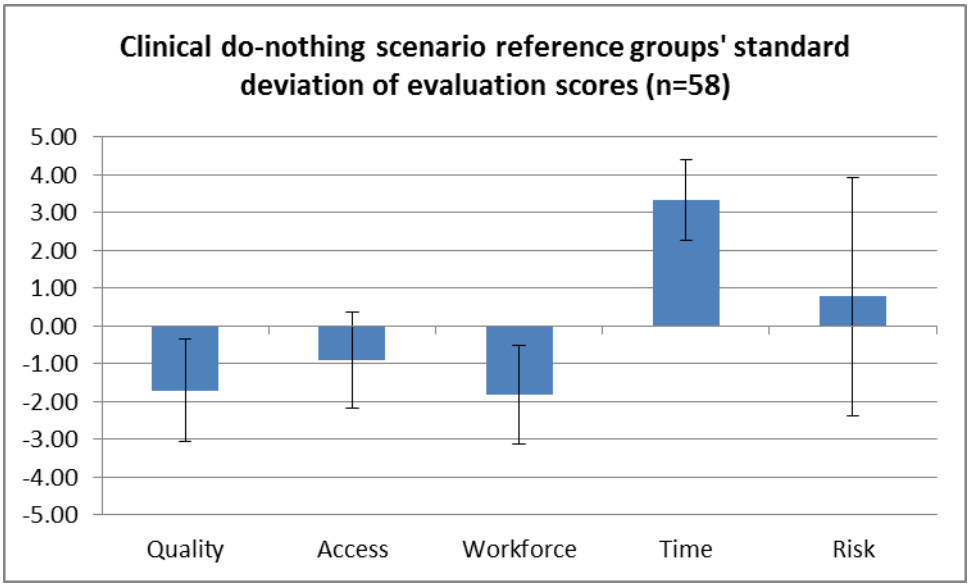


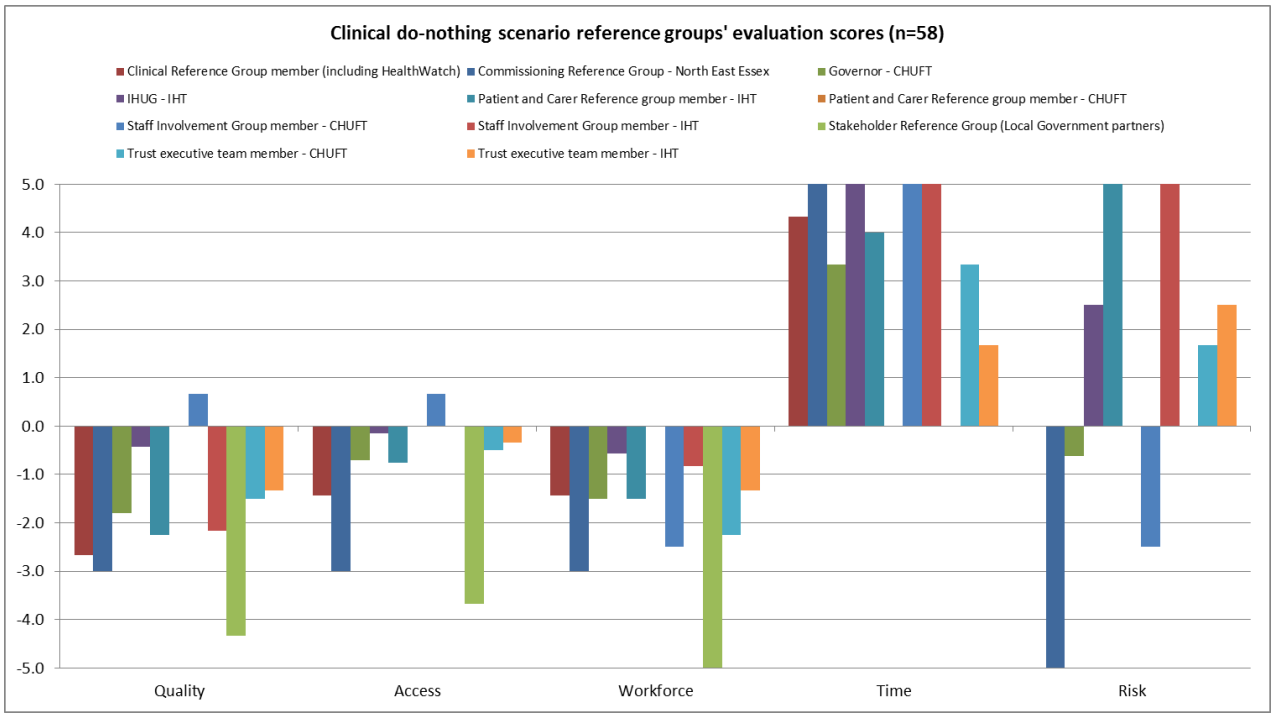


Clinical integration models

Clinical 'do nothing'

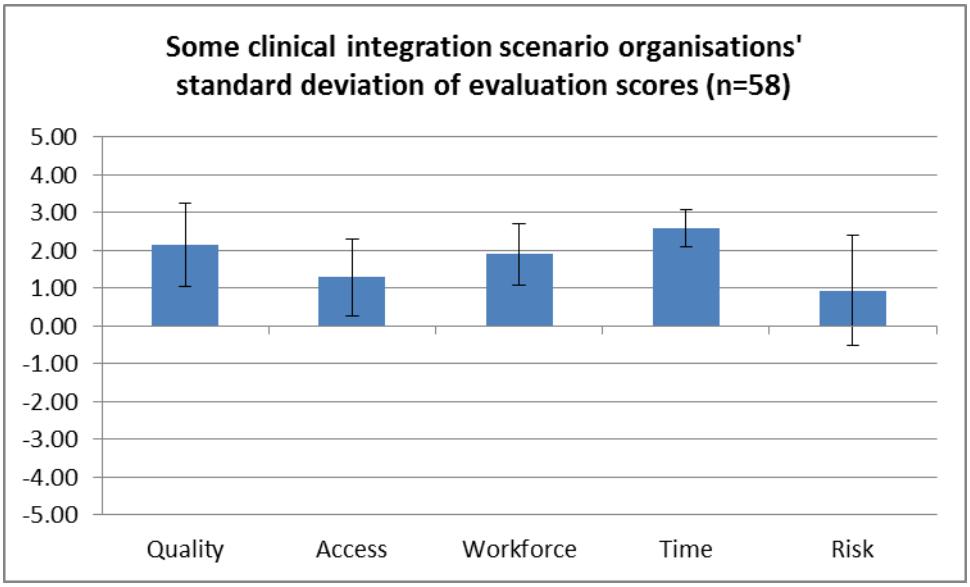
There was a narrow distribution of mostly negative evaluations for quality benefits of the 'do nothing' clinical model. There was less agreement over the risk scoring. The distribution is set out below:

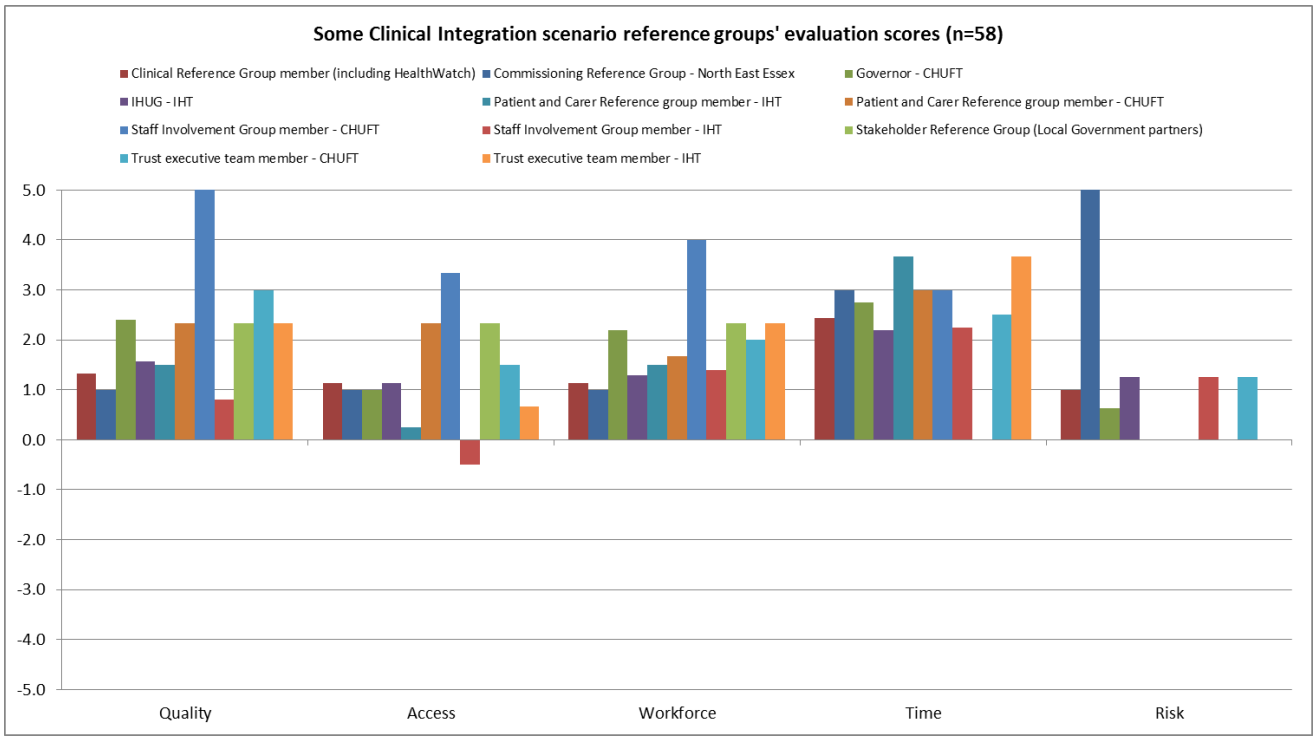




Some clinical integration

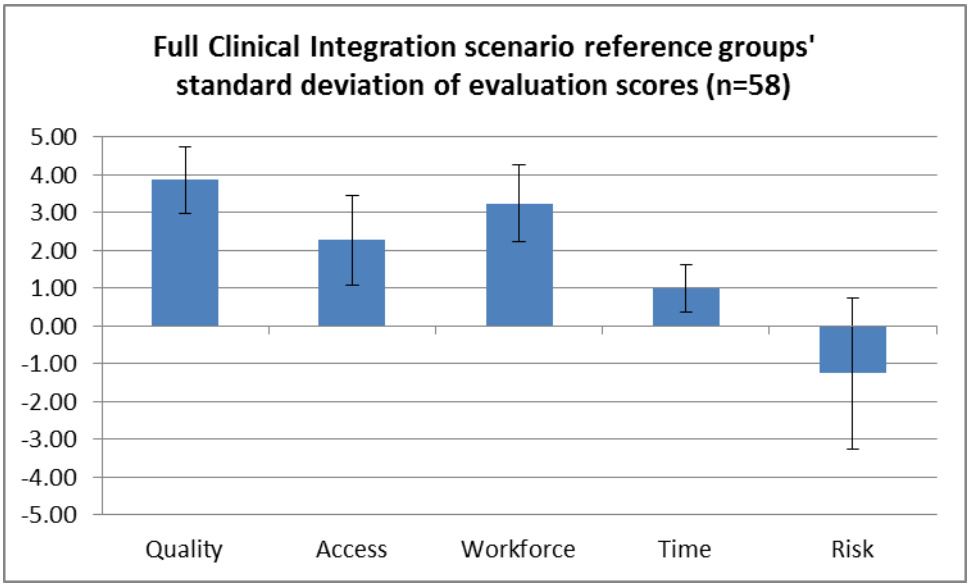
There was reasonable agreement between evaluators as to the positive nature of the benefits from some clinical integration. There was closer consensus on the risk evaluation but the distribution was still broader than for the benefits. The distribution is set out in below:

