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

Full Business Case for the merger of Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust

Supporting Appendices

22 March 2018

Final Draft Version – Prepared for Trust Board 29 March 2018

A1 Appendix 1: Partnership Option Evaluation at the SOC and OBC stages

The process for identifying the form of the long-term relationship between CHUFT and IHT has been supported by a two-stage evaluation completed in the SOC and OBC phases.

A1.1 Strategic outline case consideration of options

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*[1], models emerging from the acute care collaboration vanguards[2], and examples from NHS Improvement.

The 18 scenarios are listed below. A summary of the outcome of the scenario evaluation can be found in Annex A to this appendix:

- 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

The scenarios were reviewed and evaluated against agreed criteria by representatives from the trusts, commissioners and health and social care partners.

Following review of the SOC, three scenarios for the partnership were approved by the two trust boards to be explored further in this OBC, in addition to the 'do nothing' scenario. These scenarios were:

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

A1.2 OBC scenario evaluation

Section 5 for the OBC describes the approach and process of evaluating the scenarios shortlisted by the boards following the review of the Strategic Outline case. The OBC evaluation concluded that:

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

- Full clinical integration was the preferred scenario following a qualitative and financial evaluation
- The shortlist of three scenarios, plus 'do nothing', is derived from the SOC evaluation (see Annex A below):
    - 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 (described in Annex B below).

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.

Full clinical integration is the top ranked scenario. This scenario scored highest in both the qualitative benefits criteria 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.

A1.2.1 ANNEX 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
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

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
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 sub-contractor 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
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 imple-menting 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

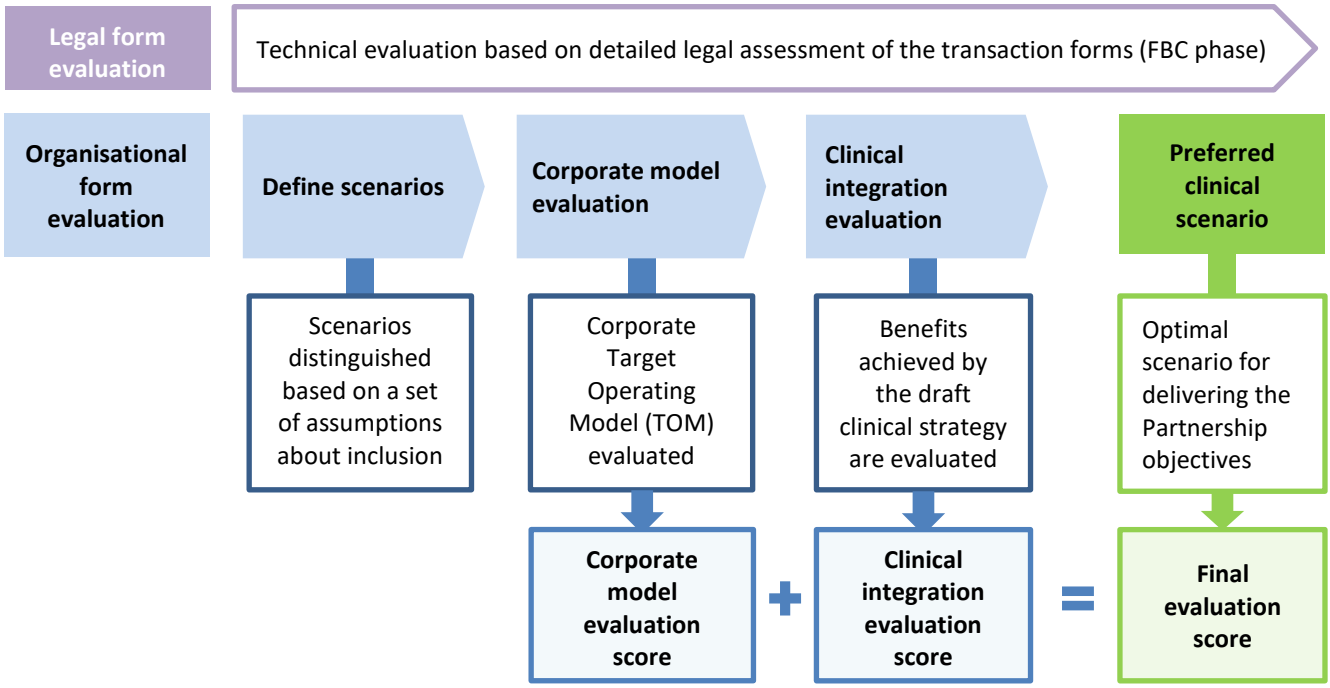
A1.2.2 ANNEX B: Scenario evaluation detailed approach

A1.2.2.1 Approach to the scenario evaluation

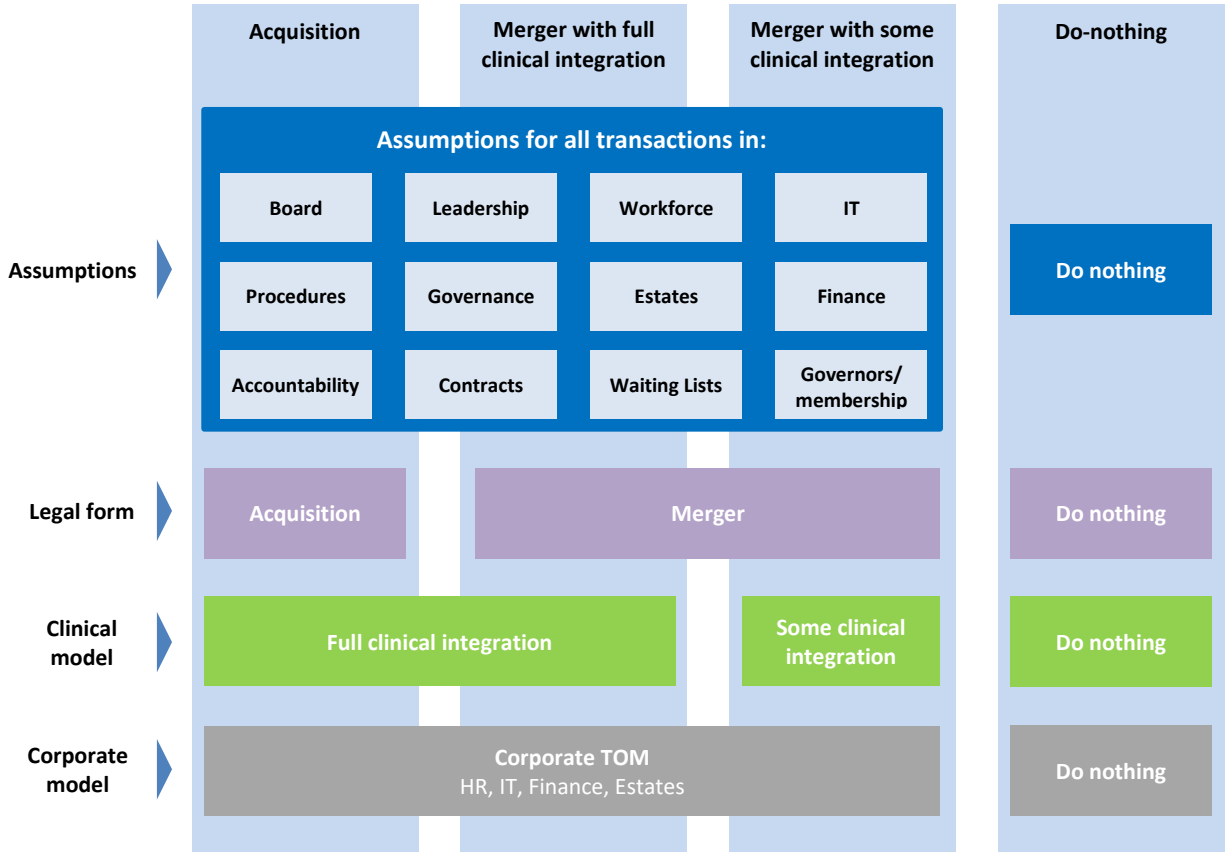
The high-level process for carrying out the scenario evaluation is outlined in the diagram below. The evaluation consists of two parallel elements:

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.

A1.2.2.2 Evaluation criteria definitions

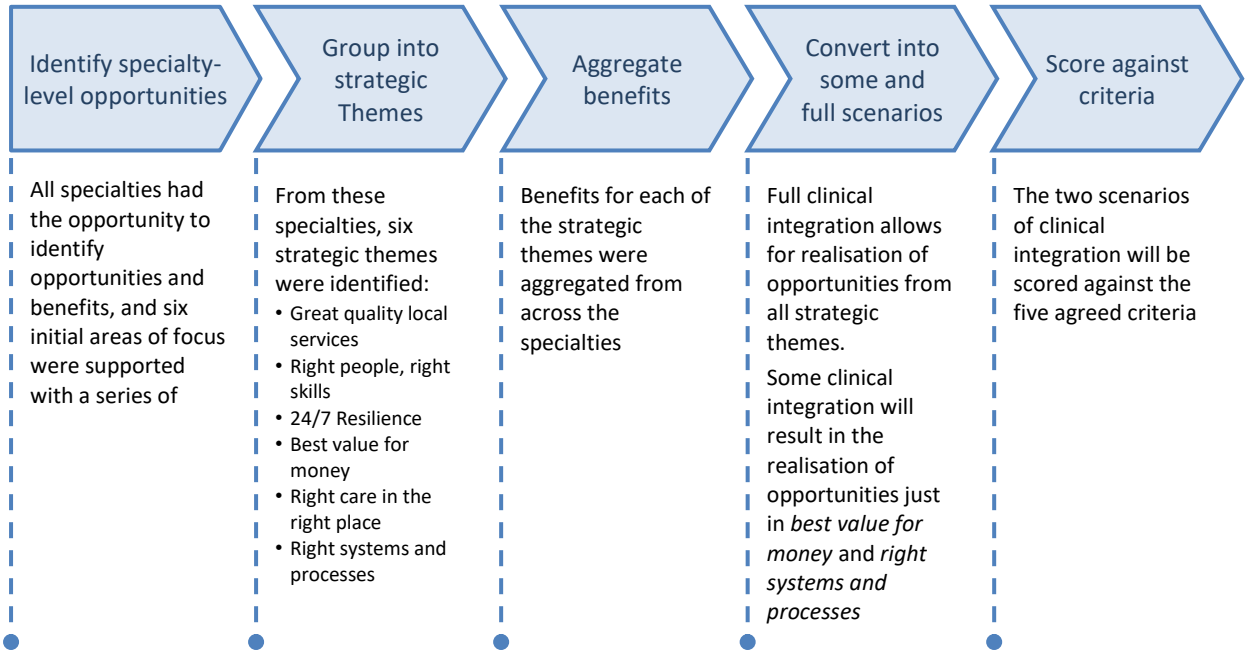
Detailed definitions of the five criteria used to evaluate the three scenarios are provided along with their weightings in the table below.

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%
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%

Criteria	Definition	Weighting
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%

A1.2.2.3 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) **Right people, right skills** (Part of *Full*	• 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
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 • Reduction in	• 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
	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				

A2 Appendix 2: Demographic Review

The new trust will serve a catchment population of over 750,000. The catchment area of the new Trust includes large towns (Colchester and Ipswich), significant rural populations and smaller market towns, traditional coastal resorts, significant port facilities, universities and armed services garrisons.

The main population served is drawn primarily from six second tier local authority areas, shown in Table A2-1

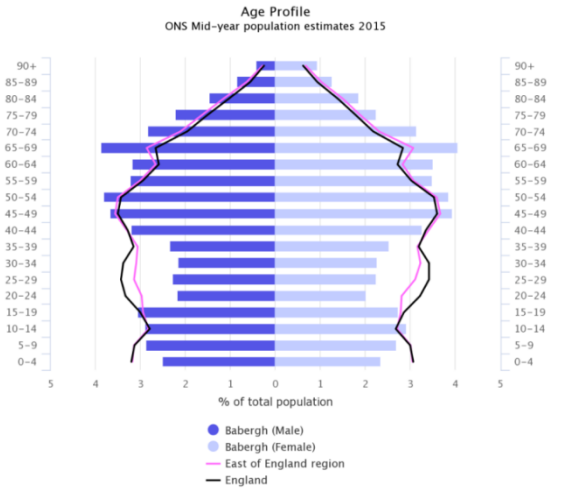
Table A2-1 Population of principal catchment by local authority areas

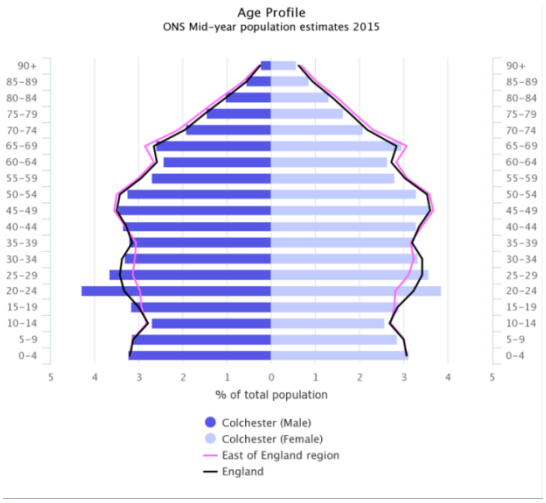
Population (000s)[3]	Males	Females	Persons
Babergh DC	43	46	89
Colchester BC	91	93	184
Ipswich BC	68	68	136
Mid Suffolk DC	49	50	100
Suffolk Coastal DC	61	64	125
Tendring DC	68	73	141

Given cross-border flows, the new trust will be the predominant focus for acute care for these local authority areas, although there is some outward flow to Norfolk providers[4] in the north, West Suffolk Hospital, Bury St Edmunds to the west and Broomfield hospital, Chelmsford to the south west. There is a substantial inflow of residents from Braintree DC to the Colchester site as the closest local acute provider to the population of Halstead and the Colne valley.

A2.1 Age structure

The population age structure across the catchment local authorities varies as shown in Figure A 2-1[5].





[3] *Health Profiles 2017,* Public Health England

[4] The Norfolk & Norwich Hospital NHS Foundation Trust in Norwich and the James Paget Hospital NHS Foundation Trust in Gorleston, Great Yarmouth

[5] Taken from *Health Profiles 2017*, Public Health England

Figure A 2-1 Age profile of the population served by local authority 2015 estimates

In summary, analysis of the data shows that the population age-structure of the mainly urban populations of both Colchester and Ipswich is largely in line with the national and regional average. However, there is a greater number of 25-34 year olds in both than the national and regional averages[6]. This is the group typically considered to be of childbearing age, which could potentially impact on service requirements.

In Suffolk Coastal, Mid Suffolk and Tendring there is a significant population aged 65 years and older[7]. The portion of the population in this age group in these areas exceeds both the national and local averages. Taken together with data on dependency and deprivation this will impact on the health needs of these population areas.

A2.2 Dependency

Analysis of the age structure of the population allows the development of a dependency ratio which estimates the number of dependents in an area by comparing the number of people considered less likely to be working (children under 16 and those of state pension are and above) with the working age population. Dependency ratios for the six second tier local authorities (and the England comparator) are shown in Table A2-2

[6] Ibid.
[7] Ibid.

Table A2-2 Dependency ratios

Babergh DC	78.3%
Colchester BC	58.4%
Ipswich BC	58.9%
Mid Suffolk DC	72.6%
Suffolk Coastal DC	81.3%
Tendring DC	89.1%
England	**60.7%**

A higher ratio, suggests need for greater level of services for older and younger people than those areas with a low ratio.

Looking at other data on older people only, and the Old Age Dependency Ratio (OADR)[8], of the 391 English Unitary and Tier 2 local authorities, Tendring has the 8th highest OADR in England, Suffolk Coastal is 16th, Babergh 33rd, Mid Suffolk 67th, Colchester 288th and Ipswich 305th.

A2.3 Ethnicity

Analysis of data for the six tier 2 local authority areas that form the new trust's main catchment area, in Table A2-3 shows a relatively low percentage of population from ethnic minority groups[9] compared to the England average.

