

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

22 March 2018

Final Draft Version – Prepared for Trust Board 29 March 2018

Contents

Contents.....	3
Abbreviations.....	7
1 Executive Summary.....	9
1.1 Introduction	9
1.2 Background	9
1.3 The case for change	9
1.4 Benefits of merging.....	10
1.5 The ESNEFT mission, vision and philosophy	11
1.6 How ESNEFT will operate as a single organisation	12
1.7 The new organisational operating model.....	13
1.8 Financial case	15
1.9 Programme governance and timeline	16
1.10 Communication and engagement.....	16
1.11 Conclusions and recommendations.....	16
2 Introduction	19
2.1 Purpose of the Full Business Case.....	19
2.2 Agreeing the OBC and the preferred form of transaction.....	21
2.3 Structure of this document.....	21
2.4 Arrangements for the oversight and development of the FBC	22
3 Background	25
3.1 Background to CHUFT and IHT.....	25
4 The case for change for CHUFT and IHT	35
4.1 The drivers for change	35
4.2 Driver: Clinical models of care provision are changing.....	35
4.3 Driver: Recruitment and retention challenges	38
4.4 Driver: Financial viability.....	39
4.5 Driver: Delivering transformational change	40
4.6 Driver: Demographic factors.....	42
4.7 Driver: Impact of technology	45
4.8 System risks if the merger does not proceed	47
4.9 Conclusion.....	47

5	The new organisation.....	49
5.1	Introduction	49
5.2	Mission, vision and philosophy	49
5.3	Organisational objectives.....	50
5.4	How ESNEFT will operate as a single organisation	51
5.5	Element 1: Governance.....	52
5.6	Element 2: Clinical operating model	57
5.7	Element 3: Corporate model.....	60
5.8	Element 4: Enablers	62
5.9	Element 5: People and organisational development.....	65
5.10	Element 6: Education and training.....	68
5.11	Element 7: Capacity and capability to deliver change	70
5.12	Element 8: Performance management.....	77
5.13	Benefits	79
6	Financial Strategy	83
6.1	Introduction	83
6.2	Overview	84
6.3	Key developments since the OBC	85
6.4	Historic trust performance and STP context.....	85
6.5	Forecast methodology	89
6.6	Standalone positions (Step 1 and 2)	89
6.7	ESNEFT before adjustments (Step 3)	98
6.8	Merger benefits and integration costs (Step 4)	99
6.9	Enlarged Partnership Post Adjustments (Step 5).....	103
6.10	Sensitivities (Step 6).....	105
6.11	Closing the Gap	107
7	Transaction and integration.....	109
7.1	Organisational form of the transaction	109
7.2	Transaction governance.....	109
7.3	Post-transaction implementation.....	115
7.4	Overview of key risks and mitigations	115
8	Communications and stakeholder engagement	120

8.1	Progress and approach since the OBC	120
8.2	Communication and engagement strategy	121
8.3	Equality impact assessment.....	121
8.4	Travel impact assessment	121
8.5	Engagement activity.....	122
8.6	Feedback summary	123
9	Conclusion and recommendations	125
10	Index of appendices	126

Abbreviations

Abbreviation	Definition
A&E	Accident & Emergency (Emergency Department)
AI	Artificial Intelligence
BC	Borough Council
BME	Black and minority ethnic
BTA	Business Transfer Agreement
CCG	Clinical Commissioning Group
CDG	Clinical Delivery Group
CEO	Chief Executive Officer
CGH	Colchester General Hospital
CHUFT	Colchester Hospital University NHS Foundation Trust
CIBA	Confidentiality and Information Barrier Agreement
CIO	Chief Information Officer
CIP	Cost Improvement Plan/Programme
CMA	Competition and Markets Authority
CNST	Clinical Negligence Scheme for Trusts
CoG	Council of Governors
CoRG	Commissioning Reference Group
CQC	Care Quality Commission
CRG	Clinical Reference Group
CRN	Clinical Research Network
CRNE	Eastern Clinical Research Network
CT	Computerised Tomography
DC	District Council
DD	Due Diligence
DGH	District General Hospital
DH	Department of Health
DToc	Delayed Transfer of Care
EBITDA	Earnings before Interest, Taxation, Depreciation and Amortisation
ECH	Essex County Hospital
ED	Emergency Department
EEG	Electroencephalography
EIA	Equality Impact Assessment
EMC	Executive Management Committee
ENT	Ear Nose & Throat
EPED	Every Patient Every Day
ESNEFT	East Suffolk and North Essex NHS Foundation Trust
FBC	Full Business Case
FDD	Financial Due Diligence
FFT	Friends & Family Test
FM	Facilities Management
FOT	Forecast Outturn
FT	Foundation Trust
GIC	Guaranteed Income Contract
GIRFT	Getting it Right First Time
GP	General Practitioner
HEE	Health Education England
HOSC	Health Overview Scrutiny Committee
HOT	Heads of Terms
HR	Human Resources
HSMR	Hospital Standardised Mortality Ratio
I&E	Income and Expenditure