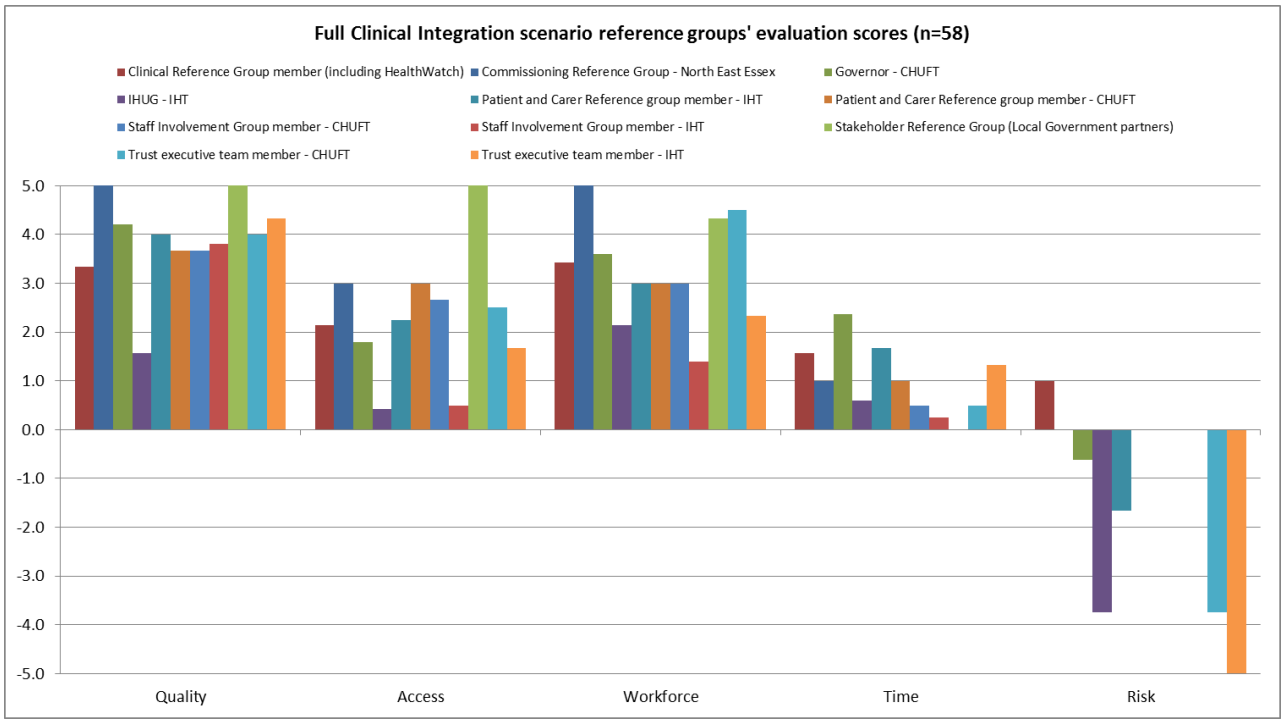




Full clinical integration

There was reasonable agreement between evaluators as to the positive benefits from full clinical integration. Similar to the other models there was the widest distribution in evaluation of risk. The distribution is set out below:





Evaluators comments

Evaluators were offered the opportunity to comment on each section of the evaluation. Comments are reported verbatim (anonymised) in this section.

Corporate model comments

Comments on the corporate model evaluation, by criterion, are set out below:

Quality criterion
Working together and sharing best practice by process mapping and sharing ideas will get the best from both organizations
I don't think there would be much change to a better quality of service for the patient however the second scenario may have a huge impact on families, carers and friends when visiting the patient; this would have to be taken into account.

I am not sure that corporate change affects the quality of care to patients to any major extent. However, if developing a model that incorporates the best of each some patient quality improvement may occur.
I don't feel qualified to answer this. Furthermore it is difficult to discern the relationship between the proposed model's characteristics, as described, and quality (of care?) for patients.
Service delivery is the key and choice for patients. Sharing/pooling of resources in theory should mean better quality outcomes for patients, best practice, innovation but only if staff from both organisations work in partnership are prepared to put patients at the centre of delivery.
We need to share expertise in the clinical field for the patients who need our care and advise
Maximising back office efficiencies should allow significant improvement in front line efficiencies and confidence in the processes to allow clinicians to manage their time better and allow them to manage workflow better e.g. not book routine follow up because the system is not robust enough to allow speedy review if problems arise.
This scoring assumes that the IT support works effectively - sufficient investment would be required particularly for the success of any "virtual" activities.
depends whether any potential savings are invested in patient care
The corporate TOM will not by itself achieve better quality outcomes for patients, the extent of quality improvement will be defined by the resources available to deliver services in conjunction with investment in new technologies, innovation and employing a suitably skilled, trained and motivated workforce.
Difficult to answer this with information given regarding the information given re new operating model - on paper looks like some possible additional services for patients i.e. virtual clinics - but will depend on how this will work - will it work for all patient groups ? - contracting out services could lead to better or poorer quality.
I don't really understand the difference between the two models in terms of patient quality and my organisation hasn't debated the matter so I can't express a view
There has already been some gains in quality from increased communication and sharing of ideas hence small gain on the 'do nothing'
some of the components to the TOM depend on significant investment-- therefore are these achievable and/or will this resource need to be diverted from clinical services
Many of the perceived benefits demonstrated within the Operating model development by both trusts could still be implemented within the 'do nothing' model e.g. automation, self-service, and remote working and public sector joint venture. Therefore I feel that the benefits from Corporate TOM are mainly to be realised within collaborative working, and shared and joint posts. These are still tangible benefits the most obvious is of the efficiency of scale; but the proposal overstates benefits that could easily also be achieved within a 'do nothing' scenario with some investment.
Gains in quality for patients will only be made with 'FULL' clinical support and involvement. No matter how well organised and committed the corporate service is, without clinical support it will fail.
Even with 'do nothing' -this exercise may lead to some improvements but minimal Corporate services model has much more potential
the potential gains for patients, of the corp. TOM, are not insubstantial. They should reduce cost allowing more money to be spent on patient care and some of the improvements should lead to real benefits in terms of patient interface with acute care. But it may be hard to actually realise some of the benefits
Access criterion
reduce waiting lists, share knowledge
I am not convinced that this will be affected.
I for one have not seen any information as to how local ambulance services will be affected, without

which it is difficult to gauge how patient access will be affected.
If "specialisms" are going to be delivered from specific hospitals consideration needs to be taken into account for day attendance as travel could be an issue for patients living in rural Suffolk who currently travel to Ipswich and who may have to travel to Colchester. Transport links are poor so there may be a higher dependency for the use of hospital "ambulance" people carriers. This could mean a whole day out for patients being picked up early and returning home late. the use of virtual clinic offering could work for some patients, those who are "savvy" with technology. If not technical skills then assistance may be required by NHS staff (hospital/GP surgery) which takes time away from the "day job". Great news if common information: enabling a single set record is held for each patient, which patients can access, is put into practice.
Some patients/relatives etc. would have travelling issues if treated at the furthest hospital from home.
Maximise access as long as it is interwoven with front line service changes focused on improving access for those that need it. Also changing clinical models so that those who require apps are easily able to and those who can be managed in a different way are using technology, advice and guidance, direct access diagnostics etc.
Again the CSOM requires good IT support to enable this to happen.
as above
A reduction in corporate overheads could indirectly result in improved access for patients as more resources may be available to invest in the provision of additional capacity for clinical services. Improved clinical support services and administration processes could also improve access through more effective and efficient deployment of staff and physical resources.
The virtual clinics and technology enabled solutions could improve access for some patient groups
I don't really understand the difference between the two models in terms of patient quality and my organisation hasn't debated the matter so I can't express a view
the benefits of the TOM may be higher -- however without the more detail difficult to judge: need to be carefully implemented such that vulnerable patients are not disadvantage by automation, virtual clinics etc, there must always be capacity to default to face to face/direct conversation option for both patients and staff . We do not want to become a "faceless" organisation
Operating model developed by both Trusts will allow for greater oversight and consistency of provision of service over a large area. This should ensure more equal access and with that greater knowledge of access routes to care.
Some patients will have to travel, but if handled carefully and with sensitivity, minimal loss of access will occur
Suggest communication with patients needs improvement.
'Do nothing' - some learning of better practice across sites Corporate services model has much more potential
Potential for significant improvement in access with better IT-enable interfaces (as in answer above)
Workforce sustainability criterion
introducing best practice and buy in from the staff would generate a better working environment and share expertise
The second scenario will achieve a moderate gain of sustainability by offering a wider choice of roles and over two sites however would staff retain the right to choose where they work?
A common model could mean more staff having to work across both sites. Some staff will not like this and may look elsewhere for work.
Difficult to say. Increased salaries and staff benefits, flexibility in working hours, good support from HR, clear line management, good team work, flexibility and staff being valued are important things to be considered to retain staff.
Job stability, improved opportunity for advancement and training opportunities should be part of the TOM.
Change is clearly required for many of the services supporting the workforce.