Table A2-3 Percentage of the population from a minority ethnic group, 2014/15 Annual Population Survey

	% males	% females	% Persons
Babergh DC	3.2%	**	2.0%
Colchester BC	8.1%	11.7%	9.9%
Ipswich BC	11.5%	10.8%	11.2%
Mid Suffolk DC	**	2.3%	2.2%
Suffolk Coastal DC	2.6%	**	2.0%
Tendring DC	**	4.5%	3.1%
England	**13.1%**	**13.4%**	**13.2%**

** values suppressed due to small numbers

The data shows that, of the local authority areas served, only Colchester and Ipswich have significant minority ethnic populations. Using more detailed 2011 Census data[10] the proportionate representation of ethnic minority groups is shown in Table A2-4

[8] *UK population aged 65 and over, aged 85 and over and the old age dependency ratio by local authority, 1996 to 2036* ONS, available at: ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/july2017

[9] *Health Profiles 2017*, Public Health England using data from the Annual Population Survey 20014/15

[10] Census data report KS201EW - Ethnic group, ONS 2011 Census

Table A2-4 Percentage of the population by ethnic group, 2011 Census

Ethnic Group**	Babergh	Colchester	Ipswich	Mid Suffolk	Suffolk Coastal	Tendring	Eng. & Wales
White	97.8%	92.0%	88.9%	97.9%	96.5%	97.6%	86.0%
Mixed/multiple ethnic groups	0.9%	1.8%	3.6%	1.0%	1.2%	1.1%	2.2%
Asian/Asian British	0.8%	3.7%	4.3%	0.7%	1.6%	0.9%	7.5%
Black/African/Caribbean/Black British	0.3%	1.5%	2.3%	0.4%	0.4%	0.3%	3.3%
Other ethnic group	0.2%	1.0%	0.9%	0.1%	0.2%	0.1%	1.0%

**The census provides data at eighteen more granular sub-classifications of ethnicity within the five classifications used

A2.4 Rurality

The overall geographic area served by the new trust is characterised by:

- two large urban settlements in Colchester and Ipswich
- coastal towns, including Southwold, Aldeburgh, Woodbridge, Felixstowe, Harwich/Dovercourt, Walton/Frinton, Clacton on Sea, and Mersea
- market towns – including Saxmundham, Framlingham, Wickham Market, Hadleigh, Manningtree, Wivenhoe, and Tiptree
- extensive more sparsely populated agricultural land with smaller villages and hamlets.

Access to vehicles and public transport in Suffolk can be an issue for some older people[11] due to the rural nature of the county and the distances to the main hospital sites. The relative lack of public transport services and travel distances has been a frequently expressed concern in relation to the merger.

A2.5 Deprivation

Figure A 2-2 shows the catchment area of the STP and (to the right of the red line) the geography served by the NEE CCG and Ipswich & East Suffolk CCG (and, *inter alia,* West Suffolk CCG). It also shows the relative deprivation of the population.

[11] *JSNA The State of Suffolk Report: Executive summary*, Suffolk Health & Wellbeing Board, 2015

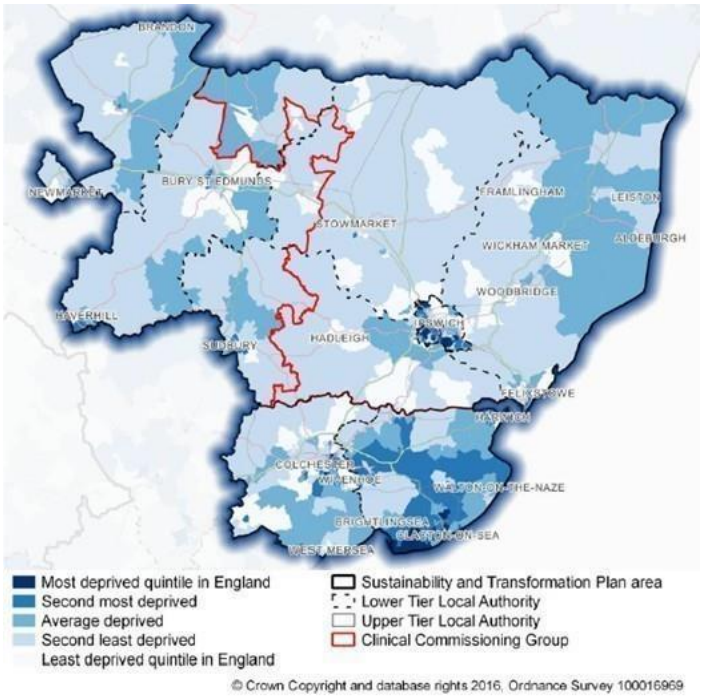


Figure A 2-2 Geographic Area of the Suffolk & Northeast Essex STP and catchment area of the new Trust

Figure A 2-3 shows the national quintiles for the Index of Multiple Deprivation 2015 for the six main catchment local authorities of the new Trust[12], the darker colouring showing the greatest deprivation.

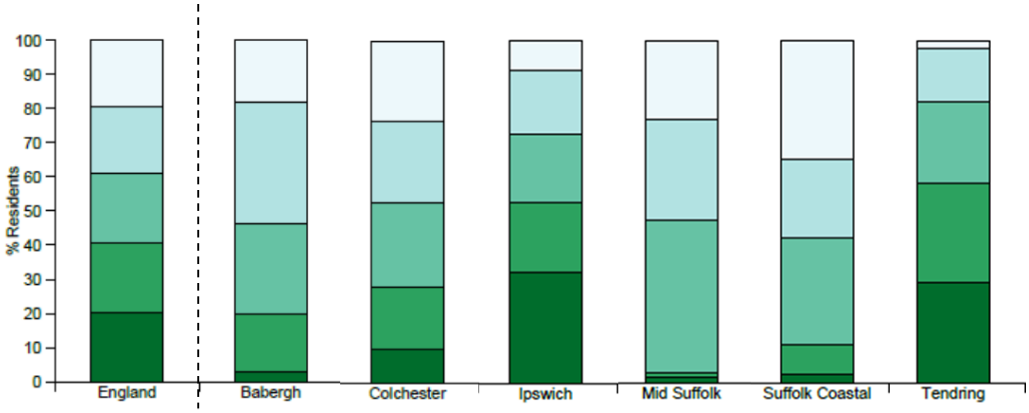


Figure A 2-3 Index of Multiple Deprivation 2015, Catchment local authorities

The new Trust will serve a diverse population, including some areas of significant deprivation in Tendring, in particular Pier ward in Clacton and Jaywick ward, both of which are amongst the most socially deprived areas in the UK, and in Ipswich. Conversely, Suffolk Coastal, Mid Suffolk, Babergh and Colchester contains some very affluent wards.

Life expectancy[13] varies significantly within the super output areas (SOA) in each local authority.

[12] ibid
[13] ibid

Table A2-5 Life Expectancy of residents – Super Output Areas in local authorities

	Male			Female		
	Most Deprived	Least Deprived	Gap	Most Deprived	Least Deprived	Gap
Babergh	78.5	84.7	6.2	82.0	87.9	5.9
Colchester	76.5	84.6	8.1	80.0	86.8	6.8
Ipswich	74.5	82.7	8.2	81.4	85.6	4.2
Mid Suffolk	79.0	83.8	4.8	81.5	90.6	9.1
Suffolk Coast	78.5	84.1	5.6	84.4	85.0	0.6
Tendring	73.5	83.5	10.0	79.0	85.3	6.3

For the new Trust, the life expectancy gap between the most deprived and least deprived SOA for males in the catchment is 11.2 years, and for females, it is 11.6 years.

A2.5.1 Population lifestyles and Morbidity

The Public Health England health Profiles 2017 report on population health characteristics and indicators providing comparative benchmarked performance on 30 indicators known to impact on health[14]. The overall assessment for the six local authorities is shown in Table A2-6.

Table A2-6 Health Summary Indicators PHE Health Profiles

	Significantly better than national average	In line with national average	Significantly worse than national average	Not compared/ data quality issues
Babergh	15	9	0	6
Colchester	11	9	6	4
Ipswich	4	12	9	5
Mid Suffolk	16	7	1	6
Suffolk Coast	14	11	0	5
Tendring	3	8	15	4

A2.5.2 Projected population growth and change into the 2030s

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 projected to grow at a fast rate[15] with extensive new homes building programmes planned. In particular, the population in the older age cohorts is expected to grow at a significant rate that will place additional demands of health care provision.

A2.5.3 Population projections

The anticipated growth in the total population of the six local authority areas, based on 2014 ONS projections, is shown in table A2-7

[14] The indicators are grouped into five categories: Community factors; Children's & young people's health; Adults' health & lifestyle; Diseases of poor health; and Life expectancy and causes of death

[15] 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)

Table A2-7 ONS 2014-based population projections

	2016 estimate	2036 estimate	% growth
Babergh	89	97	9.0%
Colchester	185	219	18.4%
Ipswich	137	148	8.0%
Mid Suffolk	100	112	12.0%
Suffolk Coast	125	133	6.4%
Tendring	140	162	15.7%
Indicative ESNEFT catchment	776	871	12.2%

A2.5.4 New residential building and population growth

Within the local plans and submissions prepared by the local authorities there are plans for significant increases in new house building and in some cases garden village/town communities in east Suffolk and northeast Essex.

Table A2-8 shows data from the individual local plans with the following projected new housing growth in the period to the mid-2030s.

Table A2-8 Summary of new house builds from Local Authority Local Plans[16]

North Essex Housing Market Area	43,720	Braintree DC, Colchester BC & Tendring DC
Ipswich Housing Market Area	39,300	Babergh DC, Ipswich BC, Mid Suffolk DC & Suffolk Coastal DC

The overall growth in the number of dwellings in the catchment area of the new trust will be over 80,000 new dwellings by 2036, space for approximately 150-190,000 residents. Indicators from the Local Plans is that a substantial part of the growth in north Essex will be focussed on two large 'garden communities' located to the immediate west (24,000 dwellings) and east (9,000 dwellings) of Colchester.

A2.5.5 Changes in the population age structure

ONS population projections[17] for 2016, 2026 and 2036 show in all areas significant growth in the proportion of the population aged over 65 and the proportion aged over 85. This older cohort of the population are the largest users of NHS services, including acute hospital services.

Figure A2-4 shows the projected growth in the proportion of the population aged over 65 and over 85, up to 2036.

[16] Data sourced from the *Publication Draft stage of the Colchester Borough Local Plan 2017 – 2033* (July 2017) and *Babergh & Mid Suffolk Joint Local plan: Consultation Document* (July 2017)

[17] Sourced from: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration

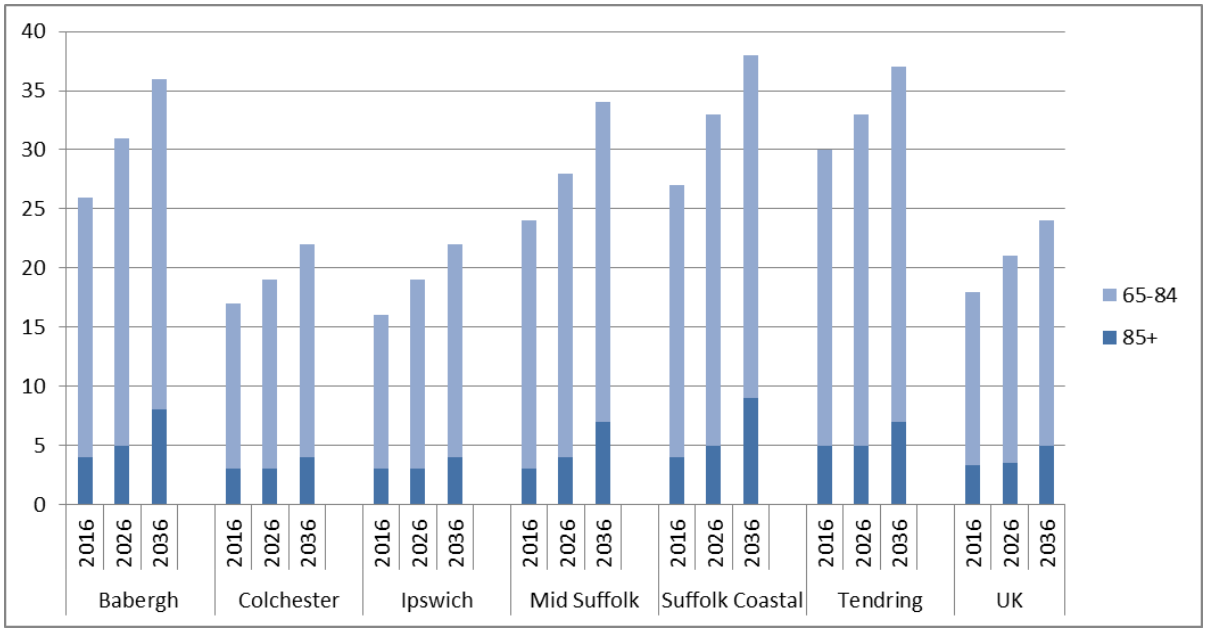


Figure A 2-4 Projected proportion of the population in older age ranges, 2016 to 2036

A3 Appendix 3: ESNEFT draft FT constitution

The draft constitution for ESNEFT will be considered at the CHUFT Council of Governors meeting on 27 March 2018.

The approved draft will then be submitted to NHSI with the application.

A copy of the draft constitution will be available on the partnership website at:

http://www.colchesteripswich.org/

A4 Appendix 4: Organisational structure design principles

A number of design principles have been developed in order to guide and to drive consistency in the development of the 'to be' organisational structure.

The organisational structure is a key element of the future operating model - therefore the org design principles are aligned with and support the overall Corporate/Clinical design principles.

Design principle	Implications and why this matters
Organisation	
1. Functions which could be delivered better centrally or through an integrated unit should be, unless there is a business reason for duplication.	Merging teams or functions which have a direct impact on the same outcome can reduce silo working, improve efficiency and drive better results at a lower cost. Duplication of capabilities across the organisation increases cost and can complicate processes and reduce efficiency.
2. There should be a principle of one function, one organisation, even if that function spans locations	Having one leader per function (even if this spans across 2 locations) reduces management overhead and thus cost in the organisation
3. The organisation structure and roles accountabilities will facilitate collaboration between teams and functions	Without collaboration between teams and functions, organisations can become silo-ed. This creates duplication, reduces efficiency and impedes communication and, therefore, continuous improvement in service delivery
4. Continue to operate with a triumvirate structure in clinical areas.	
Span of Control	
5. Average span of control should increase down the organisation structure.	Work should become less strategic, more standardised and repeatable as teams move further away from the CEO and should, therefore, require less supervisory attention and effort.
6. A manager should have more than one direct report. The ideal span of control is 5-8 direct reports	One-to-one reporting is inefficient as it requires more managers, increases organisation depth, complexity and impedes communication
Roles	
7. Economies of scale should be maximised when considering number of roles.	2 medium sized DGHs are not equal to one large DGH in terms of role requirements. Leadership roles need to grow in scale, size and complexity.
8. Peer roles should be of roughly equivalent size (spans of control, subject matter expertise, external relationships, authority and accountability)	Aligning the size of roles and positions within the organisation can increase collaboration, improve line of sight and governance over activities
9. Roles should be designed to ensure that work is done by the lowest cost and most capable person	People are more motivated and engaged when they undertake roles that utilise their maximum capabilities. Additionally, the cost of activities within the organisation is reduced when undertaken by the most appropriate resource and level of skills
10. No role should be created to cover deficiencies in other areas of the organisation or if there is a quality or cost benefit to outsource it	Work should focus on creating value rather than compensating for deficiencies to ensure that the organisation is lean and focused on its strategic goals.
11. Job design should support flexible and agile working as well as working across functional areas	Generalist roles such as Administrators or Business Partners should be able to operate across functional areas in response to business demand or to deliver a full service, reducing the number of posts or touch points required

Design principle	Implications and why this matters
12. Jobs should be designed so that work aligns align to function, not site. There should be clear mechanisms in place to support staff to work in an agile manner.	This will avoid duplication of work across sites, enable deployment of best skills effective enable equity and quality of service and minimise future harmonisation. Where appropriate, mobility should be maximised within roles and across functions. Appropriate framework needs to be set up to enable skills acquisition and to alleviate travel and/or other constraints, where possible to do so cost-effectively. Mobility clauses should be included in all new offers with standardised T&Cs. Adverts to alert to future merger – standardised T&C's.
13. Job descriptions and role titles should be simplified and standardised	By April, generic job descriptions should be available to the organisation, as they begin designing and filling posts,
14. Each role should have a clear set of accountabilities and objectives. There should be an organisational framework which gives clarity on how roles contribute towards delivering objectives.	A functional accountability framework eg RACI matrix, with R and a completed for each area. Job descriptions should clearly articulate accountabilities and objectives before the job description
15. An independent job evaluation process will to be used	Ensure capacity, consistency and fairness.
16. There should be clarity around which roles are covered by Agenda for Change or Senior Manager terms and conditions.	These should be communicated and understood by all the leaders responsible for designing the new state. This will impact selection and performance decisions.
Management	
17. Layers of management should only be introduced where this will improve the quality or productivity of the team/function	Unnecessary layers of management increase cost, impede communication between managers and employees, and slow decision making
18. Supervisors should have the appropriate level of technical skills to quality assure their team's work	Supervisors should have enough technical knowledge of the work they supervise, and hold accountability for monitoring performance
19. There should be clear definitions of leadership tiers/levels and these should be used consistently when designing the new state.	This will ensure equity, consistency and clarity about accountability, facilitates easier succession planning & leadership development & career ladders
20. Each Director must have people they can deputise to. This may be a single Deputy Director, or multiple Assistant Directors, as required. A Director may have one deputy only, or multiple assistant directors. A deputy director must have the skill and the will to be a Director. A Deputy must have their own portfolio that is a subset of the Director's portfolio.	Each Director has someone they can deputise to. The term 'associate' will no longer be used to refer to substantive deputies/assistants.
Service Design	
21. Effective use of time: New designs should maximise time efficiencies	Designs must minimise wastage of time for colleagues, patients and service users
22. Technology Enabled: Technology should be used to increase efficiency	Systems and platforms should be integrated to achieve cost synergies Technology investments should be made to agreed parameters