Abbreviation	Definition
IESCCG	Ipswich & East Suffolk Clinical Commissioning Group
IH	Ipswich Hospital (site)
IHT	The Ipswich Hospital NHS Trust
ICS	Integrated Care System
ICT	Information Communications & Technology
IT	Information Technology
ITP	Innovation and Technology Payment
JAG	Joint Advisory Group on gastrointestinal endoscopy
KPI	Key Performance Indicator
KTP	Knowledge Transfer Partnership
LTFM	Long Term Financial Model
MDT	Multi-Disciplinary Team
MRI	Magnetic Resonance Imaging
NED	Non-Executive Director
NEECCG	North East Essex Clinical Commissioning Group
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
OBC	Outline Business Case
OD	Organisational Development
ONS	Office for National Statistics
OSCE	Objective Structured Clinical Examination
PAB	Partnership Advisory Board
PALS	Patient Advice and Liaison Service
PHE	Public Health England
PMO	Programme Management Office
POD	People Organisation & Development
PPB	Partnership Programme Board
PTIP	Post Transaction Integration Plan
QI	Quality Improvement
QIA	Quality Impact Assessment
QIF	Quality Improvement Faculty
RFID	Radio-frequency identification
RTT	Referral to Treatment Time
SBRI	Small Business Research Initiative
SHMI	Summary Hospital-level Mortality Indicator
SOC	Strategic Outline Case
SOF	Single Oversight Framework
SOP	Strategic Outline Programme
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
TIA	Travel Impact Assessment
TOR	Terms of Reference
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006
VFM	Value For Money
WSH	West Suffolk Hospital NHS Foundation Trust
WTE	Whole Time Equivalent

1 Executive Summary

1.1 Introduction

The Full Business Case (FBC) is a key stage in the process that will bring about the creation of East Suffolk and North Essex NHS Foundation Trust (ESNEFT).

The proposed form of the merger is the acquisition by Colchester Hospitals University NHS Foundation Trust (CHUFT) of The Ipswich Hospital NHS Trust (IHT), under s56A of the 2006 NHS Act.

The FBC details the background and drivers for the proposed merger; how the merger will be progressed and the new trust formed; the benefits for patients, carers and the wider population of east Suffolk and north Essex; and how these benefits will be delivered.

1.2 Background

In May 2016, the Boards of IHT and CHUFT formally committed to long-term partnership. This was built on a foundation of collaborative working that has been established between the two trusts over recent years. The partnership between CHUFT and IHT began in 2016 in response to two issues:

- Following an inspection report in April 2016, the Chief Inspector of Hospitals advised NHS Improvement that a 'radical solution' was required as an immediate alternative to Trust Special Administration, following prolonged quality issues. As a result, NHSI mandated that CHUFT enter into a long-term partnership arrangement with another trust and approached IHT to undertake this role.
- The formation and development of the Suffolk and North East Essex sustainability and transformation partnership (STP) plan identified that the current model of three medium sized district general hospitals attempting to provide comprehensive services in the STP area was not clinically or financially sustainable.

Whilst the most recent CQC assessment at CHUFT in October 2017 showed significant improvement, delivering sustainable long-term high quality care will require continued support and innovation.

IHT on the other hand was consistently rated as 'good' by CQC and performing well on many external measures, but has also faced significant financial pressures.