after consultation staff could work across both Trusts
The process of transition to the new operating model in the short term could result in the loss of key staff and skills. However, in the medium term, the new model should enable sharing of specialist skills across the new organisation and improve recruitment and retention.
There has to be some gain in efficiency and consistency by creating joint posts. Enabling staff to be utilizing their full skills in their roles will help staff retention and recruitment. However there is a risk re joint posts of over stretching roles - there obviously needs to be enough capacity built in or the initiative will have opposite effect - over worked and stressed staff who will go off sick or leave.
I don't really understand the difference between the two models in terms of patient quality and my organisation hasn't debated the matter so I can't express a view
'Do nothing' may bring continued loss in sustainability
More information needed for a fully formed answer
Greater scope for workforce development, and a large team will encourage development opportunities. There should be opportunity for greater sharing of practice and more opportunity for progression within the organisation.
With 15% total staff turnover at present, any improvement in staff conditions would gain sustainability
Some concern about outsourcing housekeeping, portering etc. because of previous failings regarding standards and supervision by the contractor. Returning these responsibilities to in-house improved markedly these standards and job satisfaction by the workforce.
Perhaps the easiest benefit to envisage with corporate services model
again, it's all about the potential for significant gain, if new systems of corporate TOM make staff feel more valued
Deliverability criterion
'Do nothing' could result in services remaining static. CSOM: 2 years is a tight deadline but any longer the impetus will be lost.
Sensible timeline with TRUE staff INVOLVEMENT not token engagement is key NOT necessarily pace although a degree of pace is required.
The 'do nothing' scenario won't have any tangible benefits and is deliverable instantly given that this is the status quo scenario. The new TOM will take 2-3 years before it will be possible to determine if the benefits have been realised, if they are in fact measurable. As there are multiple factors which will impact on quality, access and workforce sustainability, it will be difficult to determine if the new model is the key influence on these factors or other more important influences exist. Financial benefits will be more tangible.
Difficult to express a realistic timescale as some elements may take far longer than others.
I don't think I have enough information to judge this.
I don't really understand the difference between the two models in terms of patient quality and my organisation hasn't debated the matter so I can't express a view
Doing nothing presents a high risk to patients because it will impact quality and compromise the sustainability of both Ipswich and Colchester. The alternative has risks associated with the speed with which it can be successfully achieved and subsequently embedded but has long-term benefit.
Not sure I fully understand what you are asking from risk point of view!
assessment of the timeline and risk requires more detail of the TOM
Depends on willingness to change and adapt
I cannot find any information regarding the timescale and cannot comment.
With full staff commitment, the scenario should be delivered quicker, but knowing the juggernaut of the NHS it will take time. The private sector would wrap this up in months.
How can you rate the deliverability of 'do nothing' as nothing new has to be delivered? I find this a rather confusing question to unpick and give an answer to!

Doing nothing easy to achieve - hence low risk. Extremely unlikely to deliver benefits. Under TOM, 2 years is estimate of when benefits begin to materialise.
No timescale for 'do nothing'. For corporate services model could take 2 years (or longer) to fully deliver -some risk, but low.
All looks good on paper, but in practice we know delivery often takes more time, with more glitches and more costs

Clinical model comments

Comments on the evaluation of clinical models, by criterion, are set out below:

Quality criterion
It's a no brainer
It all depends what changes are made to which services. It is impossible to say whether the quality to patients will improve directly as a result of integration. However, the financial savings made by the two hospitals, if fed back to improving quality for patients, could result in an improvement.
Most of the parameters for evaluation appear to be 'management' attributes (systems, value for money, capacity planning, etc.) rather than 'clinical' attributes (centres of expertise/excellence, harmonisation of clinical guideline adherence across sites, alignment of treatment plans and options, e.g. in oncology).
The vision of one clinical body delivering across 2 sites should be the aim. There will always be subtle differences and so integration may look different for each specialty. Outcomes are those that need to be achieved. With time I suspect the resistant specialties will realise they are not that different from each other.
Full clinical integration has the potential for reducing quality, if the emphasis is on financial gain and cost saving. There should only be clinical integration where demonstrable gains in quality and access can be delivered
It makes sense if the organisations are to work together to aim for full clinical integration.
I don't really understand the difference between the two models in terms of patient quality and my organisation hasn't debated the matter so I can't express a view
Full integration would seem to provide the greatest quality benefit in the long term. There will be likely challenges to staff and patients and relatives/carers as they adjust to the need to move between sites if necessary.
the benefits from full clinical integration will be higher however deliverability in a reasonable timescale may be lower- based on discussion with the clinical leads at the strategy meeting last week
Full integration is the only viable scenario long term
With the increased scale of services, the need for robust clinical governance is even greater. This clinical oversight to all services should drive quality standards.
Utilising best practice in any event results in better quality for patients
I have included the issues surrounding travel, especially from rural areas into my evaluation of quality of service, as this fact is extremely important for many predominantly older people in rural locations
Some clinical integration is a bit vague as it depends how much integration but benefits more modest though could be maximised by focussing on those areas with the most potential for benefit i.e. would not be uniform -some services with most potential could 'fully' integrate and others minimally or not at all. The scenario guidance says 'minimal' integration - doesn't have to be, does it ? It's almost like there is a preference towards full integration!
Actually I am not comfortable answering these questions without a whole lot more detail. It feels like I am being "forced" to go for full clinical integration. However, I really don't have enough detail for any of the scenarios to make a well-informed, ethical decision, especially when it comes to clinical

services and how it will affect patients, staff, and carers, especially when I am not in clinical services.
'Do nothing' = gradual loss of services over coming years. Again this is all about the potential benefits we can see. I believe the more properly integrated our units become, the more patient benefit we could see
Access criterion
Again depends on involvement of local ambulance trusts.
see above. Dependent on where services delivered, transport issues, rural areas to town(s)
Working to similar pathways and aiming for same outcomes allows the economy of scale argument to come into play here and should increase access; by having congruence patients can be offered alternative site interventions without effecting pathway duration e.g. shared diagnostic capabilities across the two sites. Pts have proven that they are happy to travel if the offer is robust.
Depends how access is defined - I suspect this will vary between patients depending upon urgency.
as above
I don't really understand the difference between the two models in terms of patient quality and my organisation hasn't debated the matter so I can't express a view
Access to expertise may increase but see above comments regarding transport for patients and their carers. Likely to be some resistance emotionally as treatments are delivered outside of the local community
Efficiency gains from full integration would i feel give most benefits on access
I do not agree with the breakdown of full vs some clinical integration in supporting slide sets. Access for some services will benefit from full integration- but not necessarily all -- here again the devil is in the detail and requires significant OD support over a significant time.. this does not mean it is not the right thing to do
Physical access will remain unchanged unless there is physical relocation of services. With both Ipswich and Colchester having large expanding populations plus well populated surrounding area, it is extremely unlikely that centralisation of majority of services to one site would be able to serve our patients well. In fact that could lead to a risk of other community based services offering care closer to home instead of the Trust.
Access to services will always depend on location. However this would be offset against better quality of best practice.
In answering this in accordance with the theory of the themes and benefits listed I am mindful of the challenges for patients gaining access to the specialist site for care from long distances with complex public transport journey's, those from deprived areas, and those on low income to name just a few issues.
I have included travelling in my equation with my answers, not sure if this is appropriate? I find the word 'access' rather ambiguous in this question
As above - for some integration - could provide better access for those areas with the greatest need
Hopefully the benefits of LTP gradually offset the extra travelling that may be required. In the longer term we may be able to repatriate services, decreasing access issues, but travel is perhaps going to be a major hurdle with the public/external onlookers
Workforce criterion
With difficulties in recruiting to some specialties clinical integration will definitely lead to improved workforce sustainability
As above workforce sustainability is dependent on conditions of employment, ethos of organisation, being a valued member of staff.
More exciting opportunities to work together to maintain services locally and teaching posts to be shared to give trainees a better experience. Nursing and allied staff more opportunities to specialise. If we limit integration these opportunities will be harder to realise.
May be some initial loss of staff but in the long term sustainability should be greater.

this relies on staff being willing to work across two sites for existing employees. This may be easier with new posts.
A very difficult area to express a view in. Some roles would work across both sites whereas others would not. I think is this possibly the most challenging area in the merger proposals. If nothing else the location and geography of the sites does not lead to easy joint working, Rita's etc.
I don't really understand the difference between the two models in terms of patient quality and my organisation hasn't debated the matter so I can't express a view
One of greatest gains to integration would be sustainability , which i feel is one of biggest risks to services at present
Full integration will give the greatest chance to recruit and retain high quality staff
Much greater scope for clinical staff to develop and progress within a larger scale organisation, also greater resilience in face of absences.
The use of best practice will allow staff to move between specialties to gain experience and thus qualifications and thus staff satisfaction. This will apply to clinical and non-clinical staff and thus turnover will improve.
Recruitment and retention may always be an issue possibly making it difficult to achieve all the benefits identified. Can all these benefits be achieved without the need for staff to travel between sites thus incurring additional costs?
Most benefits for full integration but those in most need could still benefit from some integration if this was a criterion used to decide who should integrate and how
'Do nothing' = gradual service attrition= loss of staff gradually integration should improve staff retention in the future (but not necessarily in the short term)
Deliverability criterion
I'm not sure it's possible to provide a meaningful answer to this question without knowing more of the details. For example if one or more centres of excellence are to be developed then capital funding for additional facilities is likely to be needed, e.g. if cardiac catheterisation following MI (a standard procedure) is to be made available then appropriate facilities would be needed. Without knowing whether this is feasible or even planned then it seems difficult to reliably predict timescales.
Please see answer re workforce integration.
Again, difficult to assess timescale. Some integration is already in place other areas could take longer than 4 years.
I don't really understand the difference between the two models in terms of patient quality and my organisation hasn't debated the matter so I can't express a view
I am unable to comment on timescales as I am not aware of any planned timescale at present.
This answer is 'guess based' as not enough information is available
Full integration could take 3-5 years (or longer for it to be fully sorted). Moderate risk likely for time to achieve not the eventual outcome
even the "some" integration scenarios will take significant time to establish