Design principle	Implications and why this matters
23. Customer responsive: Services should be designed around customer needs	The new organisation must address any known gaps in services and service levels
24. Professional services model: Focus should be given to value-adding services	Seek to reduce and/or outsource routine transactional tasks where possible
25. Alternative provisioning: Consider alternative approaches for provision before establishing a new role	Alternative provision options (e.g. outsourcing) could enhance quality and/ or reduce cost. Consider insourcing or outsourcing capabilities to achieve optimum service and efficiency.
26. Be cost-releasing and risk-managed	Designs must reduce costs whilst maintaining service quality Transition risk and costs should be known and manageable
Selection Principles	
27. Depersonalise: The whole organisation will go through a defined selection process. Selection will be based on the roles which need to be filled and not the people who may be available	No selection may be made in advance of the process. The best skills from across the organisation are recruited to fulfil the role. All staff have a fair chance, despite the historic site-orientation of their teams/leaders.
28. Competitive selection: Where two or more people are eligible for one post, or the post is new, a competitive process will be implemented	A policy will be defined to enable this. Anyone from across the two organisations may be eligible to apply to these roles.
29. Non-competitive selection: Where there is no competition for the role and staff are in post holding a similar job, there may be slotted automatically.	Staff will still need to go through an 'interview' with their manager to discuss any changes to job description, accountabilities and objectives.
30. Automatic slotting: Where a number of roles exist in the new organisation which are similar to previous roles, automatic slotting in will take place	
31. Redeployment: Any displaced individuals will be offered redeployment in the first instance. Opportunities will be sought across the whole system and clear timeframes and time-caps will be agreed. Where no role can be found, the organisation will be decisive about compulsory redundancy	There will be no Voluntary Redundancy on offer. A redeployment process should be defined as a policy, with implications and budget clarified for compulsory redundancies
32. Expression of Preference: Senior Manager roles (Band 8D and above) will, as a minimum, be appointed via an expression of preference process	
33. Expression of Interest: Where a number of new roles exist for the same number of people, an expression of interest process will be implemented	
34. Transition: Staff will remain the responsibility of their current managers until the formation of the new organisation and will be actively supported throughout the redeployment process	
35. Exit strategies: will bear in mind timeliness and needs of the service, sensitivity to individuals, financial implications and explore appropriate use of voluntary redundancy	

Design principle	Implications and why this matters
36. Recruitment: where all options to fill roles internally are exhausted and posts remain vacant, these will be advertised via defined recruitment process	Robust business justification for roles remaining vacant after a pre-defined and agreed period and a recruitment policy will support and enable this principle

A5 Appendix 5: Engagement activity programme

Table A 5-1 summarises all the meetings with stakeholders and the wider public that took place during the FBC 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 A 5-1 Public and Stakeholder meetings (* indicates future date as at time of publishing)

Activity	Date
Meetings with regulators/scrutiny committees	
Essex Health and Overview Scrutiny Committee meeting	11/10/2017 13/12/2017
Suffolk Health Scrutiny Committee	17/10/2017 24/01/2018
Essex and Suffolk Joint Health Scrutiny Committee (private briefing)	12/03/2018
Suffolk County Council Health & Wellbeing Board	16/11/2017
Essex County Council Health & Wellbeing Board	07/11/2017
Clinical Senate	01/11/2017
NHS England	30/11/2017
NHS Improvement	04/10/2017
NHS England and NHS Improvement (STP review meeting)	22/12/2017
Meetings with patient groups and their representatives	
CHUFT Annual Members' Meeting (Council of Governors)	14/09/2017
CHUFT Council of Governors	16/11/2017
Ipswich Hospital User Group	20/10/2017 01/12/2017 19/01/2018 16/03/2018*
Patient Participation Group, North Colchester Healthcare Centre	02/11/2017
Patient Participation Group, Riverside GP Practice, Manningtree	24/11/2017
Felixstowe Patient Participation Group event	13/02/2018
Breathe Easy Colchester	16/02/2018
North Essex Lymphoedema Support Group	06/03/2018 14/03/2018
Patient Participation Group AGM, Ambrose Avenue GP Practice, Colchester	12/03/2018
CHUFT GI Cancer Support Group	15/03/2018
CHUFT Cancer User Group	19/03/2018
Eye/Woodbridge PPG event	28/03/2018*
Meetings with stakeholder groups and organisations	
IHT Patient & Carer Advisory Group	07/09/2017 19/12/2017 22/02/2018
CHUFT Patient & Carer Advisory Group	07/09/2017 19/12/2017 16/02/2018
Chief Transformation Officer, WS &IESCCG	14/09/2017

Activity	Date
Stroke Board meeting with WS & IESCCG, NEE CCG	06/10/2017
Chief Officer, IES & WS CCG	17/10/2017 14/11/2017
Joint CHUFT/IHT Patient & Carer Advisory Group	02/11/2017 16/01/2018 16/03/2018*
Stakeholder Advisory Group	13/11/2017 29/01/2018
One Clinical Community, Ipswich	16/11/2017
NEE CCG	11/12/2017
Commissioners' Reference Group	06/03/2018
Board to Board – CHUFT to NEE CCG	06/03/2018
One Colchester Strategic Group	22/03/2018*
Suffolk Alliance Steering Group	08/03/2018
NEE Alliance Leaders Meeting	13/03/2018
Briefing with Members of Parliament	22/03/2018*
Meetings with members of the public/media	
Colchester People's Assembly	10/10/2017
Tendring Pensioners' Action Group	17/01/2018
Public drop in event – Ipswich	13/02/2018
Tendring Voluntary Sector Forum	14/02/2018
Public drop in event – Clacton	15/02/2018
Colchester Pensioners' Action Group	16/02/2018
Public drop in event – Colchester	19/02/2018
Public drop in event – Felixstowe	22/02/2018
Update to members of Colchester Garrison Medical Faculty	07/03/2018
Public drop in event – Aldeburgh	07/03/2018
International Women's day event in Ipswich	14/03/2018
Public drop in event – Halstead	22/03/2018*
Meetings with other local partners	
STP Programme Board	21/09/2017 19/10/2017 23/11/2017 20/12/2017 12/01/2018 09/02/2018 09/03/2018
Colchester Borough Council	13/11/2017
NEE Local Authority re local development plan	17/11/2017
Local Health Matters Forum (NEE)	10/01/2018 24/01/2018
Ipswich Locality Homelessness Partnership	14/02/2018
Update to NEE, WS&IES CCG Chief Transformation Officers	15/02/2018
Suffolk Local Medical Committee (no attendance but briefing material sent)	15/03/2018
North Essex Local Medical Committee	15/03/2018

Table A5-2 details meetings involving staff from The Ipswich NHS Trust and Colchester Hospital University NHS Foundation Trust that took place during the FBC phase.

Table A5-2 Meetings with staff and staff organisations

Activity	Date
CHUFT EPED Improvement Board meeting	06/09/2017
IHT Core Briefing (team brief)	02/10/2017 06/11/2017 04/12/2017 08/01/2018 05/02/2018 05/03/2018
CHUFT Core Briefing (team brief)	02/10/2017 06/11/2017 04/12/2017 08/01/2018 05/02/2018 05/03/2018
CHUFT/IHT Middle Management Conference	06/10/2017
CHUFT/Joint IHT Leadership Conference	03/11/2017
IHT Clinical Breakfast Meeting	11/10/2017
CHUFT Medical Staffing Committee	14/11/2017 16/01/2018
IHT Medical Staffing Committee	18/09/2017 16/10/2017 20/11/2017 18/12/2017 15/01/2018 19/02/2018
CHUFT Staff Partnership Forum	30/08/2017 04/12/2017 29/01/2018 13/03/2018
IHT Joint Consultation & Negotiating Committee	07/11/2017 05/12/2017 03/01/2018 06/02/2018 06/03/2018
Mobilisation - Joint Staff Partnership Forum (CHUFT)/Negotiating Committee (IHT)	29/01/2018 08/02/2018 22/02/2018 08/03/2018
IHT Local Negotiating Committee (medical staff)	01/12/2017 08/03/2018
CHUFT Local Negotiating Committee (medical staff)	05/12/2017
Open Joint Staff Reference Group	27/11/2017
Annual surgery training day	15/11/2017
IHT “Leading from the middle” conference	05/12/2017
Clinical Strategy meeting – IHT MSC/clinical lead	18/09/2017 11/10/2017

Activity	Date
Clinical Strategy meeting - CHUFT MSC/clinical leads	21/09/2017 14/11/2017
Clinical Strategy meeting - CHUFT Research and Clinical Trials	16/11/2017
Clinical Strategy meeting - IHT Oncology	07/11/2017
Clinical Strategy meeting - CHUFT Oncology	23/10/2017 13/11/2017
Clinical Strategy meeting - CHUFT Haematology	02/11/2017 15/02/2018
Clinical Strategy meeting - IHT Anaesthetics	16/11/2017
Clinical Strategy meeting - IHT Cardiology	23/11/2017
Clinical Strategy meeting - CHUFT Cardiology	05/12/2017
Clinical Strategy meeting - CHUFT Stroke	27/11/2017
Clinical Strategy meeting - IHT Stroke clinical lead	05/12/2017
Clinical Strategy meeting - IHT Urology	30/11/2017
Clinical Strategy meeting - CHUFT Urology	23/01/2018
Clinical Strategy meeting - IHT Specialist Surgery	30/11/2017
Clinical Strategy meeting - CHUFT OFMS/Specialist Surgery	13/02/2018
Clinical Strategy meeting - IHT ENT	19/02/2018
Clinical Strategy meeting - CHUFT Ophthalmology	24/11/2017 05/01/2018
Clinical Strategy meeting - CHUFT Paediatrics	20/11/2017 04/12/2017
Clinical Strategy meeting - CHUFT General Surgery	24/10/2017 06/12/2017 02/01/2018
Clinical Strategy meeting - IHT General Surgery	07/12/2017
Clinical Strategy meeting - CHUFT/IHT Vascular Surgery	05/12/2017
Clinical Strategy meeting - IHT Bariatric Surgery	02/10/2017
Clinical Strategy meeting - CHUFT O&G	11/12/2017
Clinical Strategy meeting - IHT O&G	30/10/2017
Clinical Strategy meeting - CHUFT Respiratory	12/12/2017
Clinical Strategy meeting - IHT Respiratory	12/12/2017
Clinical Strategy meeting - IHT T&O	22/11/2017 10/01/2018 15/01/2018 20/02/2018
Clinical Strategy meeting - CHUFT T&O	24/11/2017
Clinical Strategy meeting - IHT Care of the Elderly	01/12/2017 22/12/2017
Clinical Strategy meeting - CHUFT Care of the Elderly	18/01/2017
Clinical Strategy meeting - CHUFT & IHT Integrated Therapies	24/01/2018 07/02/2018 28/02/2018

Activity	Date
Clinical Strategy meeting - IHT Diabetes	16/02/2018
Clinical Strategy meeting - IHT Acute Medicine	16/02/2018
Clinical Strategy meeting - CHUFT End of Life	30/01/2018
Clinical Strategy meeting - CHUFT CCIOs	07/03/2018
Staff engagement event - Aldeburgh Hospital	22/01/2018
Staff engagement event - Clacton Hospital	23/01/2018
Staff engagement event - Harwich Hospital	23/01/2018
Staff engagement event - Colchester Hospital	23/01/2018
Staff engagement event - Halstead Hospital	26/01/2018
Staff engagement event - Ipswich Hospital	31/01/2018
IHT Staff Reference Group	22/02/2018
CHUFT Clinical Leads update	15/03/2018
IHT Clinical Leads update	16/03/2018
CHUFT Staff Involvement Group	04/12/2017 22/03/2018*

Table A5-3 summarises non-face to face communications with stakeholders and the wider public that took place during the FBC phase.

Table A5-3 non face to face communications with stakeholders and the wider public

Activity	Date
Connect monthly merger e-bulletin reaching wide audience – each edition sent to over 600 people	November 2017 December 2017 January 2018 February 2018 March 2018
Information leaflets and posters displayed at main reception, outpatients and retail outlets at Colchester General Hospital and Ipswich Hospital	January to March 2018
Colchester/Ipswich Online Crowdsourcing Event	26/01/2018
Letters to 95 “seldom heard” groups providing a merger update and inviting engagement	30/01/2018

Table A5-4 summarises programme governance meetings during the development of the FBC.

Table A5-4 Programme governance meetings

Activity	Date
CHUFT/IHT Board to Board meeting	13/09/2017 11/10/2017 08/11/2017 13/12/2017 18/01/2018 14/02/2018 14/03/2018

Activity	Date
Partnership Advisory Board	21/09/2017
	19/10/2017
	16/11/2017
	20/12/2017
	23/01/2018
	15/02/2018
CHUFT Trust Board – Private	26/09/2017
	31/10/2017
	28/11/2017
	19/12/2017
	30/01/2018
	14/03/2018
	27/03/2018*
IHT Trust Board – Private	28/09/2017
	26/10/2017
	30/11/2017
	21/12/2017
	25/01/2018
	01/03/2018
	14/03/2018
	29/03/2018*

A6 Appendix 6: Partnership Programme engagement and communication strategy

Agreed by trusts' Boards in October 2017

A6.1 Objective

To effectively communicate and engage with local residents, patients, carers, staff, stakeholders and other groups before, during and after the formation of a new NHS trust. The new Trust is a partnership between Colchester Hospital University Foundation Trust and The Ipswich Hospital NHS Trust.

A6.2 Our key messages

Colchester and Ipswich hospitals are merging to create a new NHS organisation, which will be the biggest in East Anglia.

Our aim is to see our patients on time, provide the latest treatments locally and attract the best staff.

By merging, we will invest more in our frontline services by cutting waste and the cost of running two organisations.

A6.3 Strategy

To make sure all members of our communities and stakeholders have clear information on, and regular opportunities to discuss and shape, the new organisation before, during and after its formation.

A6.4 Background

The Colchester Hospital University NHS Foundation Trust (CHUFT) has two main sites: Colchester General Hospital and Essex County Hospital. The Trust provides healthcare services to around 370,000 people from Colchester and the surrounding area of north east Essex and south Suffolk.

The Ipswich NHS Hospital Trust (IHT) has a catchment population of approximately 390,000 people, primarily drawn from the districts of Babergh, Mid Suffolk, Suffolk Coastal and Ipswich.

In May 2016, the Boards of CHUFT and 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.

In August 2017, an outline business case (OBC) with a preferred option was approved by the boards of both Colchester and Ipswich hospitals, and NHS Improvement. This included the preferred option

for the new organisation which is a partnership with full clinical integration and development of an ambitious model for corporate services.

The next step is to develop and submit a final business case (FBC) in spring which, subject to approval by NHS Improvement, would see the new organisation officially formed shortly afterwards.

A6.5 Considerations

There are a number of considerations which has shaped our approach to communications and engagement in this strategy.

- Any proposed changes to NHS services or organisations can be worrying for patients, staff, the wider public and stakeholders
- important to discuss proposed engagement and communication plan with partners to ensure it is robust
- Colchester and Ipswich serve rural communities and hard to reach groups, all of whom must have access to information and opportunities for engagement
- transport issues are likely to be the immediate number one concern for staff and patients followed by possible staff implications, regardless of actual impact which is low at this point.

A6.6 Principles

- Clear, understandable and consistent material and messaging
- focus on practical information and planned benefits, not process
- address concerns upfront
- work with and through existing networks and relationships to broaden reach and impact, especially with harder to reach communities
- use the most appropriate channels and language for the audience based on feedback from surveys
- regularly test understanding of language, use of channels and impact of activity through public/ staff / stakeholder opinion surveys
- Equality Impact Assessment (EIA) screening is underway and full EIA undertaken for any appropriate changes
- use social and digital media where appropriate to maximise reach and value for money.

A6.7 Key risks the strategy will address

- Local communities, including hard to reach groups, not having access to relevant information and engagement opportunities creating unnecessary concern
- staff and stakeholders not having access to relevant information and engagement opportunities creating unnecessary concern, especially around travel
- NHS history of mergers means slips in timetable leads to lack of credibility and buy-in.

A6.8 Key opportunities for this strategy

- Public reassurance on impact of new organisation, especially around travel
- increased buy-in to new organisation
- be a national exemplar for organisational change
- clear, consistent corporate branding in place to simplify communication with public

- intelligence-led activity will impact with all audiences
- expectations managed properly
- encourage success by highlighting joint working before Day 1
- improved staff morale, retention and recruitment, especially important given national recruitment issues and possible impact of Brexit
- new organisation raises positive profile of the region.