1.3 The case for change

The outline business case (OBC) in August 2017 identified four main drivers for change which threaten the future clinical and financial viability of the trusts in their current forms:

- Some services are not sustainable in their current form against national guidance and new models of care
- Increasing difficulty in recruiting and retaining staff
- CHUFT and IHT are financially unsustainable in their current form
- A step change in transformation is required

In developing the FBC, and with a longer-term perspective on the merger, two additional drivers have been brought into consideration:

- The impact of change in the size and structure of the population
- The impact of technology in all aspects of the delivery of health care.

The new, merged, organisation will take advantage of increased scale and shared resources to:

- Improve the recruitment and retention of highly skilled staff through improved training, education and career development
- Create larger clinical services which are more able to meet service standards, offer 24/7 services, sustain and improve the range of services to meet the needs of patients
- Create sustainable partnerships with community services to support more self- and community-based care
- Invest in innovation, research and technology to transform the services for patients and staff
- Adapt flexibly and attract investment to meet the changing needs of the population

1.4 Benefits of merging

Table 1-1 summarises the benefits of merging and outlines success measures.

Table 1-1 Benefits to be delivered by ESNEFT merger

Criteria	Target
Patient outcomes	CQC Safe and CQC Effective: Good or Outstanding
	Mortality (SHMI): SHMI within expected range from end of Y1 with a reduction over 3-5 years
	Morbidity (Sepsis): Effective sepsis screening and time to intravenous antibiotics for red flag patients - 90% within 1 hour by end Y1
	NHS delayed transfers of care below 1% by end Y2
	Strategy to responds to Getting it Right First Time (GIRFT) reports by the end Y1
Patient experience	CQC Caring: Good or Outstanding
	Patient time lost indicator – [under development]
	Top 20% of trusts for National Patient Survey by Y5
	Friends & family Test (FFT) recommended by 97% of patients by Q2 Y3
Clinical sustainability	CQC Responsive: Good or Outstanding
	Staff time lost indicator – under development
	National Standards: Deliver trajectories as agreed with NHSI
	Clinical Accreditation standards: Ongoing compliance
	Seven-day working: Deliver all standards by end Y2
	Research: Increase the number of patients benefitting from enrolment in NIHR portfolio and other research by 50% by end Y2
Workforce sustainability	CQC Use of Resources: Good or Outstanding
	Top 25% for National Staff Survey by end Y5

Criteria	Target
	Vacancy factor of less than 6% and staff turnover less than 10% by end Y3
Financial sustainability	CQC Use of Resources: Good or Outstanding
	Achievement of financial control total each year
	Corporate cost reduction: Peer benchmark in top 10% corporate efficiency cost by Year 5
	Achieve agency staff expenditure ceiling annually
Alignment/ strategic fit	CQC Well-Led: Good or Outstanding
	Trust Strategy approved by Board of Directors and STP Board by end Y1
	STP plan milestones met on time
Execution risk	SOF Segment 2 by Q1 Y2
	Zero actions at Q3 Y1

1.5 The ESNEFT mission, vision and philosophy

1.5.1 Ambition and objectives

In May 2016 the trusts agreed CHUFT and IHT would work in partnership to:

- Improve quality and patient outcomes
- Provide better value for money
- Sustain and improve access to services that meet the needs of the population
- Deliver a sustainable, skilled workforce.

1.5.2 Mission and vision

In 2018, the year of the 70th anniversary of the establishment of the NHS, the mission for the new organisation is to continue to meet the principles of the NHS identified in 1948. This means providing health care and services that meet the needs of everyone, free at the point of delivery and based on clinical need.

ESNEFT's vision is simple: to provide the communities we serve with excellent healthcare and build a better future for east Suffolk and north Essex.

1.5.3 Time matters – the ESNEFT philosophy

Dealing with ill health is stressful, both for the individual affected and for those caring for them. There is the *necessary* stress of the illness and the emotional effort of caring. However, too often the complexity of the health and care systems adds *unnecessary* stress. At the heart of this is time. Time is important to everyone whether as patients, as family or carers, or as staff delivering care. The philosophy for the trust will be that *time matters*. Together the trust and its staff will improve services to make every moment count.