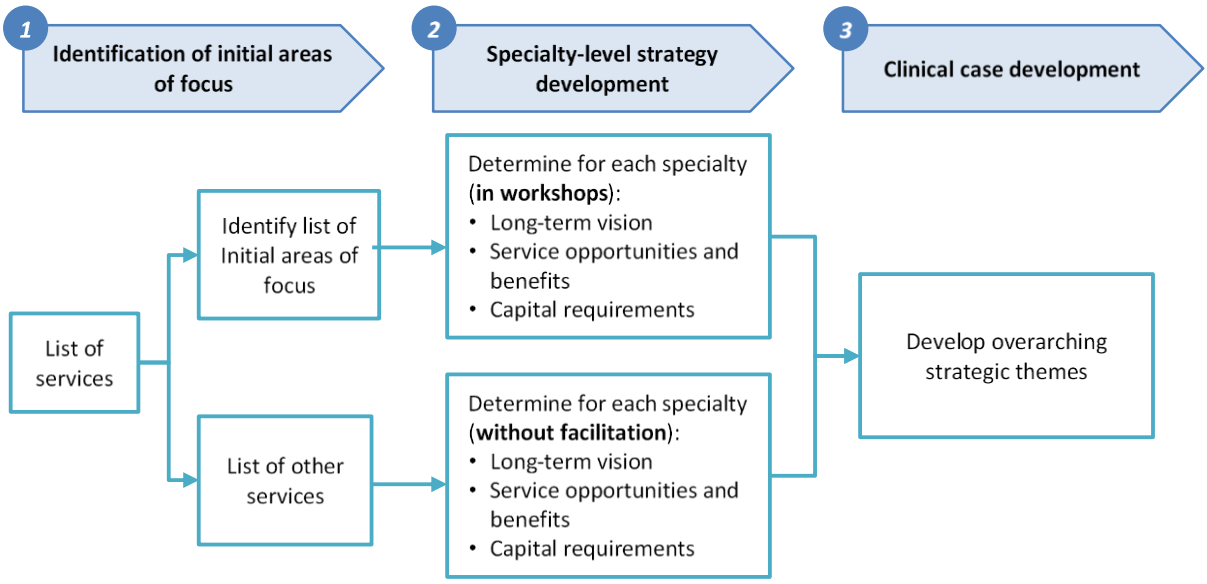
E. Clinical strategy development approach

Introduction

The clinical case was developed using the Partnership ambition and clinical design principles as the foundation to guide the strategic direction. A bottom-up approach was employed to construct the clinical case, whereby clinical specialties from both Trusts provided the clinical input into the case. This involved a group of 26 clinical specialties from the two Trusts coming together in their teams to develop specialty-level strategies. Six strategic themes were established based on these outputs, encompassing the common specialty opportunities for clinical integration along with the associated benefits. It is the opportunities and benefits derived from each strategic theme, along with the respective enablers and dependencies that form the basis of the clinical case.

Specialty engagement

The approach to working with the clinical specialties as part of developing the clinical case is outlined in the diagram below:

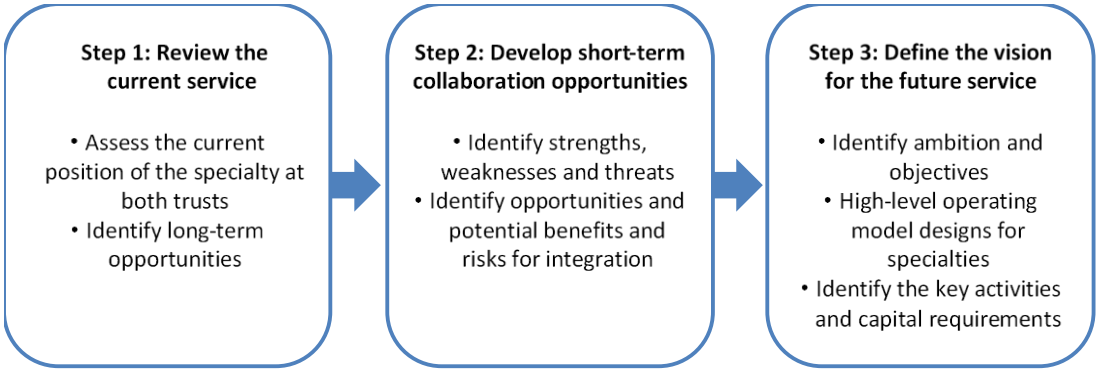


Identification of initial areas of focus

Firstly, six specialties were identified as areas of initial focus for specialty-level strategy development, based on the significant opportunities and benefits they could potentially realise. For these specialties, the collaborative working between the Trust teams was facilitated through workshops provided by the programme. While the remaining specialties did not receive direct facilitation, they were provided with a guidance framework and weekly drop-in sessions to support them through the process.

Specialty-level strategy development

The specialty-level strategies were developed by the specialties using an iterative three-step process, as shown in the diagram below. The specialties worked together in their teams (with or without workshop facilitation) to complete a purpose-built template and deliver the required outputs for each of the three steps.



A series of three workshops was held with each of the six initial areas of focus to complete the three-step process. These were collaborative working sessions bringing together the clinical teams from both organisations, including clinical leads, nursing representatives, clinical support staff and CCG representatives.

Although two different methods were used for developing the specialty-level strategies, all of the specialties developed the same outputs by identifying their long-term vision, service opportunities and benefits, and capital requirements.

Clinical case development

Following the specialty working, the programme collated all of the outputs from the 26 specialties and carried out an analysis to identify the common opportunities and benefits. These outputs were aggregated and summarised across the specialties, allowing for the identification of the six strategic themes along with their corresponding sub-themes.

F. Consideration of the separation of emergency and elective care

Introduction

This paper has been produced to explore the potential benefits and drawbacks of centralising three specialties (cardiology, stroke and vascular) onto a single site within the Partnership. It draws on relevant research and clinical guidance and applies these to the local context. It concludes with a recommendation on whether centralising the identified specialties would be optimal for the Partnership and its patients.

This 'triad' of cardio-vascular services has been mooted as a core set of services for a hot-cold site split in discussions with regulators and commissioners during the early stages of the Partnership. However, it has not been a theme which the specialties have identified as an opportunity in their work developing the clinical strategy, despite having considered it. The Partnership programme team considered that it should be examined separately to ensure that it has been given sufficient consideration.

Purpose and method

This paper takes a hypothesis testing approach to forming a recommendation. The hypothesis being tested is:

> *Cardiology, stroke and vascular services should be centralised and co-located on a single site*

This hypothesis states that all services will be co-located. Therefore the evidence base for whether centralisation is associated with improved patient quality (incorporating outcomes, safety and experience) will be examined. In addition the case for co-location of the three specialties together will be tested. The practical requirements for centralisation will then be considered. Finally the local appetite for organising services in this way is also taken into account.

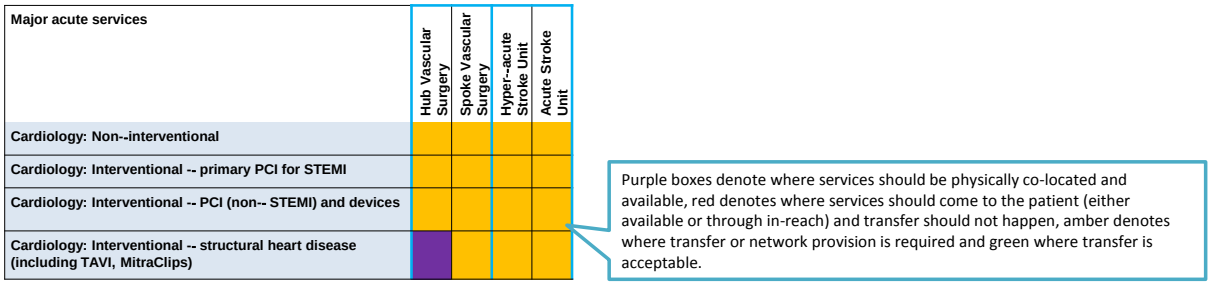
Analysis has been undertaken to test the validity of the hypothesis, leading to a recommendation. This recommendation will require further testing through clinical input and verification.

Cardiology

Acute Cardiology is a core service currently offered by both CHUFT. Both sites currently refer complex work such as PPCI to other providers.

The South East Coast Clinical Senate has undertaken a meta-analysis of evidence and identified which of the other specialties under consideration are co-dependent with acute cardiology[47]. This is shown in the summary extract table below. This shows that only if there was a desire to develop an interventional structural heart disease service would this require co-location with hub vascular surgery. For all other services, a transfer is considered acceptable.

[47] Adapted from *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review*, South East Coast Clinical Senate, 2014



Some evidence suggests that offering a 24/7 consultant-delivered service can improve outcomes following admission with acute coronary syndromes, and that the workforce requirements associated with this are cited as a reason for centralising cardiology services[48]. There are already effective on-call and out of hours services provided by both CHUFT and IHT.

An audit of PCI (non-primary, for nSTEMI patients) showed that Ipswich carried out 245 procedures in 20143, the latest year for which data has been made available. Whilst this was the initial year that the service was offered, this was significantly fewer than the 400 procedures per year that is recommended[49]. This is because there is evidence that patients treated in higher volume centres may have improved outcomes. Changing referral pathways between Colchester and Ipswich may help achieve this threshold. The service is already effectively centralised onto the IHT site.

Conclusion: For the provision of the vast range of acute cardiology services, there is limited requirement for co-location with vascular surgery or stroke services. Providing these services on a networked basis is considered suitable. Only when highly complex and specialised cardiology services considered would there be a strong rationale for consolidation onto a single site co-located with vascular surgery; these are not under consideration for the Partnership. The evidence does suggest that altering referral pathways may be beneficial for PCI procedure outcomes, though this in itself does not require additional centralisation. This reduces the requirement for acute cardiology services to be located on a single site. The main quality factor related to cardiology is the provision of a consultant-delivered service.

Vascular

Evidence suggests that there is a link between the volume of procedures undertaken and the outcomes in vascular surgery[50]. This has formed part of the case for change for the centralisation of vascular services, often into a 'hub and spoke' setup. The King's Fund found that quality and national policy were the most commonly cited reasons for centralising specialist services, including vascular surgery[51].

Vascular surgery has been the subject of reconfiguration across CHUFT and IHT over the past five years. As a result all non-elective surgery is carried out at CHUFT in the Five Rivers centre.