A6.9 Success measures - year one

- Stakeholders, public, media, staff and regulators informed and engaged
- increase in staff and public engagement / net promoter score
- reduced vacancy rates.

A6.10 Target audiences

The table below sets out the categories we are using to stratify our audiences and includes examples for each for illustration. The categories are being fully populated with relevant individuals, groups and organisations and the programme will maintain and update detailed contact lists for all audiences.

Regulator/Scrutiny This category covers dates for formal scrutiny or submission of material relating to the formation of the new organisation: Clinical Senate Essex Health & Wellbeing Board Essex Health Overview and Scrutiny Committee Suffolk Health & Wellbeing Board Suffolk Health Scrutiny Committee, Ipswich Suffolk Health & Wellbeing Board, Ipswich NHS England NHS Improvement	Staff This category covers all staff employed by Colchester or Ipswich Trusts: CHUFT Board - Private CHUFT/IHT Board to Board CHUFT Local Negotiating Committee CHUFT Staff-side CHUFT Partnership Staff Reference Group IHT Board - Private IHT Clinical Breakfast Meeting IHT Local Negotiating Committee IHT Medical Staffing Committee IHT Partnership Staff Reference Group IHT Staff-side Joint CHUFT/IHT Partnership Staff Reference Group Partnership Advisory Board
Patient Groups This category includes formal groupings of patients and public with a specific focus on health, such as IHUG, and the council of governors. CHUFT Council of Governors CHUFT Members IHUG Joint CHUFT/IHT Patient & Carer Advisory Group Patient Participation Group, GP Surgery, North Colchester Healthcare Centre Patient Participation Group North East Essex	Public/Media This category covers the wide spectrum of the general public. IHT Board - Public Colchester People's Assembly CHUFT Board - Public

Stakeholders This category covers a broad range of stakeholders, from GPs and health-related bodies like the BMA and LMC, to MPs and the charity, voluntary, education and business sector. Partnership Stakeholder Reference Group BMA LMC MPs	Local Partners This category includes NHS and local authority partners who are directly or indirectly affected or interested in the Partnership - this would be close to the same list as for the STP footprint. Babergh District Council Colchester Borough Council Essex County Council Ipswich Borough Council NEE CCG Board IES CCG Governing Body Mid Suffolk District Council STP Acute Transformation Programme Board STP Programme Board Suffolk Coastal District Council Suffolk County Council Tendring District Council

A6.11 Phased approach for the communications strategy

The overall approach to the communication and engagement strategy is to take a phased approach, with bespoke activity and targeted messaging adapted for each phase.

The phases are:

- October 2017 to submission of the FBC
- FBC submission to Day 1 of new organisation
- Year one of operation
- Years two to five.

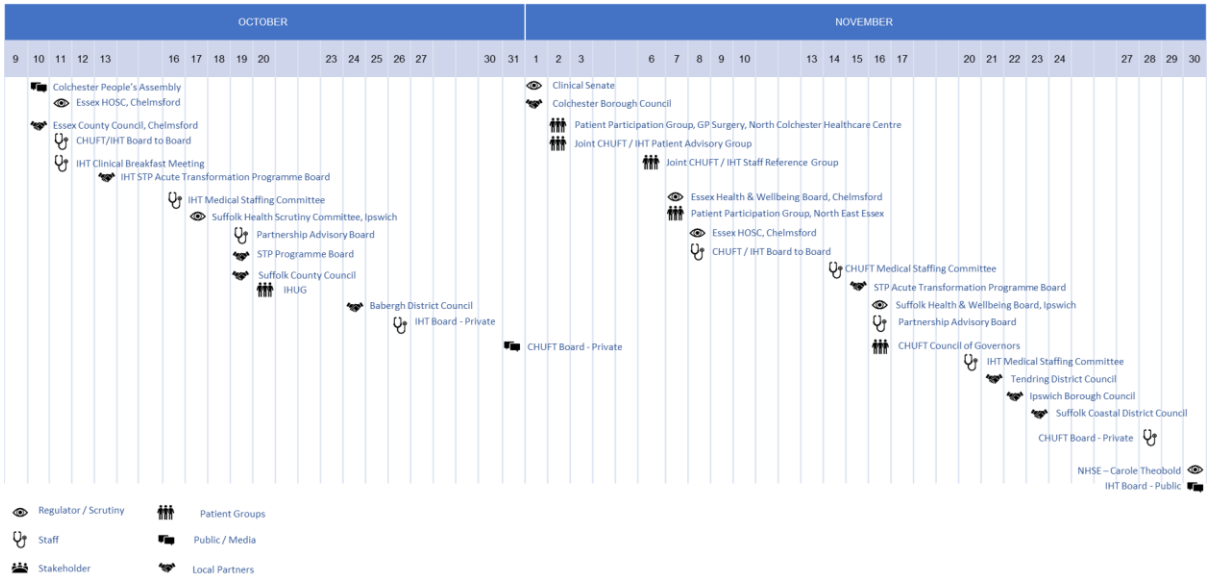
An overview of planned activity for separate audiences throughout these phases is included below.

Period / messaging	Now to FBC	FBC to Day One	Year 1	Years 2 onwards
Staff	Clarity of purpose Clarity of timeline Encourage joint-working	FBC successful - have confidence Highlight joint working successes Be involved New brand New culture/ values	Involvement in new models of care Highlight joint working successes Clarity on next steps - shared outpatient approach/new IT system	Implement new models of care Two-way feedback
Patients / public	Clarity of purpose Clarity of timeline Reassurance	Business as usual Highlight joint working Be involved	Highlight joint working Highlight next steps Highlight cost savings	Communicate new models of care Highlight improvements Two-way feedback

			Encourage engagement in new service design	
Stakeholders	Clarity of purpose Clarity of timeline FBC is process step towards new organisation	FBC successful - have confidence Promote joint working Next steps	Highlight joint working Highlight next steps Highlight cost savings Encourage engagement in new service design	Communicate new models of care Highlight improvements Two-way feedback

A6.12 Communication and engagement plan covering next two months

The latest version of a detailed two-month engagement plan is attached below. This is drawn from an excel master-database and will be updated regularly. and used to plan and log all activity to make sure we reach intended audiences and with the required regularity.



A6.13 Conclusion

This strategy will continue to be developed and adapted to adjust as necessary to feedback from partners. A full log of engagement will be maintained and regular updates on progress will be included as part of the Partnership programme management.

Ali Bailey, Director of Communication

A7 Appendix 7: Equality Impact Assessment

Colchester Hospital University NHS Foundation Trust

The Ipswich Hospital NHS Trust

Equality Impact Assessment (EIA)
A record of the assessment of the Full Business Case (FBC) for the merger of Colchester Hospital University NHS Foundation Trust (CHUFT) and The Ipswich Hospital NHS Trust (IHT).

Contact Person for EIA
Nesta Williams, interim equality and diversity lead IHT.

Date of initial assessment: 7 March 2018
Date of group assessment: 12 March 2018

1.0 Introduction

An assessment of the implications of the FBC for considerations of equality, diversity and human rights (EDHR) was requested by the boards of both trusts as part of the planning undertaken for their merger, which is due to take place in July 2018 at the earliest.

This document summarises the findings of the initial assessment which was undertaken partly by a review of documentation by Nesta Williams, interim equality and diversity lead for IHT and partly as a group exercise undertaken by the members of an assessment team whose members were:

- Nesta Williams interim equality and diversity lead IHT.
- Clare Edmondson, director of human resources CHUFT and IHT
- Gillian Orves, Chair of Ipswich Hospital User Group (IHUG)
- Andy Yacoub, chief executive of Healthwatch Suffolk
- Ray Hardisty, Chair of NEE CCG Health Forum Committee
- Yaa Dankwa Ampadu-Sackey, Public Governor of CHUFT

This assessment has made observations about the documentation, the plans for the new organisation and the strengths and weaknesses of the arrangements for supporting EDHR issues in the trusts in their current form. Eight key recommendations have been made which are summarised at the end of the document. Specific recommendations of the assessment team are reproduced in full as an Annex to this document.

It is anticipated that in the new trust any significant changes to clinical services would require a separate detailed EIA to be undertaken to consider how the changes would potentially impact EDHR with respect to both staff, patients, carers and all other relevant audiences and stakeholders.

2.0 Background - equality diversity and human rights legislative requirements and relevance to the merger.

The public sector equality duty (PSED) extends to organisations that are exercising public functions. It is non-delegable and remains the responsibility of trusts as the organisations subject to the duty. Equality and diversity cuts across all activities of trusts and should be completely embedded in their day to day work.

Implementation of the PSED is fundamentally based on use of equality information and equality objectives. There is a duty to gather, use and analyse equality data to help inform progress reports, and to be able to assess the impact of change so as to better inform objectives, actions or decisions.

The new trust will be required to consider how its strategies, plans, procedures, policies, projects and decisions will affect patients, carers, communities, employees and other stakeholders with particular regard to the needs of protected groups and minorities in the nine protected characteristics (see diagram 1). This also includes engaging with, consulting and involving service users, staff and other stakeholders.

Public authorities are required to have due regard to the aims of the general equality duty when making decisions and when setting policies. Understanding the effect of policies and practices on people with different protected characteristics is an important part of complying with the general equality duty.

The general equality duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under The Equality Act 2010
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

The Equality Act 2010 explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics
- Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people
- Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

It states that meeting different needs involves taking steps to take account of disabled people's disabilities. It describes fostering good relations, tackling prejudice and promoting understanding between people from different groups.

There is no prescribed methodology for assessing the impact on equality of decisions such as that to merge two large public sector organisations, but a consistent methodology and proportionate approach has been applied in developing this document based on the Equality Impact Assessment (EIA) toolkit currently used by The Ipswich Hospital NHS Trust (IHT).

Both CHUFT and IHT are required to have due regard to the aims of the general equality duty when making decisions and setting policies. This can help both organisations to consider whether the merger and policies will be effective for different people and help to identify any negative impacts or potentially unlawful discrimination, as well as positive opportunities to advance equality.

Identifying these areas may help both trusts to develop practical courses of action to mitigate negative consequences or to promote positive ones.

Having due regard to the aims of the general equality duty is about using good equality information and analysis, at the right time, as a part of decision-making processes. It also requires thought to the relevance and proportionality of strategies, policies, functions and services while always considering equality, diversity, and human rights. It also helps determine whether an impact assessment is required.

Due regard comprises of two linked elements: relevance and proportionality**.**

Relevance may be identified using the following factors:

- The extent to which a service is or is not used by particular groups of people
- Whether the strategy/policy relates to functions that previous consultation has identified as important
- If different groups have different needs or experiences in the area the policy relates to.

Proportionality ensures that we can focus our effort and use our resources most effectively. There is little to be gained by carrying out an impact assessment of strategies, policies, services, and functions which are clearly not relevant. However, if an important strategy, policy, service or function is left out because relevance has not been identified; the proposal to merge is left vulnerable to legal challenge and implementing poor decisions.

Those areas with greater relevance will include, for example:

- Changes to service delivery (including withdrawal of service),
- Recruitment, redundancies, pay policies
- Policies which set quality standards for others to follow.

These should always be impact assessed.

Those with less or no relevance will include the internal systems, for example for processing travel expenses. It is likely that looking at such policies, services and functions to decide if they are relevant for EDHR and integration will be sufficient to show that due regard has been taken.

The weighting given to EDHR should be proportionate to its relevance to a particular strategy, policy, service or function. The greater the relevance of a strategy, policy, service or function to equality, diversity, cohesion and integration, the greater the regard which should be paid. This is the approach that has been taken with the chapters and specific elements of the FBC.

2.1 When to undertake an EIA

A full impact assessment is required where the policy/service/function is major in terms of scale or significance, or there is a clear indication that although the policy/service/function is minor, it is likely to have a major impact on different sections of the community.

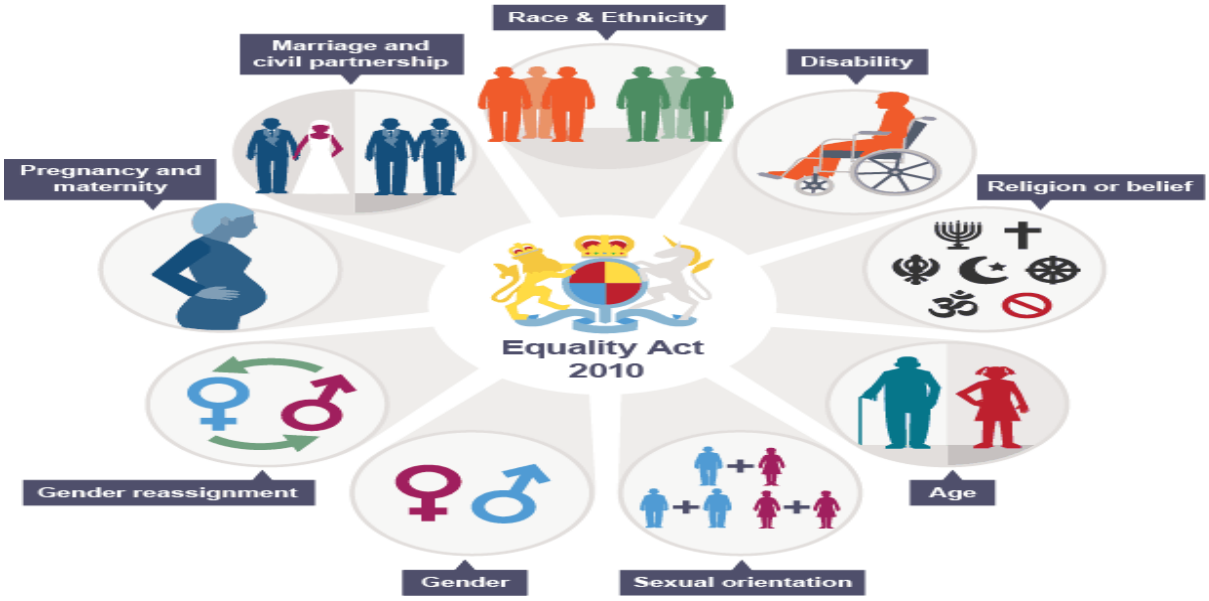
Undertaking an EIA is a way of identifying whether a current or proposed policy/service/function affects different groups of people in different ways.

By undertaking an EIA we are able to:

- Take into account the needs, circumstances and experiences of those who are affected by our policies
- Demonstrate that a “one size fits all” approach is inappropriate
- Identify actual and potential inequalities of outcomes
- Consider other ways of achieving the aims of the policies
- Increase public confidence in the fairness of our policies
- Help develop better policies and accessible services for our community
- Recognise the diversity needs of our community
- Offer culturally sensitive services.

EIAs help us to ensure our services are accessible to everyone and we do not unlawfully discriminate. Through this process the organisation will gain a deeper knowledge about whom their services are provided for and plan for further usage with an equalities perspective.

Diagram 1 – protected characteristics of the Equality Act 2010



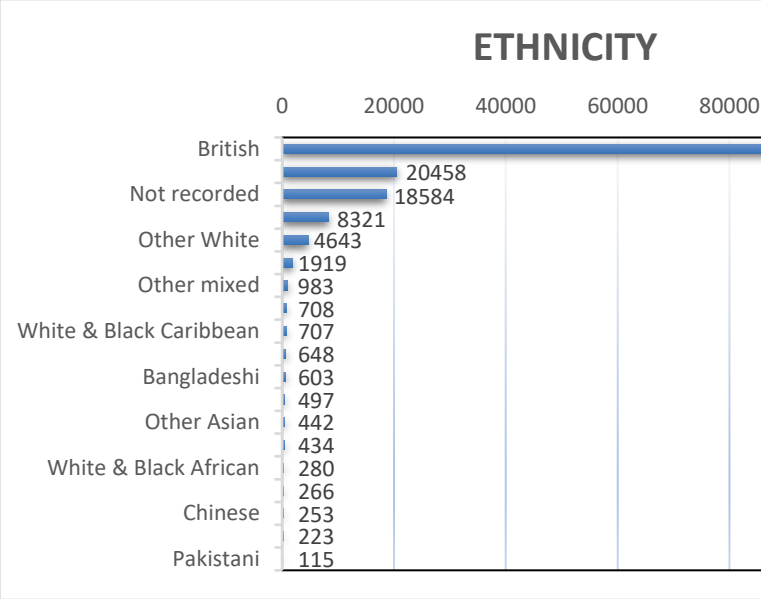
3.0 Equality and diversity data from CHUFT and IHT

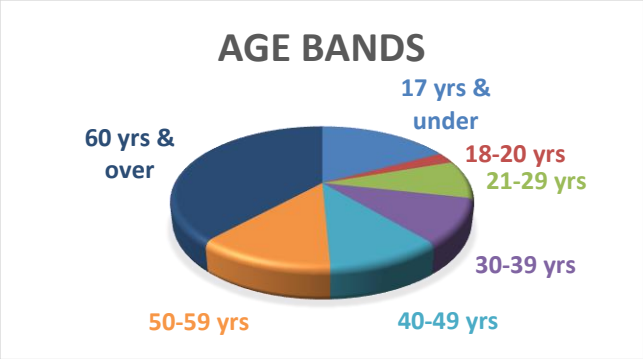
The data on the following two pages shows patient activity data from both CHUFT and IHT during the financial year 2016/17.

Patient activity data - IHT

Patient Activity for 2016-17

Ethnic Group IHT	Count
British	115,610
Not stated	20,458
Not recorded	18,584
Not known	8,321
Other White	4,643
Other ethnic group	1,919
Other mixed	983
Indian	708
White & Black Caribbean	707
Caribbean	648
Bangladeshi	603
Other Black	497
Other Asian	442
African	434
White & Black African	280
Irish	266
Chinese	253
White & Asian	223
Pakistani	115
TOTAL	**175,694**





Age IHT	Count
17 & under	30,148
18-20	4,429
21-29	15,388
30-39	18,317
40-49	18,325
50-59	21,936
60 & over	67,151
TOTAL	**175,694**

Maternity Age Group CHUFT	Number
Under 20	136
20-24	657
25-29	1122
30-34	1044
35-39	567
40-44	116
45+	13
Grand Total	**3655**

Age breakdown of attendances CHUFT	Number
Child	33346
18-20	4328
21-29	15048
30-39	14927
40-49	16044
50-59	18320
60+	62369
Grand Total	**164382**

Attendances by Ethnicity CHUFT	Number
White British	133657
White Irish	980
Any other White background	3979
Mixed White and Black Caribbean	588
Mixed White and Black African	292
Mixed White and Asian	375
Any other mixed background	748
Indian or British Indian	547
Pakistani or British Pakistani	133
Bangladeshi or British Bangladeshi	181
Asian - other	443
Black Caribbean or Black British Caribbean	147
Black African or Black British African	610
Any other Black background	285
Chinese	412
Any other ethnic group	1804
Not Stated	5280
Unknown	13921
Grand Total	**164382**

Gender breakdown CHUFT	Number
Female	88525
Male	75833
Not Specified	12
Unknown	12
Grand Total	**164382**

Patient activity data – CHUFT

Patient activity for 2016/17

The data shown in the previous pages clearly reflects the ethnicity breakdown provided in the FBC. As a result, there are a large number of White British patients attending both hospitals. This is statistically relevant as White British is the largest ethnicity group recorded as resident within the geographical footprint of the new organisation, therefore this presentation is expected.

However it should be noted there are a significant number of entries reported as not stated or not recorded. This is relevant if the new organisation intends to embed a culture of EDHR ensuring patients with diverse needs are treated equally and services are designed with due consideration given to ethnicity data amongst other profiles. Without the availability of complete data, there is the potential for decisions to be made based upon incomplete indicators. Marriage and maternity data was available but has not been reproduced here.

Creating a culture of robust data collection, interpretation and application to support understanding how diverse patient groups respond to service provision will ensure the development of an organisation which is data-optimised, productive, efficient and truly responsive. Ensuring workforce data is broken down into the protected characteristics, will inform organisational improvements, staff satisfaction and provide an opportunity for targeted interventions.

For the completion of this EIA, workforce and patient disability data, sexual orientation, religious/belief and gender reassignment data was not fully available and therefore could not be included. This could, longer term, impede the new organisations ability to have a full appreciation of patient and workforce profiles, service development and the contribution to national data requirements.

4.0 Assessing the impact of the FBC

An EIA provides a framework to examine in detail, the chapters of the FBC while considering its impact (whether negative, positive or neutral). Through this detailed work gaps can be identified and proposed actions recommended which can be taken forward as an integral part of the merger approval and implementation process.

This document is an assessment of the impact of the FBC for the merger of CHUFT and IHT on EDHR. The assessment has included a desktop review of the document undertaken by the interim equality and diversity lead at IHT, Nesta Williams, and a group review undertaken with the support of an assessment team whose members are listed in the introduction to this document.

As work progresses on the various work streams, all areas should have an initial analysis of relevance to the PSED carried out and recorded. For those areas with greater relevance, detailed action plans should be drawn up and reported upon as part of the project reporting systems.

As an early priority, for the new organisation, work should start to prepare for the developing and publishing of equality objectives. Workforce diversity data should be collected in order for the new organisation to have a baseline for any restructuring that may take place.

Workforce plans should include details of how the workforce can be reflective of the communities served by the new Trust and the new organisation should have a plan in place to tackle any under-representation of staff groups with regards to protected characteristics in relation to middle and senior management.

The EIA will be continually updated as actions are completed and recommendations implemented. The example outline action plan included here in Annex 2 will form the basis for this work and will be a key reporting tool. This assessment is crucial to enabling and demonstrating due regard. It will assist to fully understand the relevance and effect of the FBC and help in identifying the most proportionate and effective responses.

Table 1 below identifies each chapter in the FBC, whether any part of that chapter content is relevant to the EDHR agenda, and whether the likely impact on EDHR is negative, positive or neutral. It is possible to have all three impacts, and the recommendations then aim to accentuate the positive and mitigate, as far as possible, the likelihood of negative impacts emerging.

This EIA will be used to engage further with appropriate stakeholders and relevant local community groups.

Table 1 – The FBC by chapter

Chapters	Chapters of the FBC being assessed	Is the component relevant to the EDHR agenda	Initial assessment of potential impact (positive negative neutral)
3 and 4	Background and case for change.	Yes	Positive and Neutral
5	The new organisation	Yes	Positive and Negative
6	Financial case for change	Yes	Neutral and negative
7	Transaction and Integration	Yes	Positive and negative
8	Communications and Stakeholder engagement	Yes	Positive
9	Post Transaction Implementation Plan	Yes	Positive and negative

5.0 An assessment of each chapter of the FBC

This section of the paper takes each of the FBC chapters where relevance to the EDHR agenda has been identified. The EDHR components are described, highlighting gaps which have been identified in respect of the equality component as well as providing recommendations to address these gaps.

5.1 Chapters 3 and 4 - Background and case for change

This chapter sets out background information to the two Trusts and as such is considered overall **Positive and Neutral** with regards to impact on equality.

5.1.1 Key issues covered in this chapter of relevance to EDHR

- Demographic factors and changes to the population served
- Widening health and wellbeing gap
- Changes in clinical practice
- Workforce factors,
- Vision, objectives and priorities of the Suffolk and North East Essex STP
- Reduction of inequalities in health outcomes
- Key clinical priorities

- Reducing unwarranted variation in processes and quality of care

5.1.2 Positive Impact.

The FBC lays out its case for change by recognising the predicted change in its catchment population in a number of key areas. Population projections and housing growth plans in the catchment area of the new trust are significant. The growth is especially significant in the numbers and proportion of the population aged 65 and over and aged 85 and over. Consideration is also given to:

- an economically inactive population
- life expectancy and deprivation
- hard to reach groups
- minority ethnic groups
- rurality and transportation challenges

All of the above clearly links into the legislative requirements to:

- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Remove or minimising disadvantages suffered by people due to their protected characteristics
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.

5.1.3 Gaps and recommendations.

Although reference is made to an aging population and ethnicity, information on other protected characteristics of service users could have strengthened the case for change by linking epidemiology and changes in patterns of disease, lifestyle diseases such as heart disease, diabetes, obesity to gender, disability, ethnicity etc.

Reference is also made to population growth and housing growth plans, however, consideration could be given to population mobility such as movement of families to the area from London and environs due to improved transportation links. This might impact demand for services as well as the diversity profile of service users.

The following reference to education and training and improving the skill-mix of staff was made:

> "Many of these staffing shortages are likely to worsen over the next five years. The workforce will be unsustainable and care to patients will be under threat unless the model of service delivery is changed, underpinned by training to change the skill-mix of staff"

However, information about the new organisation's plan to develop a culture where there is a clear progressional route for all staff in the new organisation would have improved this section. Equally, having a clear understanding of the national perspective of the characteristics and skills of the new leader, as expressed in the NHS Improvement "Developing People Improving Care" document (see Annex 3) could strengthen this section.

5.2 Chapter 5 - The New Organisation.

The potential impact on equality of this chapter is assessed as **positive and negative.**

5.2.1 Key issues covered in this chapter of relevance to EDHR

- The vision and mission for the new organisation
- Proposed board and subcommittee structure including details of non-executive and executive director arrangements
- Clear governance and accountability for the delivery and mainstreaming of equality, diversity and human rights in all areas of policy development, service delivery and workforce development
- Attracting and retaining the right staff
- Proposals outlining the clinical model
- The philosophy of the organisation
- People and organisational development.

5.2.2 Positive impact

The statement made about the new trust's vision (below), demonstrates compliance with the general equality duty and compliance with due regard.

> "The Trust will make sure that time matters in all aspects of the way it does its job, from the way it plans clinical models of care, the way it conducts every contact with patients, to the way it provides IT infrastructure, through to how it manages processes like staff recruitment and the procurement of goods and services."

The below statement equally complies with the general equality duty and demonstrates due regard for advancing equality as per the Equality Act 2010.

> "it is imperative that patients can continue to access high quality, specialist care locally. This is particularly important for patients who are elderly or who have complex needs, for whom a longer travel time may be unacceptable. The new organisation will review how services are delivered in the community and the opportunities for further development"

5.2.3 Gaps and recommendations

Although reference is made to an ageing population with complex needs and the provision of specialist services, this section could be strengthened by including the findings from patient data, for example indicating highest/lowest attendance in groups of age, gender, and ethnicity and other fields and indicating how this informs future design of services..

The equality and diversity section could be further strengthened by including throughout the people and organisational development section narrative highlighting the new organisation's commitment to ensuring equality and diversity is "integral to the way things are done". An EDHR committee/group is not included in the governance structure presented and some detail could be provided on monitoring of compliance with the Equality Act 2010.

There is an excellent opportunity in this chapter to make explicit how the new organisation plans to demonstrate its commitment to inclusivity. Using language which is positive and inclusive, will support change of culture and create momentum towards a new organisation which fully appreciates the benefits of equality and diversity both for patents and staff alike.

The section could make reference to:

- An agreed framework for identifying equality objectives and measuring success.
- evidence of how roles and responsibilities of the new board will be aligned with EDHR requirements
- narrative outlining continued compliance with the PSED (pre- and post-merger)
- the priority given to EDHR within a governance framework
- clear articulation of the mechanism for embedding EDHR
- evidence that the proposed performance management systems will take account of equality and diversity

5.3 Chapter 6 - Financial case for change.

The potential impact on equality of this chapter is assessed as **neutral and negative**.

5.3.1 Key issues covered in this chapter of relevance to EDHR

- New models of care delivery
- Recruitment and retention of suitably qualified staff
- Representation at senior levels following especially BME staff
- Redundancies (if any)
- Staff reconfiguration and impact on flexible working arrangements

The chapter summarises the expected financial implications and benefits over a five year period from 2019/20 – 2023/24. The base year is 2018/19.

The focus of this chapter is to summarise the financial projections of the merger however there is very little information given within this chapter on how income growth and expenditure would impact;

- The new models of care
- Recruitment and retention
- Staff reconfigurations and redundancies
- Development of IT systems

The financial analysis and forecasts in this chapter are produced to model the strategy proposed in the rest of the document. In themselves the finances do not set out the means by which the organisation will achieve its goals.

5.3.2 Gaps and recommendations

It is recommended that consideration is given as to how to support EDHR in any programmes that reduce headcount, including through redundancy. For instance the new trust should ensure that interview panels are a mix of protected characteristics where possible and that panellists have recently been trained in interviewing techniques and how to avoid unconscious bias.

It would also be appropriate and useful for finance teams to review their obligations with regard to EDHR and the legislation as set out in published advice and guidance on the following web pages:

- https://www.equalityhumanrights.com/en/advice-and-guidance/guidance-procurement
- https://www.equalityhumanrights.com/en/advice-and-guidance/reporting-requirements-uk

Furthermore the financial strategy could consider:

- analyses of staff equality data
- assessments of how equality groups could be impacted in options for change identified
- identification and implementation of actions to mitigate negative impact or to promote equality
- Reviews of how equality impact has been considered

5.4 Chapter 7 - Transaction and Integration.

The potential impact of this chapter on equality is assessed as **positive and negative**.

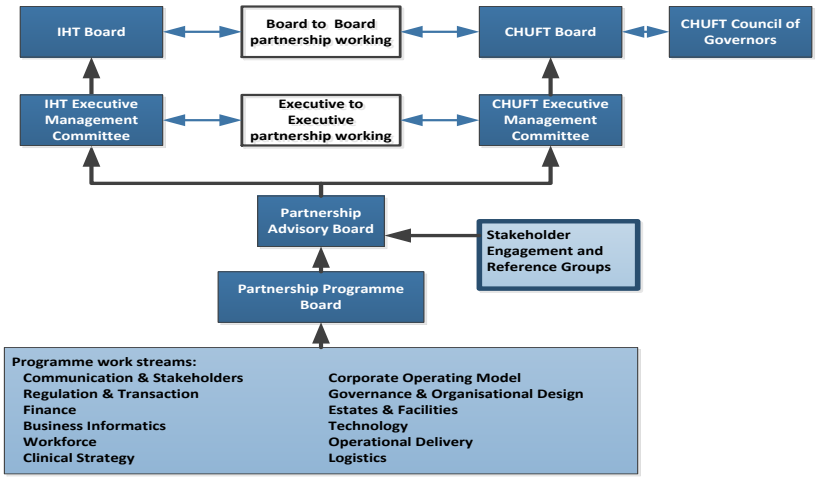
5.4.1 Key issues covered in this chapter of relevance to EDHR

- How the Trust will prepare for the new Trust in relation to a new Board
- The arrangements to deliver the merger across both organisations.

5.4.2 Positive impact

The diagram below highlights the inclusivity and considerations of the joint boards in the process of merging. This links into the PSED and demonstrates due regard.

Diagram 2: Governance arrangements during development of the FBC



In section 7.4.1 and 7.4.3 Programme risks and integration risks it was useful to see the potential risks and mitigations.

5.4.3 Gaps and recommendations

This chapter could be further enhanced by describing the current make-up of the boards across both organisations in relation to the protected characteristics. With this acknowledgement there should be a commitment to ensuring the new board is representative of the population it serves and allows for diversity of thought to support future decision making. The aforementioned point should also be considered with regard to the Council of Governors.

Further strengthening of the chapter could be achieved by outlining how members of the workforce, patients and carers with protected characteristics would experience the new organisation and its

services. Whilst general references are made, the failure to acknowledge specific requirements for some groups of the community or workforce is negative to EDHR.

5.5 Chapter 8 - Communications and Stakeholder Engagement.
The potential impact of this chapter on equality is assessed as **positive.**

5.5.1 Key issues covered in this chapter of relevance to EDHR

- Overview of communications and engagement activities regarding the proposed merger and the summary of key themes raised by stakeholders.

5.5.2 Positive impact

This chapter highlights the steps taken to engage with staff, public and stakeholders on the progress of the merger. A number of methods were used to reach all groups. The steps taken link into the Equality Act 2010 and demonstrate due regard by:

- Removing or minimising disadvantages suffered by people due to their protected characteristics
- Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people
- Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

5.5.3 Gaps and recommendations

This section could be further strengthened by including whether Large Print and Braille printed material was available on request and how many times was this type of format was requested.

It was apparent through this process that some seldom heard groups were not engaging in the communication requests, or stakeholder events. As a result small numbers if any have contributed to the discussions. This chapter could be further enhanced with the inclusion of the challenges experienced to engage with seldom heard groups despite efforts.

Expressing the challenges, will add richness to the chapter, make explicit the difficulties of engagement with certain groups of the community and bring a focus on designing steps to be taken in the future to improve outreach to these community groups.

5.6 Post Transaction Implementation Plan (PTIP)

The PTIP is a separate document to the FBC and has been reviewed in draft form. The potential impact on equality is assessed as **positive and negative.**

5.6.1 Key issues covered in this document to EDHR

- How the Trusts propose to establish the new organisation, East Suffolk and North Essex NHS Foundation Trust (ESNEFT), integrate the functions and implement the vision for the future organisation, by day one
- The first 100 days after the transaction and longer term plans for the merged organisation.
- The elements of the Post Transaction Implementation Plan (PTIP)

5.6.2 Positive impact

The information provided demonstrates the proposed new organisation will exercise due regard to the general equality duty and:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

The document illustrates how this will be achieved by outlining the formation of the new organisation's approach to the development of the clinical and corporate services using the 'intelligent care' (i-Care) approach. This approach focuses on achieving three objectives:

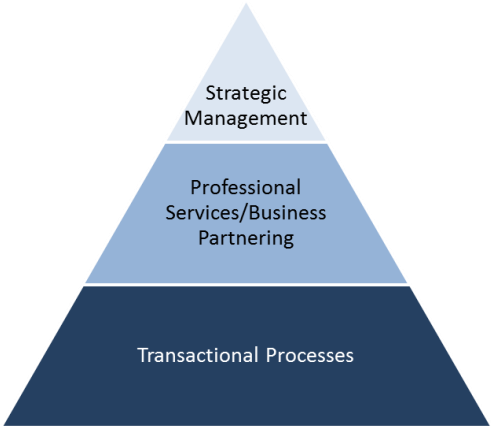
- To see people at the right time
- To retain and attract the best staff
- To provide the latest treatments locally

Enshrined in the operating principle of "Time Matters".