The Vascular Society of Great Britain and Ireland has considered the requirements for complementary services to vascular surgery. These include both Cardiology and Stroke medicine[52]. It

[48] *The reconfiguration of clinical services: What is the evidence?*, King's Fund, 2014
[49] *National Audit of Percutaneous Coronary Interventions: Annual Public Report 2015*, 2016
[50] For example: *An epidemiological study of the relationship between annual surgical volumes and outcomes from abdominal aortic aneurysm surgery in the UK from 2000 to 2005*, Holt, P. J. E. at al., British Journal of Surgery, 2007
[51] *The reconfiguration of clinical services: What is the evidence?*, King's Fund, 2014
[52] *The Provision of Services For Patients with Vascular Disease 2015*, Vascular Society of Great Britain and Ireland, 2015

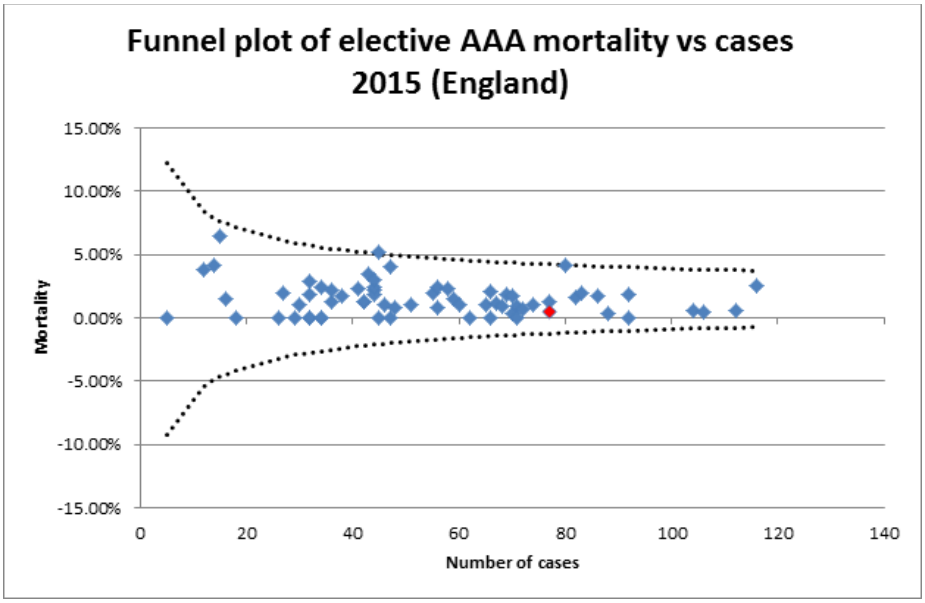
was recognised that Cardiology input can improve surgical outcomes. It is also recommended that hyper-acute stroke units are co-located with vascular surgery.

This is endorsed by the South East Coast Clinical Senate[53], who identify that a vascular surgery hub (the service at CHUFT) should be co-located and have available both acute cardiology and hyper-acute stroke unit, as shown in the summary extract table below[54].

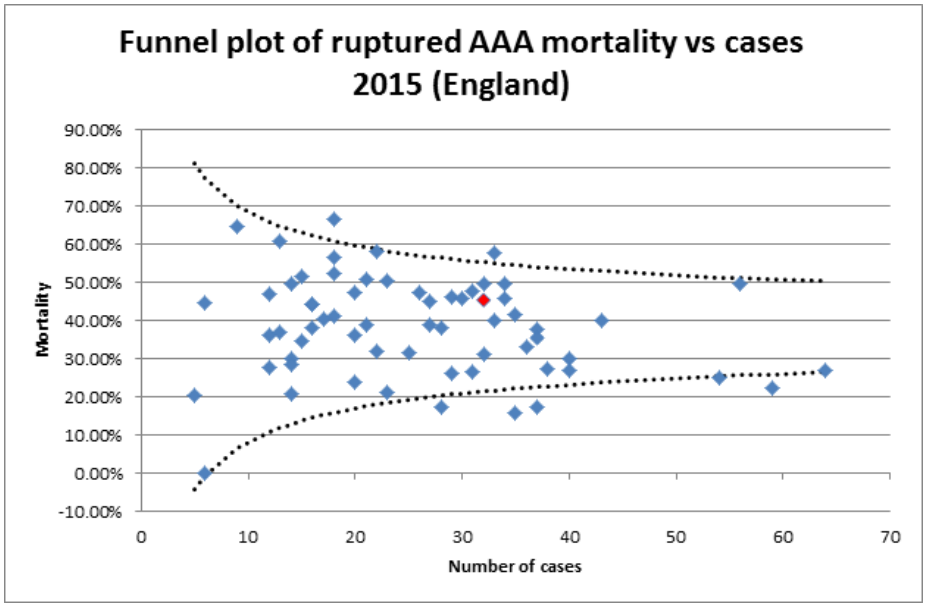
Major acute services	Acute Cardiology	Hyper-acute Stroke Unit	Acute Stroke Unit
Vascular Surgery (Hub)			
Vascular Surgery (spoke)			

Purple boxes denote where services should be physically co-located and available, red denotes where services should come to the patient (either available or through in-reach) and transfer should not happen, amber denotes where transfer or network provision is required and green where transfer is acceptable.

Local data on mortality compared with the number of cases is shown below and on the following page[55], for Colchester (the 'hub' for vascular surgery). This demonstrates that a relatively higher number of cases are undertaken compared with other providers. In addition, the mortality rate is within the expected ranges.



[53] *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review*, South East Coast Clinical Senate; 2014
[54] Ibid.
[55] Trust provided data



Conclusion: Vascular services have already been centralised into the preferred 'hub and spoke' model between CHUFT and IHT. As a result of this, the outcomes (with respect to mortality for elective and emergency AAA procedures) are within the expected ranges. In this configuration there are currently the required co-dependent services, as identified in the relevant evidence.

Stroke

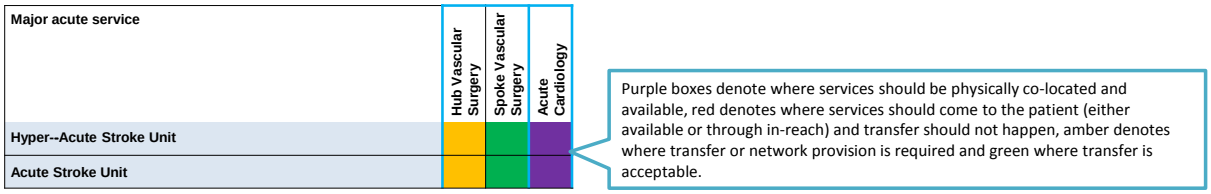
Stroke is recognised as a leading cause of death and disability in England[56]. As a result, there has been a national focus on improving the outcomes for stroke patients. As with vascular surgery, there has been a trend towards centralisation.

Reviews of available evidence suggest that there is a link between outcomes and access to hyper-acute care, in particular rapid access to imaging and thrombolysis[57]. This evidence was derived from comparing mortality and disability rates in an urban setting (London and Manchester). Care must therefore be applied when extrapolating this to a rural or less urban setting.

The study also noted that "Organised inpatient stroke unit care, which is provided by multidisciplinary teams that exclusively manage patients with stroke in a dedicated ward, is associated with better quality and reduced death and dependency."[58] This reflects the current provision at both CHUFT and IHT.

The South East Coast Clinical Senate also considered the co-dependencies for both hyper-acute and acute stroke units[59]. This showed that there should be network arrangements with spoke vascular surgery, whilst acute cardiology should be co-located:

[56] *Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis*, Morris, S. et al., British Medical Journal, 2014
[57] Ibid.
[58] Ibid.
[59] *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review*, South East Coast Clinical Senate; 2014



Much of the drive for reconfiguration of stroke services has been to achieve improved outcomes. In common with vascular services, the most often cited reason for reconfiguring stroke services was to achieve better quality[60].

Both stroke units at both CHUFT and IHT currently perform strongly compared with other units nationally. The Sentinel Stroke National Audit Programme (SSNAP)[61] collates data from each stroke unit, comparing this against national guidelines. Summary outputs on an organisational level are shown in the following page.

Conclusion: Although there is a national tend towards the centralisation of stroke services to improve outcomes, SSNAP data indicate that both units meet the majority of standards. The local case for reconfiguring services to realise quality benefits is therefore less clear than the national direction of travel suggests.

			CHUFT	IHT
Key indicator	Response required to meet indicator	National results*		
Staffing/Workforce				
1. Establishment of band 6 and band 7 nurses per 10 SU beds	Met if sum of band 6 and 7 (WTE) nurses per 10 SU beds equal to/above 2.375 per 10 SU beds	51% (90/178) of sites meet KI	Yes	Yes
2. Presence of a clinical psychologist (qualified)	Access to at least one (WTE) qualified clinical psychologist per 30 SU beds	6% (10/178) of sites meet KI	No	No
7-day working				
3. Stroke consultant led ward rounds**				
Type 1 beds	At least one ward round per day (7 a week minimum)	72% (112/156) of sites meet KI	Yes	Yes
Type 3 beds	At least one ward round per day (7 a week minimum)			
4. Nurses on duty at 10am weekends***				
Type 1 beds	3.0 or more nurses per 10 type 1 and 3 beds (average number of nurses on duty on type 1 and 3 beds)	20% (31/156) of sites meet KI	Yes	No
Type 3 beds				
5. At least two types of therapy available 7 days a week	7 day working for at least two types of qualified therapy. Includes occupational therapy, physiotherapy and speech and language therapy.	31% (55/178) of sites meet KI	Yes	Yes
Access to specialist treatment and support				
6. Patients can access intra-arterial (thrombectomy) treatment	Yes Yes, by referral	67% (105/156) of sites meet KI	No	Yes
7. Intermittent pneumatic compression device (IPC) used as first line prevention of venous thromboembolism	Intermittent pneumatic compression device is first line preventative measure.	80% (143/178) of sites meet KI	Yes	Yes
8. Access to a specialist (stroke/neurological specific) Early Supported Discharge (ESD) team	Yes	81% (145/178) of sites meet KI	Yes	Yes
9. Timescale to see, investigate and initiate treatment for both high risk and low risk patients ****:	HIGH risk TIA patients = The same day or next day 7 days a week LOW risk TIA patients = Within a week	73% (130/178) of sites meet KI	Yes	Yes
Patient and carer engagement				
10. Formal survey undertaken seeking patient/carer views on stroke services	At least one a year	61% (108/178) of sites meet KI	No	Yes
Total number of key indicators achieved (Maximum = 10) *Percentages refer to the proportion of sites that are achieving that number of key indicators*	1: 2% (3/178) 2: 2% (4/178) 3: 12% (21/178) 4: 13% (24/178) 5: 19% (33/178)	6: 21% (37/178) 7: 15% (27/178) 8: 11% (19/178) 9: 4% (8/178) 10: 1% (2/178)	7	8

* Sites that have been assigned the performance of the site that treats their patients in the first 72 hours have not been included in the national denominators.
**If a site has both type 1 and type 3 beds consultant led ward rounds must take place at least once a day on both in order for the key indicator to be met.
*** If a site has both type 1 and type 3 beds an average of Saturday and Sunday per 10 Type 1 and 3 beds.
****Can apply to both inpatient and outpatient services. If site has both the one with the BEST time is used.