The approach appears inclusive and using the "Time Matters" operating principle, this will provide a framework for enabling equality of opportunities for the workforce and care provision for patients and carers.

The corporate operating model defines the key areas where the new organisation's ambitions are realised.

Diagram 3: The corporate operating model



The PTIP also links into the Equality Act 2010 and demonstrates consideration of the protected characteristics.

Diagram 4: Governance in the new trust

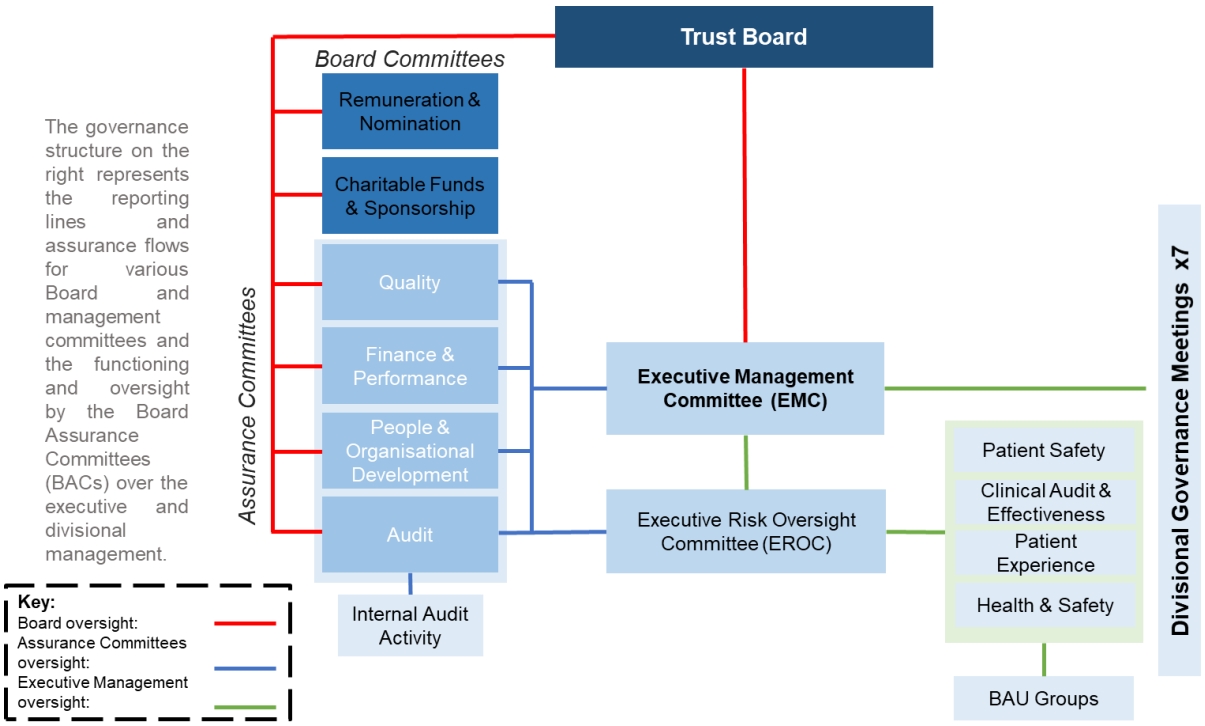


Diagram 4 usefully illustrates the governance structure of the new organisation, a great opportunity to build in an equality, diversity and inclusion committee/group to provide assurance the agenda is being progressed across all areas of the new organisation.

5.6.3 Gaps and recommendations

This document could be further strengthened by stating how an EDHR agenda would be built into initial integration priorities. For example, understanding the patient population in relation to protected characteristics could go some way to shaping new pathways and improving capacity. Working alongside IT colleagues and providing training for staff to ensure everyone appreciates the importance of collecting and recording relevant monitoring data could be made a priority.

No clear reference is made within the PTIP to the drafting of an equality and diversity strategy or that EDHR makes up one of the work streams or is embedded in the principles of each workstream. In addition there is no evidence of how the appointment of future Governors will engage seldom heard groups or staff from diverse backgrounds given there is under representation currently.

There is no reference made to the responsibility of the finance directorate to consider EDHR in their procurement strategy, ensuring that the new trust's suppliers support it in delivering its responsibilities with respect to the PSED.

6.0 Conclusion

This EIA has made a number of observations and comments about the FBC itself and how it has been written. Some of these have already been incorporated into the document while others are being worked on.

6.1 The eleven recommendations

For the organisation as a whole, eleven early recommendations have been made to put ESNEFT on a firm footing to support EDHR best practice from the start. These are:

1. Begin to create a culture of robust data collection, interpretation and application featuring all protected characteristics.

2. Establish a formal equality diversity and inclusion group which will support the preparation and publishing of the equality objectives for day one of the new legally constituted organisation.

3. Review governance to consider forming an EDHR committee that reports to the Board.

4. Develop a clear proposal for performance management metrics in the new organization to clearly incorporate EDHR metrics.

5. Prepare to collate and make ready workforce ethnicity data and establish a baseline to support restructuring decisions and develop interventions which can be measured and will improve BME representation across senior bands.

6. Set out a clear plan outlining the organisation's intention to ensure a higher representation of staff groups with protected characteristics at middle and senior management level.

7. Implement equality delivery system 2 (EDS2) and make public the trust's commitment to the equality agenda

8. All work streams identified as a part of the merger to undertake an initial analysis of relevance to the equality duty and have this formally recorded. Where deemed necessary and of greater relevance, a detailed action plan should be developed and progress reported upon as a part of the project management reporting structures

9. For the selection of Governors, interventions undertaken to engage with seldom heard groups should be recorded to ensure openness, transparency and a demonstration of the new organisation's commitment to having a diverse Council of Governors' that is representative of the community.

10. To ensure inclusivity and compliance with the Equality Act 2010, recognition of the ways in which seldom heard groups prefer to be engaged will promote participation in trust activities and has the potential to increase diverse candidates applications for roles, thus improving the organisation's performance

11. Ensure all staff sitting on interview panels have received up to date Equality and Diversity training and undertaken Recruitment and Selection Training which includes a section on avoiding unconscious bias; within the last two years.

Annex 1 – Summary of recommendations made by the assessment group

Recommendation	Action	Status
Chapter 3, Page 1. is it possible to insert some staff demographics information (e.g. from staff survey data)?	Recommended for inclusion. APPENDIX 11 referred to in 5.9.5	Closed
Given the number of acronyms used throughout, include a glossary of terms.	None necessary A glossary is included in the latest version.	Closed
Chapter 3, Page 4. Where we list the services, and state that some are not provided by us in one or the other area, can we include a note to say who *is* the provider?	Recommended for inclusion	Closed
Can 3.2.4 be updated following the latest CQC inspection results?	None necessary. The information is current, and is given sufficient emphasis for the purposes of this document.	Closed
Section 3.2.5 – STP. As an indicator of support in the local system for the Equality and Diversity agenda, worth noting that the STP Programme Board membership includes representatives of the voluntary sector, both from Suffolk and North East Essex	Recommended for inclusion	Closed
3.3.3.1 – Technology – can we include the potential for improving public wi-fi provision, enabling patients and carers to have video calls with loved ones, rather than necessarily having physical visits?	Will be raised with Chief Information Officer	Open
3.3.3.1.9 – In relation to the new dwellings planned for the area, the Local Authority will be able to advise on what type of dwellings these will be, which will in turn provide an insight into the likely demographics of the owners/tenants and therefore inform any possible impact on healthcare services.	None necessary - local plans are referenced in the document.	Closed
Reference should be to “seldom heard” groups, not “hard to reach”.	Action – None necessary – already updated in current version.	Closed
Section 5.5.4 and 5.5.6 – Should an equality and diversity portfolio be allocated as the responsibility of a designated Executive Director, and of a designated Governor?	Action – recommendation to be made to the Trust Executive. This recommendation will be tracked through the log of recommendations from reference and advisory groups.	Open
At 5.4.4 Could we include a note about how the governors are elected (i.e. by the members)?	Action – recommended for inclusion.	Closed
How will we ensure an equitable governor election process, which gives the opportunity for seldom heard groups to	Action – Throughout engagement activities, ensure that membership recruitment is included – particularly	Closed

Recommendation	Action	Status
engage or not, as they see fit?	from seldom heard groups. A slide will be added to the key message pack.	
Can we include details of the proposed makeup of the Council of Governors, i.e. number of governors for each area etc?	Action – recommended for inclusion in FBC	Closed
5.5.12 Quality Improvement. A new bullet point should be added relating to patient and carer involvement.	Action – none necessary. The first bullet point already refers.	Closed
There is currently no patient involvement group at CHUFT. Recommended that one is created for the new organisation.	Action – Recommendation to be made to the Trust Executive. This recommendation will be tracked through the log of recommendations from reference and advisory groups.	Closed
Under "Retain and attract" section of Chapter 5, the Equality and Diversity agenda needs to be included.	Action – none necessary, as there is an Equality and Diversity section in the current version.	Closed
In Chapter 7 – Shadow Board section, can we include an org chart showing shadow board structure?	Action – recommended for inclusion Done but in 5.5.5	Closed
Chapter 8 – Comms and engagement. Can we include the fact that representation from the partnership at the different meetings/events has been very varied in terms of who attended – this has added a richness to the engagement.	Action – fed back, but not for inclusion in the document.	Closed
8.5.3 – Need to include the engagement log,	Action – none necessary. The log will be included as an appendix. Nesta noted that the challenges of engaging with seldom heard groups/communities will be ongoing, and this will be reflected in the EIA document This will be APPENDIX 7	Closed
The future comms and engagement strategy should be included.	Action – none necessary. The future comms and engagement strategy has not yet been built, as the merger needs to be signed off first. The PTIP includes comms and engagement activities required at the various stages of implementation (Day 1, day 100 etc). Draft strategy included at Appendix 8	Closed
Could Chapter 8 (Comms and engagement) be brought forward in the document?	Action – none necessary. The chapter is in the right place for the flow of the document, and the structure of the FBC follows that of the OBC.	Closed
Throughout the document, ensure carers are included alongside patients.	Action – recommended for inclusion.	Closed

Recommendation	Action	Status
	DONE where appropriate to the meaning of the text	
In 1.6.4 (Enablers) of the Executive Summary, should we include the equalities and diversity agenda under "Investing in people", e.g. training re disabilities etc.	Action – recommended for inclusion.	Closed
Will equality and diversity be measured in the "investing in people" section?	Action – none necessary. Although there are no measures in this document, current section 5.9.5 notes that e and d in staff will be baselined and understood.	Closed
1.6.7. Under capacity and capability for change, could we talk about co-production?	Action – to be raised with HR Director, requesting some exact wording.	Open
Under logistics management, patient pathways should be "accessible" as well as "optimal".	Action – whole point is under review as it doesn't read well. Has been revised, see 5.11.4.1	Closed
Where do we include our commitment to the accessible information standard?	Action – none necessary. As this is a statutory requirement, it doesn't warrant inclusion as a commitment in this FBC.	Closed

Annex 2 – Example outline EDHR action plan

To be developed when actions are identified and agreed.

Areas to consider are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and human rights

Identified Barrier	**Groups affected**	**Actions required**	**SRO**	**Due by**	**Verified completion – (*Who will sign off completion?)***
EXAMPLE: Information and communication	All of the above	Collection of equality data for local population, workforce and key diversity groups. Create database of active and responsive community groups. Establish baseline workforce	? AD HR/Workforce & E&D lead. ? IM&T manager Head of communications and E&D lead	Day 1 of new organisation	? HRD ? Equality, Diversity and inclusion group IM&T lead Director of communications and engagement

		ethnicity monitoring information for new organisation. Consistent communication messages to support staff understanding the relevance of robust data collection to support excellent care delivery.			

Annex 3 – Sources and references

Sources of information used, with references, location or links.

- Baseline EIA for Outline Business Case
- Census data. https://www.nomisweb.co.uk (accessed Feb 2018)
- CHUFT and IHT vision and values
- CHUFT patient data,
- CHUFT workforce data,
- IHT patient data
- IHT workforce data
- Developing People Improving Care (DPIC) https://improvement.nhs.uk/resources/developing-people-improving-care/ (Accessed Feb 2018 and March 2018)

Equality and Human Rights Commission

- https://www.equalityhumanrights.com/en/advice-and-guidance/guidance-procurement (Accessed Feb 2018 and March 2018) https://www.equalityhumanrights.com/en/advice-and-guidance/reporting-requirements-uk (Accessed March 2018)
- Equality and Human Rights Commission https://www.equalityhumanrights.com/en

Five year Forward View

- Five Year Forward View https://www.england.nhs.uk/five-year-forward-view/ (Accessed Feb 2018)
- Next Steps on the NHS Five Year Forward View https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/ (Accessed Feb 2018 and March 2018)
- Office National statistics. https://www.ons.gov.uk/census

- Outline Business Case Summary
- Public Health England, 2017 Health Profiles www.healthprofiles.info (Accessed Feb 2018)

The Health Profiles provided information on Life expectancy, age profiles, lifestyle related diseases, deprivation scores and health inequalities.

The above information has been used to inform the EIA process and assist in clarifying the health needs of groups that fall within protected characteristics of residents living in Babergh, Colchester, Ipswich, Mid Suffolk, Suffolk Coast and Tendring

A8 Appendix 8: Travel Impact Assessment

Assessing the impact of the merger full business case on travel for local residents and staff.

This document is an assessment of the travel impact on patients and staff of the merger of Colchester Hospital University Foundation Trust (CHUFT) and The Ipswich Hospital NHS Trust (IHT) outlined in the Full Business Case (FBC). The new organisation formed by the merger will be called East Suffolk and North Essex NHS Foundation Trust (ESNEFT).

This assessment should be read as a companion to the Equality Impact Assessment undertaken for this FBC.

The current FBC does not propose any significant changes to services. There is a firm commitment by the leadership that any such changes proposed post-merger would be subject to a Travel Impact Assessment in line with best practice.

The following has been a key message from the CEO to patients and the wider public throughout the merger process.

> "*I know that transport, especially public transport, is already a concern in your day to day lives, regardless of hospital visits.*
>
> *There will be no changes to A&E or maternity services at either Colchester or Ipswich hospital. Both will also continue to provide 24/7 emergency admissions. The vast majority of outpatient appointments will continue to take place as they do now.*
>
> *Over time, our doctors and other clinicians may decide that concentrating some very specialised expertise at one hospital is the best way to diagnose or treat patients with less common conditions.*
>
> *Although this would only affect small numbers of patients, change like this would need public consultation and a robust assessment of impact on travel. We would make sure any travel concerns were properly addressed. There is no point improving services if it is too difficult, expensive or impossible for patients to use them."*
>
> Nick Hulme, Chief Executive
>
> February 2018

Overview

The benefits of the proposed merger between Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust has been described in the Full Business Case (FBC).

The merger will provide the conditions for the new organisation, working with local partners, to achieve three key aims which have been shared and discussed with staff, public and stakeholders through communication and engagement activity since the respective boards agreed the Outline

Business Case in August 2017. These aims are to see residents at the right time; attract and retain the best staff and; provide the latest treatments locally.

These benefits are based on the preferred scenario set out in the FBC of one organisation with single teams working across east Suffolk and north Essex.

The merger will also introduce a new organisational culture of *time matters*, which will focus on removing unnecessary stress for patients and freeing up staff to care. This approach may also impact on travel requirements on a wider scale than service change. For example:

- Patients should only come to hospital for an appointment if there is a clinical need to do so - not just because 'that's what we always do'.
- ESNEFT will use technology to reduce the number of times patients need to attend, and increase the use of, for example, telephone follow-up consultations to save residents travel time and cost.
- ESNEFT will make better use of the community hospitals in Felixstowe, Harwich, Clacton, Halstead, Aldeburgh and Bluebird Lodge in Ipswich, and community services, again reducing travel time and cost.

There are three fixed points for the merger. These are that both Colchester and Ipswich hospitals will continue to offer full accident and emergency and maternity services and 24/7 emergency admissions.

The current clinical model in the FBC does not propose any significant changes to services which would have any notable transport or travel implications or impact - positive or negative - on specific services or treatments, population or geographies at this time, or the majority of staff.

There is, however, an expectation set out within the Post Transaction Integration Plan that the new Trust leadership and senior management will need to have an increased presence across both sites to support the single team model.

The principles of the current approach to travel planning is consistent with that of the accompanying Equality Impact Assessment (appendix 9 to the FBC). As with the EIA, this document assesses the effect of the merger by considering its potential impact (whether negative, positive or neutral) based on current plans and modelling in the FBC. It identifies gaps in the analysis and proposes a number of actions which will be taken forward as an integral part of the merger approval and implementation process.

Again, as with the approach set out in the EIA, individual TIAs will be developed where relevant service or other changes are developed. This is vital to ensure that travel implications for staff and residents are fully considered as part of future clinical planning, and effective mitigation put in place where needed. Such TIAs would be aligned with relevant EIAs and likewise require further information, analysis and engagement at the right time, as a part of the decision-making processes.

This impact assessment will be subject to approval by both existing boards alongside the FBC. It will also be used to engage further with appropriate stakeholders and relevant local community groups.

Again, as with an EIA, any TIA would identify whether a current or proposed policy/service/function affects different groups of people in different ways. For instance, the maps of journey times, attached in Annex 1, clearly show that implications for those who mainly use public transport to get to hospital will be affected in different ways to those who mainly travel by car.

By undertaking an EIA and/or TIA the trust is able to:

- Take into account the needs, circumstances and experiences of those who are affected by our policies
- Demonstrate that a "one size fits all" approach is inappropriate
- Identify actual and potential inequalities of outcomes
- Consider other ways of achieving the aims of the policies
- Increase public confidence in the fairness of our policies
- Help develop better policies and accessible services for our community
- Recognise the diversity needs of our community
- Offer culturally sensitive services.

Approach to date

Since agreement of the Outline Business Case in August 2017, the trusts have undertaken wide-ranging engagement with public, staff and stakeholders. Travel and transport issues has emerged as the strongest themes from this engagement. The engagement has included public events, online and written surveys, sessions with staff at all of the trusts' physical sites, and public 'drop-in' sessions in town centre locations.

Staff have raised concerns about additional cost of moving between different sites; changes to their agreed working patterns and; logistics of parking at different sites.

The public have raised concerns about additional travel time and impact on their health if services are moved from one site to another; lack of public transport options; cost of transport and car parking.

The trusts have responded to these concerns for the short-term by producing clear briefing material for the public to explain and reassure that no significant changes are planned at the current time and that any such changes would be subject to national guidance on public engagement and consultation and there would be a robust assessment of impact on travel.

Current population and travel patterns

Detail on the population of east Suffolk and north Essex is included in Appendix 4 produced for this FBC. It is however recognising that there are issues around deprivation, rurality and access to transport that are and will be key considerations for future travel impact assessments.

For example, there are significant pockets of rural deprivation in the region. The 2016 Joint Strategic Needs Assessment for Essex highlighted that some of the worst areas (the most deprived one

percent of nearly 33,000 areas in England) are within north Essex, with six in Tendring. Majority of trips to hospital, especially for staff, are by car - for example - 85% of Colchester staff travel by car.

In Suffolk, the proportion of households with access to a car or van was higher in rural areas of (89.2%) compared to urban areas (77.5%), but this still means that around 1 in 10 rural households (just over 13,000) do not have access to a car or van. The 2015 State of Suffolk report said this lack of access to private transport "...is an important consideration because of the potential implications for access to services and key amenities". The same report also highlighted the problems with the "infrequency and timetabling of local transport, particularly in rural areas."

Conclusion and recommendations

An analysis of references to travel and transport within the full business case chapters shows:

- There are no significant changes proposed which would negatively impact on existing travel and transport requirements for patients, families and carers
- An emphasis within the FBC on greater use of community services and new technology to reduce travel time in some cases
- Opportunities to save, strengthen and grow services, especially more specialised services, which may reduce the need to travel out of the region
- No changes impacting on majority of staff, but new trust leadership and senior management will need to have an increased presence across both sites to support the single team model
- A commitment to work with commissioners and wider health and care system, and to monitor relevant national changes to standards and specialised services, to minimise impact on travel and transport for our residents.

Recommendations

- Detailed TIAs should be undertaken for all relevant service changes in the future
- ESNEFT should establish a travel working group which should include representatives from staff, patients, residents and other interested parties to discuss current and future travel and transport plans
- ESNEFT should engage with local residents to develop the use of technology and community services which may reduce existing travel time
- ESNEFT should make sure all staff are aware of relevant policies relating to travel and transport.

Annex 1: Isochrome mapping

Isochromes show the points of equal travel times from a fixed location.

The six isochrome diagrams below show:

- Peak road transport travel times to Colchester General Hospital and the Ipswich Hospital
- Off-peak travel times to Colchester General Hospital and the Ipswich Hospital
- Public transport travel times to Colchester General Hospital and the Ipswich Hospital.

The isochrome mapping is sourced from https://shapeatlas.net

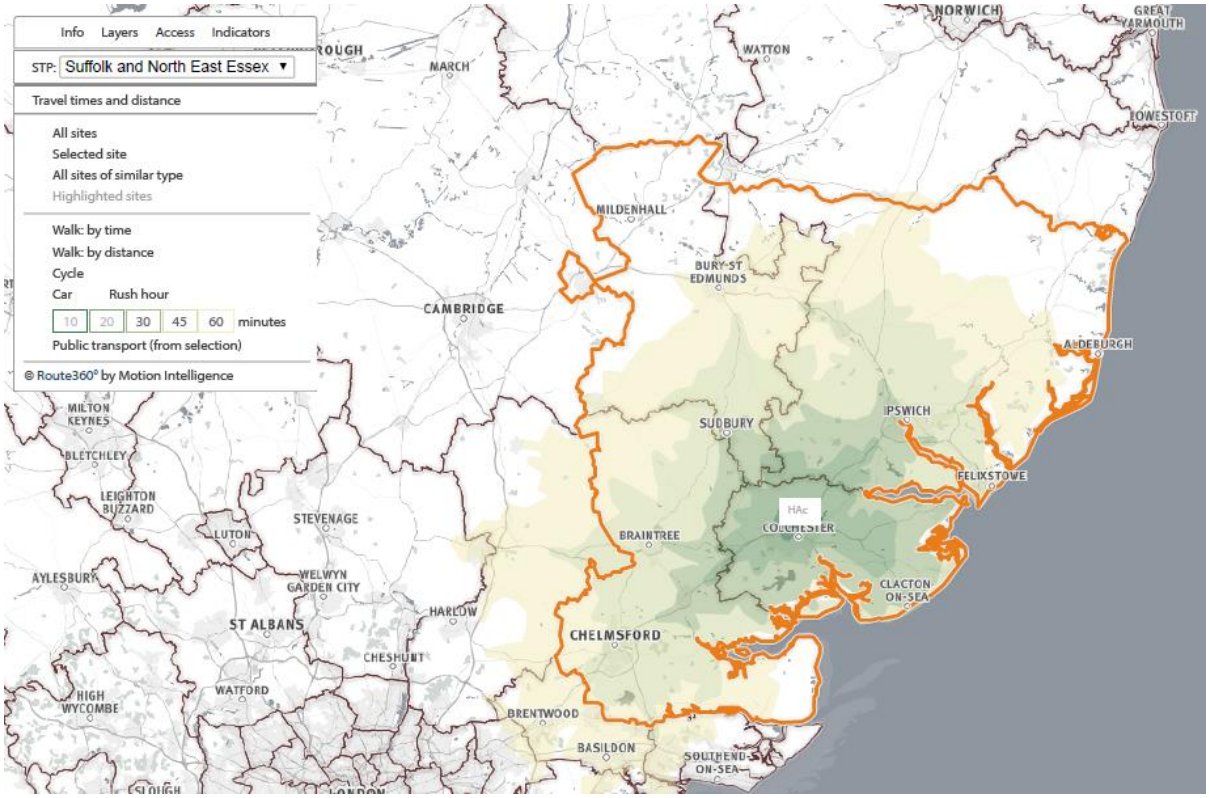


Figure A10-1 Peak time road transport travel times to Colchester General Hospital

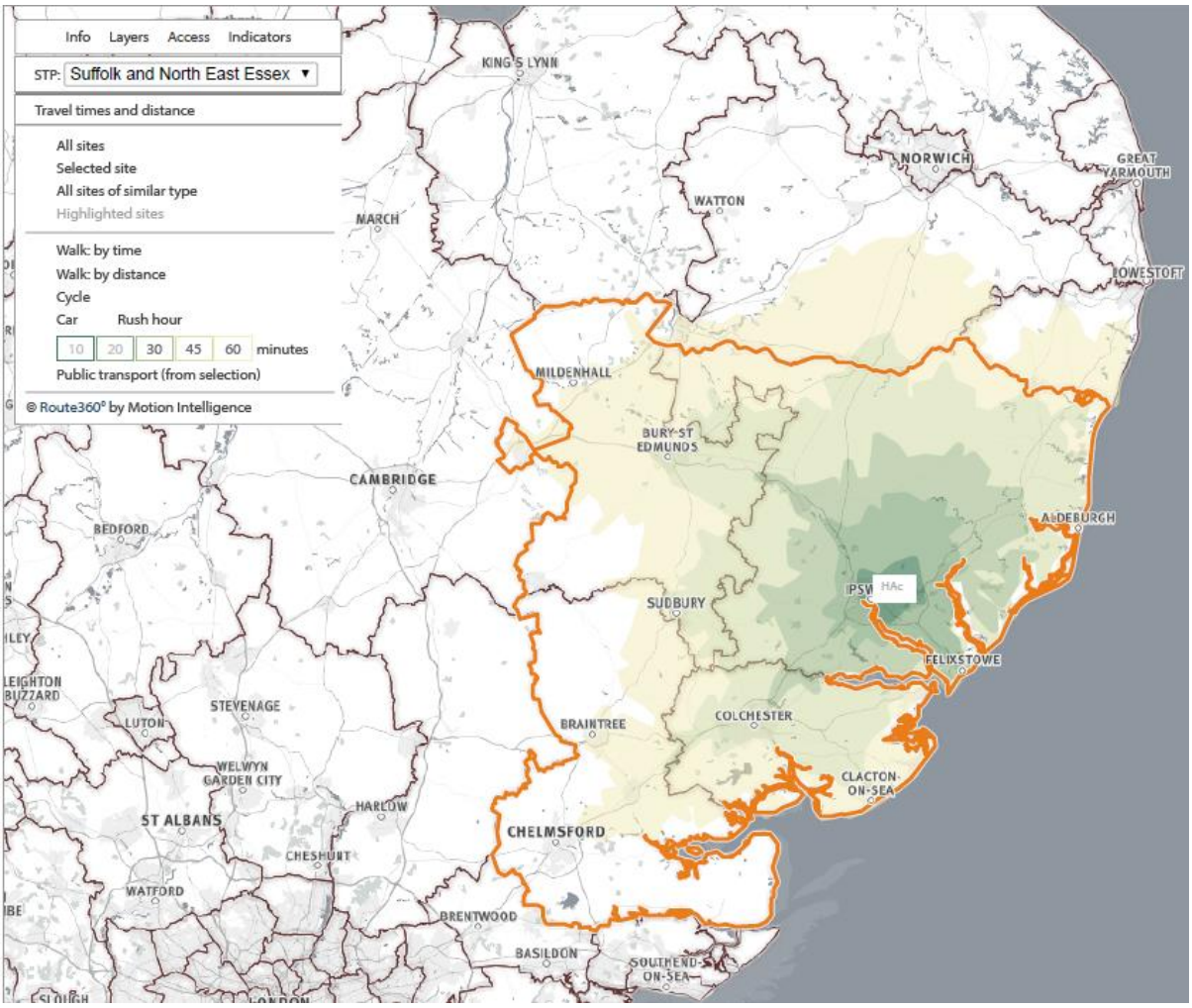


Figure A10-2 Peak time road transport travel times to Ipswich Hospital

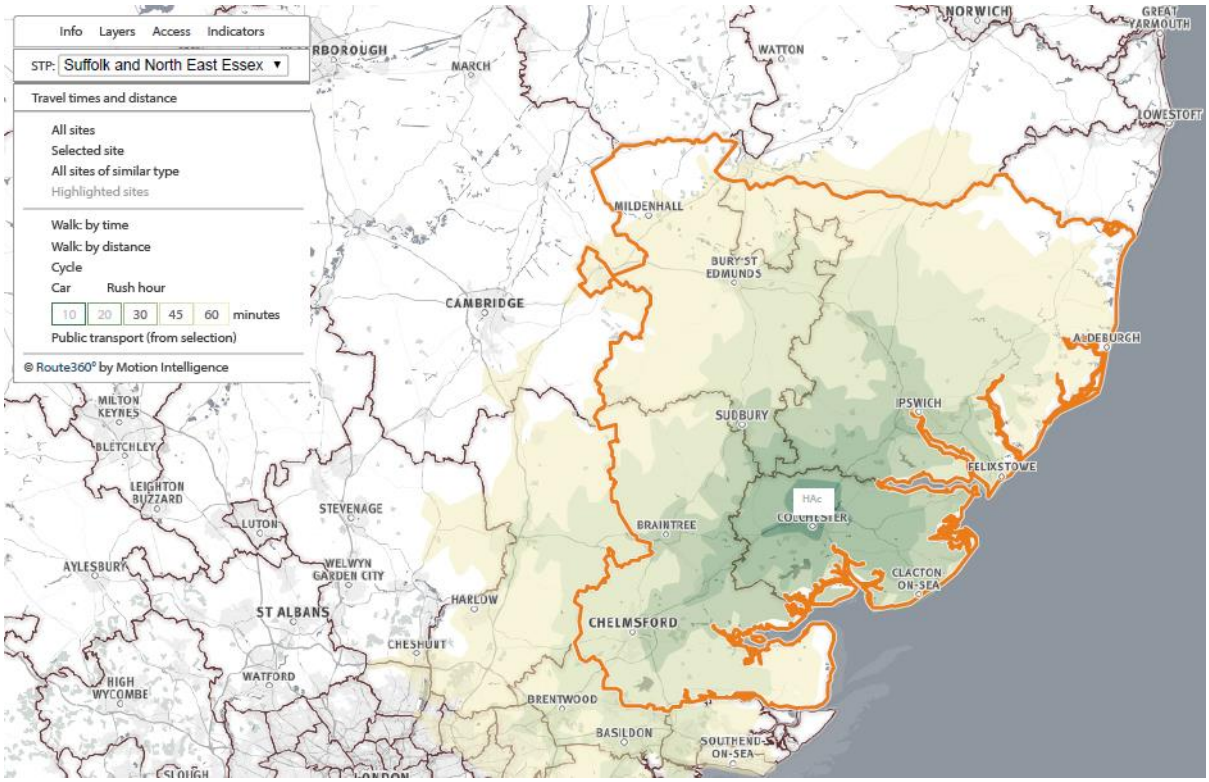


Figure A10-3 Off-peak time road transport travel times to Colchester General Hospital