Adapted from Sentinel Stroke National Audit Programme (SSNAP): Results – Acute Organisational Audit, 2016, Royal College of Physicians, Available from https://www.strokeaudit.org/results/Organisational.aspx

[60] *The reconfiguration of clinical services: What is the evidence?*, King's Fund, 2014
[61] Available from: https://www.strokeaudit.org/results/Organisational.aspx

Local considerations

The hypothesis can also be tested against more local factors. This can determine whether the proposed change identified through the hypothesis could be practically implemented.

Outputs from the clinical workshops: The six specialties that were designated as initial areas of focus had a series of facilitated workshops to develop opportunities enabled by the Partnership. In these, all specialties were encouraged to consider benefits that could be achieved through centralisation, including moving services onto a single site. Cardiology and stroke were both initial areas of focus. Neither considered that consolidation onto a single site would deliver benefits to patients. As a result there is limited appetite amongst clinicians to implement a centralised service in these areas.

Estates and facilities: As detailed above, currently CHUFT is the 'hub' within the vascular surgery network, and estates at both CHUFT and IHT have been altered to reflect this. IHT has the 'Heart Centre' and two catheter laboratories, whilst the single catheter laboratory at CHUFT is beyond replacement date. Both CHUFT and IHT have hyper-acute stroke units. Centralisation and co-location of the three specialties onto a single site would require capital investment to ensure that changes can be accommodated. A prioritisation process would also need to consider which site would be optimal for locating services.

Existing service quality: Whilst the national policy direction for some services under consideration is for centralisation, this is often as a result of quality or workforce drivers. In particular, stroke services at both CHUFT and IHT continue to perform well in national audits, often exceeding 'exemplar' national performance. This may be improved through centralisation, but this needs to be balanced against the risk of disrupting a well-performing existing service.

Implications for the hypothesis

A consideration of the practical requirements for centralisation has also been carried out. This covers the relevant clinical adjacencies in terms of what other specialties require the three specialties to be co-located, including the recommendation from the clinical senate meta-analysis and Royal Colleges. This has demonstrated that:

- Acute cardiology is a co-dependency for both vascular surgery (at both the hub and the spoke site) and stroke (both acute and hyper-acute units); therefore it must be co-located with and available to both services
- The inverse is not true, though. It is acceptable for both vascular surgery and stroke services to be offered through a network arrangement for sites offering all but the most complex acute cardiology
- As a result there is neither a clear rationale for co-location of all services onto a site, nor duplicating services across both sites; the hypothesis is not strongly supported and also not refuted

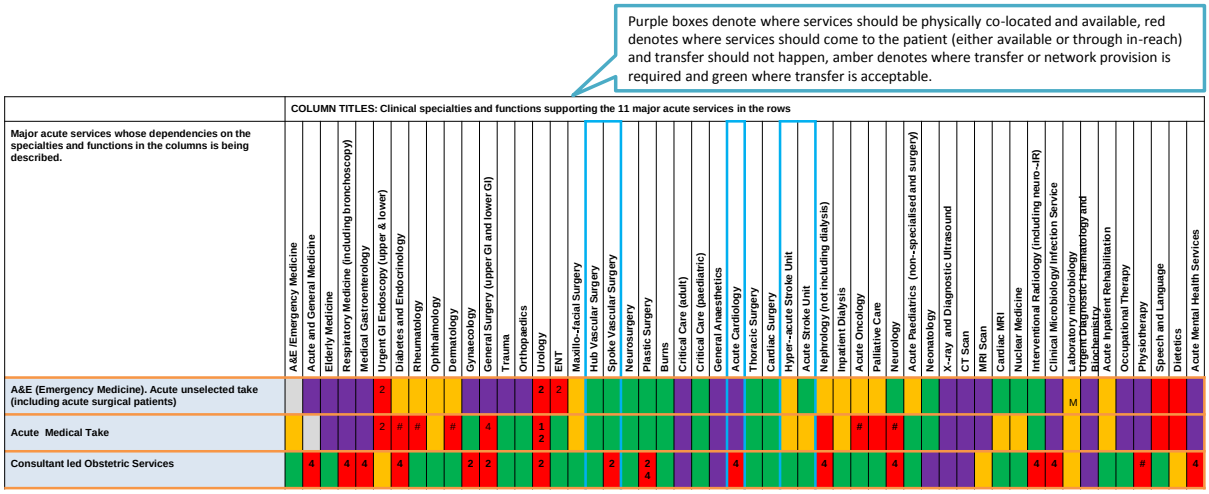
Co-dependent services also need to be considered against the design principles fixed points. This expands the range of services that will be offered on both sites to include A&E, an undifferentiated medical take and Obstetric-led maternity services. As a result, the required co-dependent services also need to be tested. This analysis is shown in detail in the following section.

Fixed points

An extract of the South East Coast Clinical Senate meta-analysis of the interdependencies between major acute services and supporting specialties[62] is shown below. This extract table shows just the acute services that are identified as design principle fixed points, mapped against clinical specialties.

With respect to the three fixed points there is no requirement for co-location of either vascular surgery or stroke services. It would be generally acceptable for these patients to be safely transferred to an alternative site. This reflects the current state for vascular surgery.

This also shows that the evidence suggests that where a site has an A&E or an acute medical take then acute cardiology should be co-located and available; patients should not require transfer



This is supported by an earlier study by the British Cardiovascular Society, that stated "All hospitals admitting unselected acute medical patients should have an appropriately sized, staffed and equipped Acute Cardiac Care Unit, where high risk patients with a primary cardiac diagnosis should be managed."[63]

Conclusion: To enable the design principle fixed points to be delivered safely it is recommended that acute cardiology is available on both sites. There is limited requirement for other services under consideration to be co-located.

Conclusion

This paper has sought to test the following hypothesis:

> *Cardiology, stroke and vascular services should be centralised and co-located on a single site*

The hypothesis was tested for each of the services against guidance and evidence, local considerations, and in the context of the design principle fixed points. A specific reason for centralising services was sought. In the individual specialty reviews, the evidence was not conclusive that services would be significantly improved by centralisation:

[62] Adapted from *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review*, South East Coast Clinical Senate, 2014

[63] *From Coronary Care Unit to Acute Cardiac Care Unit – the evolving role of specialist cardiac care*, British Cardiovascular Society, 2011

- Cardiology: The primary driver of improved outcomes was the provision of a 24/7 Consultant-led service; there is limited evidence that co-location with vascular or stroke services was required
- Vascular surgery: There is a relationship between volume and outcomes, and the national direction is that services are arranged into 'hub and spoke' networks; this reflects the current service configuration
- Stroke: Centralising hyper-acute stroke services is associated with an improvement in outcomes (both mortality and disability)

Overall, there is some support for the hypothesis that services should be centralised. Less clear is whether the evidence supports centralisation onto a single site. Testing the hypothesis against local considerations showed that:

- There is limited local appetite to configure services onto a single highly specialist site; Vascular surgery is already organised into a network and centralised, and PCI is only carried out on a single (different) site
- The local case for change, particularly in relation to stroke services, is less compelling than the national picture as services already have good outcomes
- The design principle fixed points are not conducive to centralising the three services on a single site, given that there is an ambition to offer A&E and an undifferentiated acute medical take from both sites

Recommendation

This paper has sought to test the stated hypothesis and found that there is only limited supporting evidence to support it. In particular, there are local considerations that should be taken into account when considering centralisation of services.

At this stage there is limited evidence that the centralisation of services would result in patient benefits or significant efficiencies. It is recommended that additional investigation related to stroke services is undertaken to determine the optimum local configuration.

G. Finance case: Overarching assumptions and principles

Activity growth

Demographic growth uses Indicative Hospital Activity Model (IHAM)[64] projections as this is consistent with current Sustainability and Transformation Plan (STP) modelling. The growth figures used in the STP and therefore the modelling are as follows:

Table G-1 Growth assumptions by year

IHAM Growth	2018/19	2019/20	2020/21	2021/22
Colchester	2.80%	2.50%	2.50%	2.50%
Ipswich	2.28%	2.38%	2.28%	2.28%
STP solutions	-1.80%	-1.40%	-1.40%	0.00%

The modelling of STP solutions only extends as far as 2020/21 and therefore it is assumed for the purposes of this modelling that no further solutions will be applied beyond 2020/21 and therefore the full benefit from IHAM is reflected by Trusts.

Given the uncertainty over national funding beyond year 0 (2017/18) of the planning period, the existing level of income for subsequent years has simply been adjusted for NHSI's forecast of cost inflation and efficiency requirements. There will be no adjustment for expected structural or individual price adjustments.

Tariff and efficiency

NHSI issued their guidance on cost inflation and efficiency requirements in March 2016 which provides an indicative net uplift to tariff in future years. NHSI indicated that Trusts should assume efficiency requirements of 2% for the purposes of long-term modelling

Table G-2 Tariff increases by year

	2018/19	2019/20	2020/21
Overall cost increase	2.00%	2.00%	2.90%
Efficiency Requirement	-2.00%	-2.00%	-2.00%
Tariff increase	**0.00%**	**0.00%**	**0.90%**

Tariff and efficiency requirements beyond 2020/21 are not published; for the purposes of the model beyond this these are assumed to be the same as 2020/21.

Cost Inflation and impact of CNST

The only change to the generic NHSI assumptions for cost inflation included in the modelling is further uplift for clinical negligence costs (CNST). To ensure consistency with the cost uplifts included in the Sustainability and Transformation Plan, a separate growth rate for CNST has been incorporated.

[64] IHAM is an interactive tool developed by NHS England that has been used by local areas to support commissioners and providers in their understanding of how different planning assumptions affect secondary care activity. It generates indicative activity figures based on historic trends and demography (the 'do nothing' trajectory) which can be used by local areas in their development of their activity plan. It has also been used in developing the STP.

Table G-3 Cost inflation by type for 2018/19 to 2020/21

Element	NHSI (Monitor) 2018/19	STP 2018/19	NHSI (Monitor) 2019/20	STP 2019/20	NHSI (Monitor) 2020/21	STP 2020/21
Pay and pensions (including drift and mix effects)	1.60%	1.60%	1.60%	1.60%	2.90%	2.90%
Drugs	3.60%	3.60%	4.10%	4.10%	4.10%	4.10%
Capital costs	3.20%	3.20%	3.10%	3.10%	3.10%	3.10%
Other operating costs	2.10%	2.10%	1.90%	1.90%	2.00%	2.00%
Overall (excluding CNST)	**2.00%**	**2.00%**	**2.00%**	**2.00%**	**2.90%**	**2.90%**
Local adjustment CNST*		10.00%		10.00%		10.00%
Overall (including CNST)	**2.00%**	**3.15%**	**2.00%**	**2.31%**	**2.90%**	**3.12%**

**The STP includes an adjustment of 17% for increase CNST contributions. However both CHUFT and IHT saw their contributions increase by a lower value of 10% in 2017/18 and therefore this lower rate has been applied for future years.*

Cost improvement programme targets

The base case assumes that recurrent cost improvement targets (CIP) will be realised in each year. The total quantum of CIP to be delivered each year is assumed to equal the value of the 2% expected national efficiency requirement.