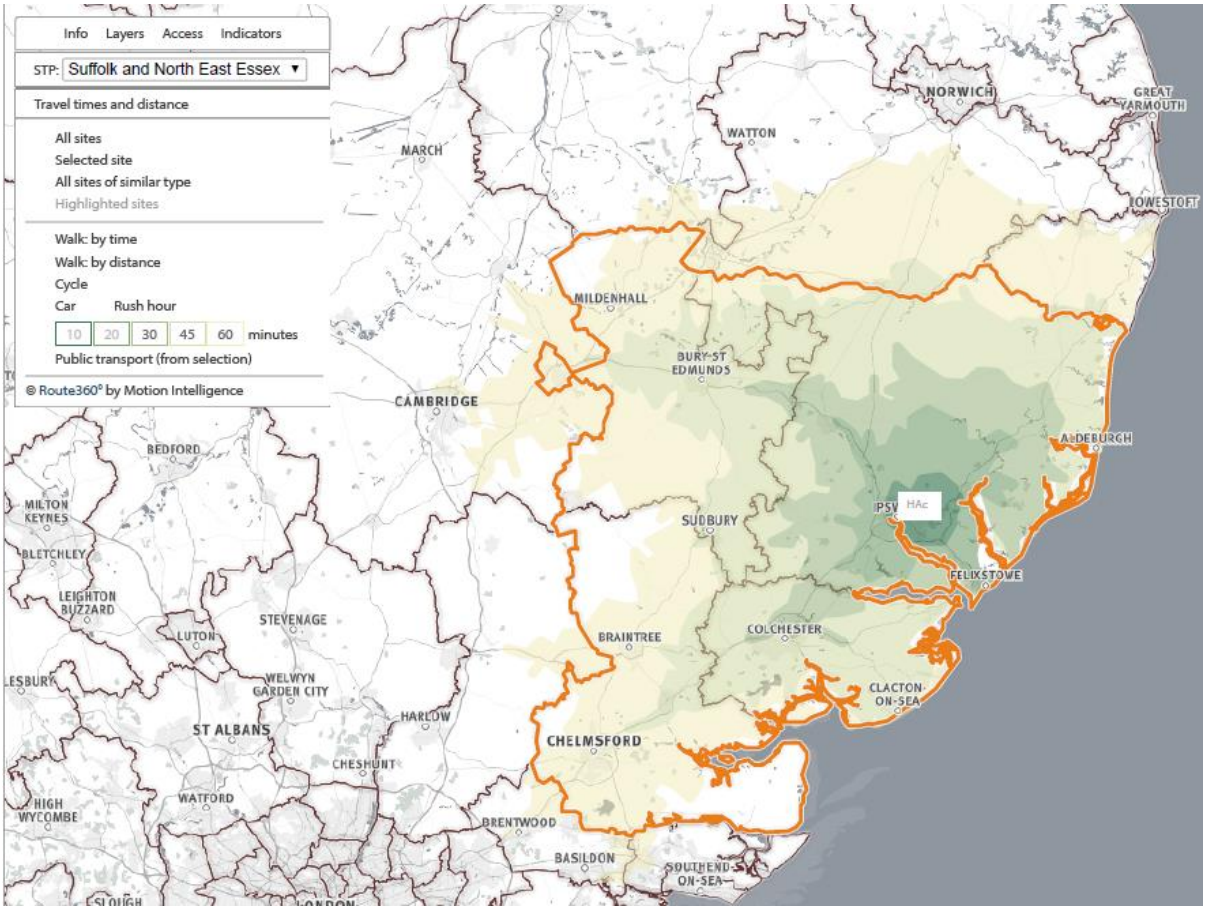


Figure A10-4 Off-peak time road transport travel times to Ipswich Hospital

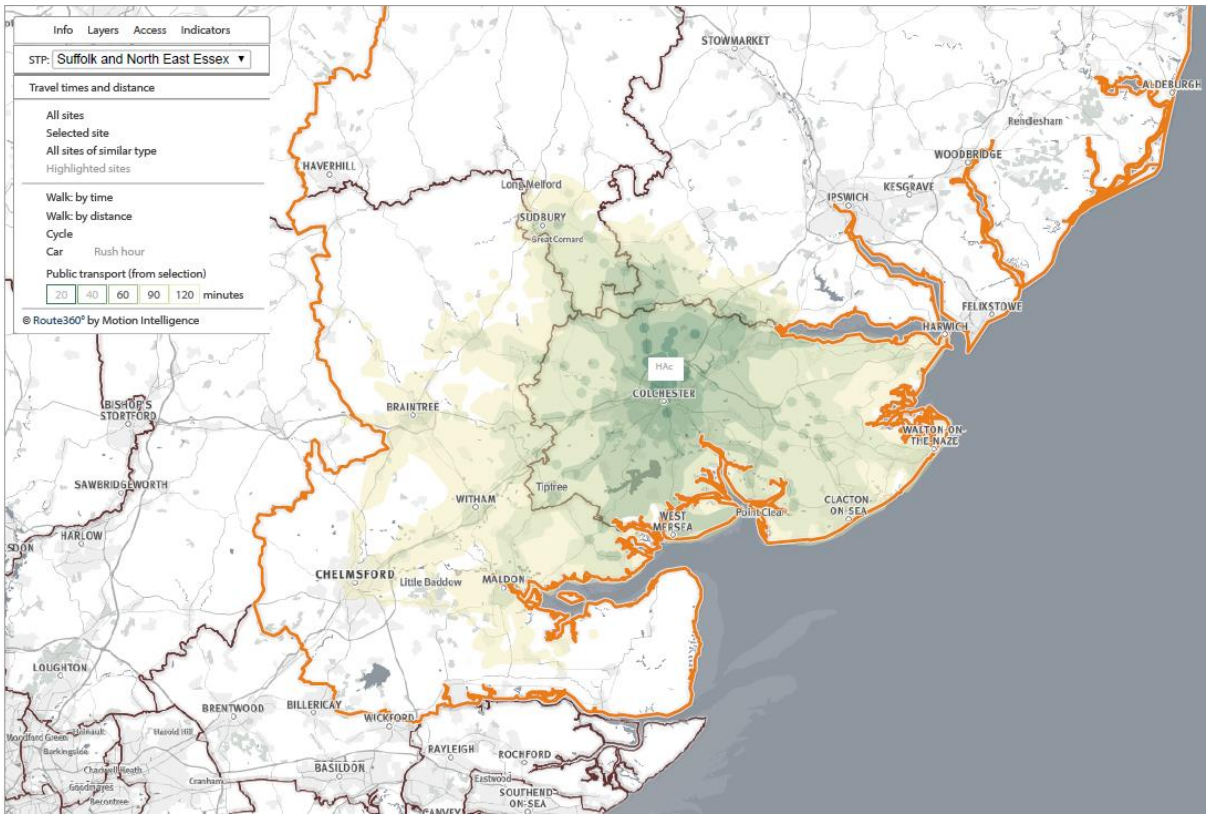


Figure A10-5 Public transport road transport travel times to Colchester General Hospital

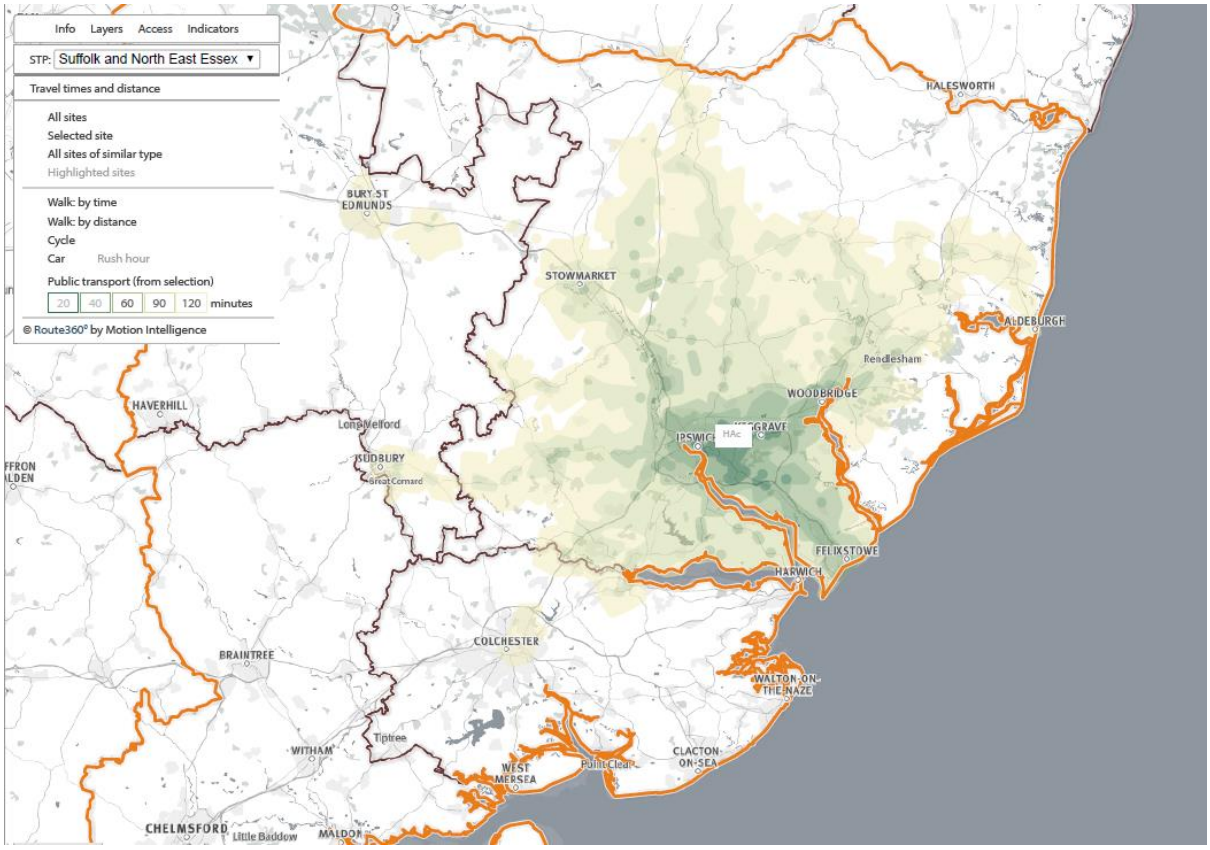


Figure A10-6 Public transport road transport travel times to Ipswich Hospital

A9 Appendix 9: Workforce demographic data CHUFT and IHT

The following is a high-level analysis of workforce demography data based on staff in post at CHUFT and IHT as at 31 December 2017

Gender	CHUFT (%)	IHT (%)
Male	23.4	19.7
Female	76.6	80.3

Age	CHUFT (%)	IHT (%)
16-20	3.4	0.8
21-25	11.8	8.1
26-30	16.5	11.3
31-35	11.1	10.9
36-40	12.9	11.3
41-45	7.4	12.5
46-50	6.3	12.9
51-55	9.5	14.5
56-60	9.8	10.7
61-65	6.8	5.6
66-70	2.2	1.0
71+	2.5	0.4

Ethnic Group	CHUFT (%)	IHT (%)
White	80.9	74.2
Mixed/multiple ethnic groups	1.5	1.3
Asian/Asian British	10.5	6.3
Black/African/Caribbean/Black British	1.5	1.1
Other ethnic group	1.8	0.8
Not specified	2.8	16.3

A10 Appendix 10: Financial Sensitivity Analysis

The following tables are the sensitivity analysis undertaken as part of the assessment of 'Downside Risks', and more generalised actions the Trust would seek to implement if it became apparent that the financial position modelled was under pressure.

Downside risks	Net impact (Deficit) / Surplus for the year (£m)						Risk Level (H/M/L)	Comment on Risk Level
	2018/19 Outturn	2019/20 Forecast	2020/21 Forecast	2021/22 Forecast	2022/23 Forecast	2023/24 Forecast		
Integrated model (with benefits)	**(22.4)**	**(16.7)**	**(16.1)**	**(18.0)**	**(18.3)**	**(27.9)**		
Impact on base model								
Annual level of funding - commissioning settlements		(5.8)	(11.8)	(17.8)	(23.8)	(30.0)	**Low**	Commissioning discussions for 18/19 have broadly confirmed the principle that commissioners will pass to providers the growth uplifts they receive from their funding allocations. The government's Spring statement, whilst not announcing new spending commitments, has indicated that spending restraint focussed on reducing the deficit may be relaxed and in particular monies flow to the NHS. This national context, coupled with rapidly growing populations of both East Suffolk and North East Essex suggests that the funding uplifts sourced calculated in 2016 may actually be conservative. If funding levels were curtailed, then the Trust would need to discuss with Commissioners, possible options in terms of the cessation or reconfiguration of existing services.

Marginal cost behaviour		(0.7)	(1.3)	(2.0)	(2.7)	(3.5)	**Medium**	Whilst the costing systems and information available at both current hospitals is of a high standard, it is recognised that more development is needed in relation to understanding and more accurately modelling semi-fixed costs in particular. Within the financial modelling, semi-fixed costs have been treated as marginal costs. This is likely to misstate the change in cost that will result from activity changes. Moreover it not possible to presently explain why a greater % of the cost base has been identified as flexible at CHUFT compared to IHT. Given this, it is just as possible that the marginal cost analysis of IHT is actually more representative and costs are actually overstated. Upon merger, costing expertise between the two Trusts will be consolidated and more capacity will exist to undertake such analysis and improve costing information. This work will help to highlight variances between the two organisations and increase the likelihood of 'best practice' and help to minimise costs; rather for them to grow.
Cost inflation		(2.0)	(4.1)	(6.2)	(8.3)	(10.7)	**Low**	The Autumn Budget 2017 confirmed that further funding will be provided in this this parliament for pay awards for NHS staff on Agenda for Change contracts. This funding will be in addition to the funding increases that have already been announced. The Budget notes that funding for pay awards will be conditional on a pay deal being agreed with unions on modernising the pay structure for Agenda for Change staff to improve productivity, and staff recruitment and retention. It is highly likely then that national pay awards will be backed by funding. If they were not, it would be hoped that a level of discretion would be afforded to NHS organisations to implement only what they could afford.

CIP delivery	(20.2)	(27.1)	(34.0)	(41.0)	(47.9)	(54.8)	**Low**	The level of CIPs assumed beyond 2018/19 is only 2%. This will not be easy to deliver but nor is it considered unrealistic. Robust monitoring of schemes progress should provide early warning of areas where non-delivery is anticipated and corrective action or alternative plans will be developed.
Corporate TOM delivery and level of savings	(0.5)	(1.0)	(1.9)	(2.1)	(2.2)	(2.2)	**Medium**	A systematic process, led by Deloitte, was followed to identify, describe and quantify the savings opportunities that existed. Detailed implementation plans are being developed, and robust monitoring of scheme progress should ensure the best possible change of the expected quantum of savings being achieved. Like CIPs, if deviation from plans is identified early then the expectation will be that corrective action or alternative plans will be identified. Nevertheless, it is acknowledged that some schemes are not as far progressed as would be desirable, and for this reason the risk has been highlighted as medium.
Clinical integration delivery and level of savings	(1.6)	(2.9)	(4.9)	(5.9)	(5.9)	(5.9)	**Medium**	This relates to clinical integration before service reconfiguration, and the significant majority of the benefits included in the financial modelling are related to dramatically reducing present agency costs. The end point required in terms of spend on agency staff is consistent with the current highest performing NHS Trusts. Therefore it is clearly not unachievable. Furthermore, it is envisaged that further financial benefits will be identified as clinical reviews and pathways redesign are advanced. However, it is also understood that some of the areas where the Trust presently incurs the greatest agency expenditure, such as the Emergency Department, are services where there are national shortages of staff and being able to recruit substantively will be challenging regardless of how attractive the Trust becomes as a workplace.

Costs to deliver transformation: both corporate and clinical	(0.9)	(1.6)	(2.9)	(4.7)	(3.0)	(3.0)	**Medium**	Other Trusts that have recently merged have been contacted to provide a better and more realistic understanding of likely integration costs. 'Area' experts (such as HR and IT) have also been consulted to formulate costs. However, some of the integration programmes (such as the use of robotics and automated processes) are innovative, certainly with few examples in the NHS to learn from. Consequently, costs must be considered quite volatile.
Revised integrated model (with benefits)	**(45.6)**	**(57.9)**	**(77.0)**	**(97.7)**	**(112.1)**	**(138.0)**		

	Net impact (Deficit) / Surplus for the year (£m)						
Financial Pressures Mitigation	2018/19 Outturn	2019/20 Forecast	2020/21 Forecast	2021/22 Forecast	2022/23 Forecast	2023/24 Forecast	**Comment**
Workforce: changes in pay rates and conditions		4.1	8.2	12.4	16.6	21.5	Changes in pay rates and conditions would potentially include schemes like changes in sickness pay, enhancements, annual leave entitlement and incremental pay increase gateway enforcement. It is recognised that some of these proposals are potentially challenging to implement, especially unilaterally, and would require consultation with staff / unions. The mitigation nevertheless assumes that it would be possible to mitigate and control the impact of incremental drift (1%).
Estates: cut capital programme		0.3	0.6	0.9	1.2	1.5	Estates scheme mitigations would include the closing or selling surplus estate, and pulling back on capital spend. Again, this would not be easy and the impact on quality / performance would need to be thoroughly assessed before such actions were pursued. Nevertheless, it is not unrealistic to assume that approximately £0.3m in capital charges could be reduced per annum.

Other: reduce management costs	0.5	0.5	0.5	0.5	0.5	0.5	A number of initiatives are already identified and underway (such as the work on the Corporate Target Operating Model) with the objective of reducing management costs. Nevertheless, more aggressive steps could possibly be taken with new organisational structures providing opportunities for further expenditure reductions (including at Board level).
Other: release of reserves / contingencies	2.0	2.0	2.0	2.0	2.0	2.0	Within the CHUFT plans for 2018/19 there is a small amount of contingency that would be released.
Other: bring forward CIP programme and CIP stretch		6.9	13.8	20.7	27.6	34.6	The 'base' CIP to be delivered is 2%. Although this is considered realistic and challenging to deliver, it is acknowledged that higher levels of CIP have actually been achieved by both organisations in previous years and are actually planned for in 2018/19. Caution does need to be exercised in that ambitious corporate and clinical reconfiguration programmes are also already assumed in the partnership modelling, and there cannot be any duplication, but a further 1% stretch on CIP would be aspired to (from 2019/20 only).
Other: negotiate for an adjustment in the system control total		5	7.5	9.9	10.2	12.2	STP modelling has shown that it should be possible for the health economy of East Suffolk and North East Essex to be in financial balance. It equally shows though that without an adjustment to funding flows, providers will continue to report growing deficits whilst commissioners conversely show strengthening financial positions. Discussions which have already begun, would be advanced to ensure that an element of realignment would occur to redress this imbalance. The mitigation assumes that at the very least Commissioners would offset the impact of demand management on provider funding levels.
Total value of mitigations	**2.5**	**14.4**	**23.8**	**33.1**	**40.3**	**49.3**	