Sustainability and transformation funding

The model assumes that Sustainability and Transformation Funding (STF)[65] will be combined and remain at the same level. STF has only been confirmed for 2018/19 and it is not yet known what arrangements will apply from 2019/20. If STF ceases and is not replaced then the deficit and cash support requirements increase by a similar amount plus interest on the additional financing.

Other assumptions

The key assumptions used in the analysis for the further options were as follows:

- Any additional income, over and above the baseline activity assumptions, will not be an additional cost to the local health economy. It is anticipated that this will come from repatriation of activity currently undertaken in settings outside of IHT and CHUFT.
- Only material changes to expenditure have been modelled. These include costs expected to be incurred to deliver the corporate TOM and relevant clinical strategy. Small value efficiency schemes have not been separately included but have been assumed to help deliver the inherent savings targets built into national tariff funding.

[65] If providers fail to meet the finance and performance requirements that underpin their control totals, access to all or some of their planned payments from the Sustainability and Transformation Fund can be withheld.

H. Finance case: Historical financial performance

Colchester Hospital University NHS Foundation Trust (CHUFT)

The tables below show the historical financial performance of CHUFT, detailing the previous three years' income and expenditure accounts, CIP delivery and capital investment.

Income and expenditure

Table H-1 Historical financial performance of CHUFT

Income and Expenditure All in £m	2014/15 Actual	2015/16 Actual	2016/17 Actual
Income from patient care activities	247.9	248.6	262.0
Other Income	20.1	21.4	39.6
Total Income	**268.0**	**269.9**	**301.6**
Pay	(180.5)	(191.4)	(192.5)
Non Pay	(104.0)	(111.1)	(123.8)
Total Operating Expenses	**(284.4)**	**(302.5)**	**(316.3)**
Financing Costs	(0.8)	(0.9)	(1.6)
Public Dividend Capital	(5.1)	(4.7)	(2.7)
Net (Deficit)/Surplus for the year	**(22.3)**	**(38.1)**	**(18.9)**
Control Total issued by NHSI	n/a	n/a	(31.7)

Trust specific control totals[66] were first issued by NHSI in 2016/17, with CHUFT delivering its target in 2016/17. This though was supported by £14.4m of sustainability and transformation funding (STF), of which £5.5m related to additional incentive funding for managing national pressures.

In 2016/17, a large proportion of the Trust income was also assured by virtue of a 'guaranteed income arrangement' agreed with its main commissioner North East Essex CCG for emergency care.

Cost improvement programme

The table below shows the previous three years CIP delivery.

Table H-2 Historical CIP performance of CHUFT

CIP and Income generation	2014/15		2015/16		2016/17	
All in £m	Plan	Actual	Plan	Actual	Plan	Actual
Pay	2.8	1.7	7.2	4.9	4.5	3.1
Non Pay	2.8	4.3	3.6	2.0	4.5	4.6
Total CIP	**5.7**	**6.1**	**10.8**	**6.9**	**9.1**	**7.7**
Income generation	2.6	1.5	3.2	1.8	5.3	0.0
Total Savings	**8.3**	**7.6**	**14.0**	**8.7**	**14.3**	**7.7**
% achieved total savings		*91%*		*62%*		*54%*
CIP % of Operating Expenditure	*2.0%*	*2.1%*	*3.7%*	*2.3%*	*3.0%*	*2.5%*

[66] Control totals are the financial targets for each organisation – they set the maximum deficit (or minimum surplus) an organisation is allowed to run. Each organisation has its own control total, which is agreed with NHS Improvement depending on its financial strength.

Capital Investment

The table below shows the previous three years capital investment commitments and delivery against plan.

Table H-3 Historical capital investment performance of CHUFT

Capital	2014/15		2015/16		2016/17	
	Plan	Actual	Plan	Actual	Plan	Actual
Capital Investment	13.0	11.9	14.9	10.0	14.2	9.6
% of plan achieved		*92%*		*67%*		*67%*

Ipswich Hospital NHS Trust (IHT)

The table below shows the historical financial position of IHT, showing the previous three years income and expenditure accounts, CIP delivery and capital investment.

Income and expenditure

Table H-4 Historical financial performance of IHT

Income and Expenditure All in £m	2014/15 Actual	2015/16 Actual	2016/17 Actual
Income from patient care activities	225.6	241.1	259.5
Other Income	25.1	25.2	37.0
Total Income	**250.6**	**266.3**	**296.5**
Total Operating Expenses	(256.7)	(283.7)	(314.5)
Financing Costs	(2.0)	(2.2)	(2.5)
Public Dividend Capital	(3.2)	(2.7)	(1.7)
Retained (Deficit)/surplus for the year	**(11.2)**	**(22.3)**	**(22.3)**
Technical adjustments	(0.6)	0.2	4.8
Net (Deficit)/Surplus	**(11.9)**	**(22.1)**	**(17.6)**
Control Total issued by NHSI	n/a	n/a	(20.1)

In 2016/17, IHT also over achieved against its control total. Again, this was in part supported by £9.3m of STF funding, of which £2.7m was the additional incentive monies for managing national pressures.

The vast majority of the Trust's income In 2016/17 was confirmed because of a guaranteed income arrangement with its main commissioner Ipswich and East Suffolk CCG.

Cost improvement programme

The table below shows the previous three years CIP delivery.

Table H-5 Historical CIP performance of IHT

CIP and Income generation	2014/15		2015/16		2016/17	
All in £m	Plan	Actual	Plan	Actual	Plan	Actual
Pay	2.7	2.9	2.0	2.8	5.0	3.9
Non Pay	8.4	5.7	3.0	2.9	5.4	4.0
Total CIP	**11.1**	**8.6**	**5.0**	**5.7**	**10.4**	**7.9**
Income generation	3.2	5.4	4.8	4.4	1.6	3.7
Total Savings	**14.3**	**14.0**	**9.8**	**10.1**	**12.0**	**11.6**
% achieved total savings		*98%*		*103%*		*97%*
CIP % of Operating Expenditure		*5.4%*		*3.5%*		*3.7%*

Capital investment

The table below shows the previous three years capital investment.

Table H-6 Historical capital investment performance of IHT

Capital	2014/15		2015/16		2016/17	
All in £m	Plan	Actual	Plan	Actual	Plan	Actual
Capital Investment	11.8	11.8	12.9	12.6	8.2	8.2
% of plan achieved		*100%*		*98%*		*100%*

I. Finance case: Baseline modelling

Baseline modelling assumptions

Further details on the assumptions used in modelling future years financial performance, discussed in table 4, are described below.

The first year of modelling is 2017/18, and the financial plans resubmitted by both organisations to NHSI on 30 March 2017 and approved by both boards, have been used in the OBC.

For 2018/19, whilst control totals have been issued by NHSI, these have not formally been agreed by the two boards. Given this, the LTFM has not been reconciled back to these totals. Only the efficiency target of 2% notified by NHSI for planning purposes has been used in modelling, and no additional CIP has been included.

NHS Improvement has confirmed sustainability and transformation funding only to 2018/19 (£8.85m for CHUFT and £7.105m for IHT). Arrangements beyond this year are not presently known. The baseline modelling assumes that STF monies will be forthcoming after 2018/19 but if this does not actually materialise then the deficit and cash support requirements will increase by a similar amount.

CHUFT currently has debt that it is required to make payments against. Broad assumptions have been included for the cost of servicing the Trust's interim support and other debt.

Depreciation for both organisations has been modelled based on their existing five year capital plans as currently constituted. The CHUFT plans are potentially subject to revision as the 2017/18 programme is £2m short of financing. A loan application has been made to NHSI to bridge this gap.

For the IHT modelling, the switch from the current joint venture model for running the community services to the alliance contract has been assumed to have no significant impact.

CHUFT

The tables below show the anticipated financial performance modelled by CHUFT in its five year long term financial model. These include the income and expenditure positons, CIP delivery and capital investment.

Income and expenditure

Table I-1 I&E summary of future years' plan/projections CHUFT

Income and Expenditure All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Income from patient care activities	262.9	267.5	271.2	277.2	286.5
Other Income	28.3	28.5	28.5	28.5	28.5
Total Income	**291.2**	**296.0**	**299.6**	**305.7**	**315.0**
Pay	(189.3)	(191.5)	(192.2)	(195.5)	(201.0)
Non Pay	(119.3)	(121.6)	(124.5)	(127.2)	(131.0)
Total Operating Expenses	**(308.6)**	**(313.1)**	**(316.8)**	**(322.8)**	**(332.0)**
Financing Costs	(1.8)	(2.0)	(2.5)	(2.7)	(2.8)
Public Dividend Capital	(2.9)	(2.8)	(2.8)	(2.8)	(2.8)
Net (Deficit)/Surplus for the year	**(22.1)**	**(21.9)**	**(22.4)**	**(22.5)**	**(22.7)**

Control Total issued by NHSI	(22.1)	(13.9)	n/a	n/a	n/a

Cost improvement plan

In NHS Improvement's March 2016 guidance for long term planning, it suggested Trusts continue to assume an efficiency factor of 2% for the years to 2020/21. The Trust has assumed this as part of its modelling and the following CIP targets are assumed in the I&E projections shown above.

Table I-2 Forecast of cost improvement plan (CIP) requirements for CHUFT

CIP All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Pay	10.8	3.6	4.3	4.3	4.3
Non Pay	6.2	2.5	1.8	1.8	1.8
Total CIP	**17.0**	**6.1**	**6.1**	**6.1**	**6.1**
CIP % of Operating Expenditure	*6%*	*2%*	*2%*	*2%*	*2%*

Capital investment

CHUFT has a capital programme of £15.796m for 2017/18. This programme has been fully reviewed by the Trust Board. A number of schemes have been removed or deferred into later years, with the remainder being deemed essential for the safe running of the Trust.

A significant number of the schemes in the capital programme are already in progress and/or carried forward from prior years, in particular larger schemes relating to the Trusts' relocation of services from the Essex County Hospital (ECH). The Trust has plans for the site to be disposed and realising a capital receipt in later years.

The Trust's internally generated capital cash financing for 2017/18 is £13.7m, therefore there is a funding shortfall of £2.1m. This shortfall relates to two particular schemes (Interventional Radiology and car parking partnership) for which a loan application has been made to NHS Improvement.

For later years the capital programme is constrained within the Trust's ability to source internal financing (e.g. depreciation etc.).

Table I-3Forecast of capital investment required by CHUFT

Capital All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Capital Investment	15.8	12.3	13.8	10.8	9.9
Total Capital	**15.8**	**12.3**	**13.8**	**10.8**	**9.9**
Financed by:					
Depreciation	9.5	9.8	9.8	9.8	9.9
Loans	3.3	2.5	0.0	0.0	0.0
Other	3.0	0.0	4.0	1.0	0.0
Total Financing	**15.8**	**12.3**	**13.8**	**10.8**	**9.9**

Currently there is a detailed programme of schemes for the first three years of the planning period (i.e. to 2019/20).

IHT

The tables below show the anticipated financial performance modelled by IHT in its five year long term financial model. These include the income and expenditure positons, CIP delivery and capital investment.

Income and expenditure

Table I-4 I&E summary of future years plan/projections IHT

Income and Expenditure All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Revenue from patient care activities	251.4	251.3	248.5	247.3	256.0
Other Income	41.4	41.7	42.5	43.3	44.1
Total Income	**292.8**	**292.9**	**291.0**	**290.6**	**300.1**
Total Operating Expenses	(296.6)	(298.7)	(294.5)	(295.9)	(306.7)
Financing Costs	(12.8)	(13.1)	(13.5)	(14.3)	(14.7)
Public Dividend Capital	(1.2)	(0.6)	(0.5)	(0.5)	(0.5)
Net (Deficit)/Surplus	**(17.8)**	**(19.5)**	**(17.5)**	**(20.1)**	**(21.8)**
Control Total issued by NHSI	(18.1)	(16.8)	n/a	n/a	n/a

Cost Improvement Plan

The direction from NHSI (March 2016 long term planning guidance) that Trusts continue to assume an efficiency factor of 2% for the years to 2020/21 has also been followed by IHT. The Trust has assumed this as part of its modelling and the following CIP targets are assumed in the income and expenditure forecasts above.

Table I-5Forecast of cost improvement plan (CIP) requirements for IHT

CIP All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Pay	5.3	3.7	3.3	3.1	3.1
Non Pay	8.7	2.3	2.4	2.5	2.6
Income	1.8	0.0	0.0	0.0	0.0
Total CIP	**15.8**	**6.0**	**5.7**	**5.6**	**5.7**
CIP % of Operating Expenditure	*5.3%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*

Capital Investment

IHT has a capital programme of £12.004m for 2017/18. This programme has been fully reviewed by both the Planning and Investment Group and the Trust Board.

A large prioritisation exercise has been carried out by the various areas (Estates, IT, Medical Equipment) that feed into the Planning and Investment Group, considering the safety of services for patients as the main driver. This has ensured that top priority items have been allocated budgets within the 2017/18 capital programme, along with budgets for projects that have carried over from previous financial years. All other planned expenditure has been deferred to future financial years, with any associated risks being highlighted and mitigated.

The Trust's capital resource limit totals £9.804m. This represents internally generated resources (i.e. depreciation), plus associated adjustments and also allows for the funding impact of capital

repayments for finance leases and the private finance initiative (PFI). Additional amounts totalling £2.2m are also included in the programme, relating to PDC funding applications (GP Streaming of £0.5m and linear accelerator purchase of £1.7m) for which agreements are in place, but the funding has yet to be received by the Trust.

Planning for the capital programme in future years is restricted according to the Trust's ability to source internal financing, whilst allowing for the funding impact of capital repayments on finance leases and PFI.

Table I-6Forecast of capital investment required by IHT

Capital All in £m	2017/18 Plan	2018/19 Projection	2019/20 Projection	2020/21 Projection	2021/22 Projection
Capital Investment	9.9	9.8	9.6	9.6	9.6
Total Capital	**9.9**	**9.8**	**9.6**	**9.6**	**9.6**
Financed by:					
Depreciation	10.3	10.0	10.0	10.4	10.5
Loans	(1.1)	(0.4)	(0.6)	(0.9)	(1.1)
Other	0.7	0.2	0.2	0.2	0.2
Total Financing	**9.9**	**9.8**	**9.6**	**9.6**	**9.6**

J. Engagement log

Table summarises all the meetings with the public and wider stakeholders that took place during the OBC phase. In addition, a number of board meetings of local NHS organisations were held in public during which the Partnership was discussed; the minutes of these meetings are available online.

Table J-1 Public and Stakeholder meetings

Activity	Date	Senior Partnership representative
With Local Government		
Essex Health and Overview Scrutiny Committee meeting	08/02/17	Chief Executive, IHT & CHUFT
Essex and Suffolk Joint Health Scrutiny Committee	10/03/17 21/07/17	Director of Finance and Strategy, IHT
Cllr. Sarah Adams	07/02/17	Chief Executive, IHT & CHUFT
Ipswich Borough Council and IHT Bi-monthly meetings	27/02/17, 23/4/17	Director of Finance and Strategy, IHT, Managing Director, IHT
Essex Assembly	06/03/17	Chief Executive, IHT & CHUFT
Tendring DC Health & Wellbeing Board	01/06/17	Chief Executive, IHT & CHUFT
Suffolk CC Health & Wellbeing Board	13/07/17	Director of Clinical Integration, CHUFT
Essex CC Health & Wellbeing Board	24/07/17	Director of Clinical Integration, CHUFT
Cllr. Tony Goldson, Public Health Suffolk CC	01/06/17	Chief Executive, IHT & CHUFT
Meetings with NHS bodies, National Bodies and officials		
NHS England Director of Commissioning Operations	06/03/17	Chief Executive, IHT & CHUFT
IHT Ipswich and East Suffolk CCG Joint Working Group meeting	06/03/17	Director of Finance and Strategy, IHT Managing Director, IHT
Executive Medical Director, NHS Improvement	10/03/17	Chief Executive, IHT & CHUFT
Executive Regional Managing Director (Midlands and East)	15/03/17	Chief Executive, IHT & CHUFT
Chief Executive of NHS England	04/05/17	Chief Executive, IHT & CHUFT
Chief Executive, General Medical Council	23/06/17	Chief Executive, IHT & CHUFT Managing Director, IHT Medical Director, IHT
President of the Royal College of Physicians	30/06/17	Chief Executive, IHT & CHUFT Managing Director, IHT Medical Director, IHT
With Patient Groups and their representatives		
CHUFT Council of Governors meeting	16/02/17 15/06/17	Director of Clinical Integration, CHUFT
Meeting with Ipswich Hospital User Group (IHUG)	07/04/17 19/06/17 07/07/17	Director of Clinical Integration, CHUFT
IHT Partnership Patient Advisory Group	10/05/17	Director of Clinical Integration, CHUFT
Suffolk & North East Essex Acute Transformation Board	15/05/17	Chief Executive, IHT & CHUFT

CHUFT Partnership Patient Advisory Group	22/05/17	Director of Clinical Integration, CHUFT
Joint Partnership Patient Advisory Group	19/06/17	Programme Manager, IHT
With local Politicians		
Meeting with MP for Ipswich	21/04/17	Chief Executive, IHT & CHUFT
Colchester constituency Liberal Democrat Parliamentary candidate	23/05/17	Chief Executive, IHT & CHUFT
Colchester constituency Labour Parliamentary candidate	02/06/17	Chief Executive, IHT & CHUFT
With other local Partners		
North East Essex Accountable Care System meeting	17/02/17	Managing Director, CHUFT
Meeting with Anglia Ruskin University	02/05/17	Chief Executive, IHT & CHUFT
Partnership Stakeholder Advisory Group	20/04/17 14/06/17	Chief Executive, IHT & CHUFT, Director of Clinical Integration, CHUFT
Chief Executive's Informal Reference Group	24/04/17	Chief Executive, IHT & CHUFT
Commissioners' Reference Group	02/05/17 04/07/17	Director of Clinical Integration, CHUFT
North East Essex and Suffolk STP leads meeting	22/05/17	Chief Executive, IHT & CHUFT

Table below represents meetings with staff from The Ipswich NHS Trust and Colchester Hospital University NHS Foundation Trust that took place during the OBC phase.

In addition, a number of board meetings of local NHS organisations were held in public during which the Partnership was discussed; minutes of these meetings are available online.

Table J-2 Meetings with staff and staff organisations

Activity	Date	Senior Partnership representative
CHUFT Staff partnership forum	01/02/17 10/03/17 27/04/17 23/05/17 01/06/17 29/06/17 17/07/17	Chief Executive, IHT & CHUFT Director of Integration, CHUFT
IHT Joint Consultative & Negotiation Group briefing	04/04/17 02/05/17 06/06/17 04/07/17	Chief Executive, IHT & CHUFT
BMA North Essex Division meeting	06/02/17	Chief Executive, IHT & CHUFT
Local Negotiating Committee IHT	03/03/17	Managing Director, IHT Director of Finance and Strategy, IHT
IHT Staff Reference Group	04/05/17 03/07/17	Director of Integration, CHUFT
CHUFT Staff Involvement Group (Staff Reference Group)	23/03/17	Director of Integration, CHUFT

IHT Union representative briefing	05/07/17	Director of Integration, CHUFT
CHUFT Union representative briefing	05/07/17	Director of Integration, CHUFT
Clinical Reference Group	14/03/17 04/04/17 06/06/17 04/07/17	Director of Integration, CHUFT Director of Finance and Strategy, IHT
IHT Leadership Conference	28/04/17	Managing Director, IHT
CHUFT Leadership Conference	17/03/17	Chief Executive, IHT & CHUFT Director of Integration, CHUFT
IHT Staff Feedback Session	06/02/17	Managing Director, IHT
IHT Leadership Session	21/02/17	Chief Executive, IHT & CHUFT
IHT Leadership Briefing	24/02/17 26/05/07	Managing Director, IHT
Collaborative working	01/03/17	Managing Director, CHUFT Managing Director, IHT
IHT Non-surgical cancer services	01/03/17	Programme Manager, IHT Managing Director, IHT
IHT GP & Consultants Engagement event	02/03/17	Chief Executive, IHT & CHUFT
All staff briefing IHT	24/03/17 09/06/17	Chief Executive, IHT & CHUFT Managing Director, IHT