The trust will consider 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, the way it provides IT

infrastructure, through to how it manages processes such as staff recruitment or the procurement of goods and services.

1.6 How ESNEFT will operate as a single organisation

The *time matters* philosophy will be instrumental in shaping the new culture. The following design principles have been established in preparing the clinical and corporate operating model to rapidly support a unified approach to delivering services on multiple sites.

1.6.1 Integrated teams across sites

The teams will be defined in each service or specialty from Day One including:

- A unified clinical and operational leadership and governance structure with a single clinical lead with accountability for services across all sites.
- A unified approach to managing a single specialty waiting list/patient transfer list.
- A unified specialty approach to audit, training, research and innovation.

1.6.2 Cross-site leadership

ESNEFT will maintain leadership presence on both sites with all executive directors working at times on one site or the other. The Board and Council of Governors meetings will take account of the need for visibility and presence on both main hospital sites.

There will be three Director of Operations posts. These posts will have two key functions: site responsibilities for CGH, IH and the community services and sites respectively, and responsibility for executive co-ordination of a number of the clinical divisions and clinical services.

1.6.3 Harnessing technology

Focus has been given to delivering an IT service at that provides the organisation with:

- Federated network interoperability to allow the former trusts' systems to be accessed from any ESNEFT site
- Shared email, calendar and instant message infrastructure
- A single point of access to an IT service desk operating extended hours
- Shared telephony extension infrastructure to support cross-organisational dialling
- Internal, external patient and staff communications infrastructure support

Travel between sites is wasteful of staff time so ESNEFT will take advantage of the use of technology to join up team members across all sites.

1.6.4 Harmonising employment terms and conditions

Actions have been identified to reduce variations in the development of terms and conditions for employees. There are inevitably some areas where, for example, grading of posts apparently with equivalent duties is not consistent between the organisations. These issues will need to be addressed early to establish a consistent approach.

1.6.5 Harmonising commissioner plans

ESNEFT's local acute services will be commissioned by two Clinical Commissioning Groups (CCGs), North East Essex Clinical Commissioning Group and Ipswich & East Suffolk Clinical Commissioning Group. Both CCGs are part of the Suffolk & North East Essex STP. Arrangements have been made with the two CCG commissioners to establish a single approach to contract management.

1.7 The new organisational operating model

There are eight key elements that describe how the new organisation will operate. These are shown Figure 1-1.

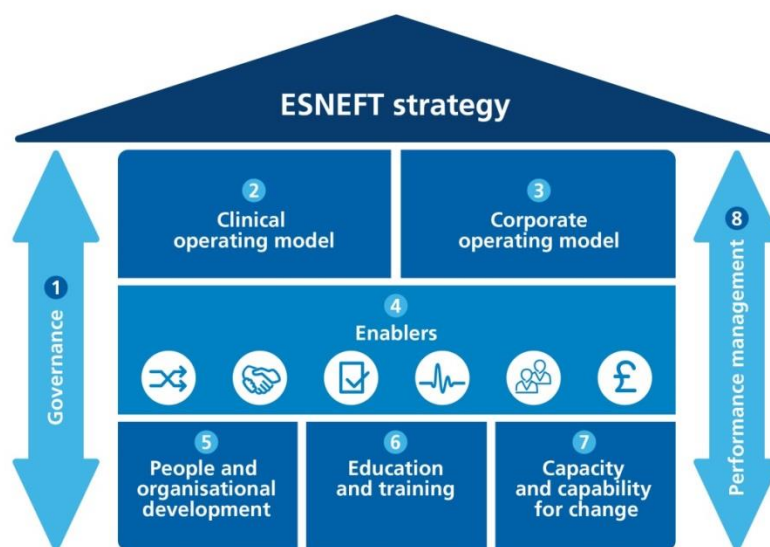


Figure 1-1 ESNEFT organisational construct

1.7.1 Governance

ESNEFT will have a unified governance and leadership structure while maintaining the identity of the individual hospitals. Leadership roles will cross the hospital boundaries and will increasingly focus on managing patient pathways with front line service-to-board governance and assurance structures.

1.7.2 Clinical operating model

The clinical model of care, and the ethos of ESNEFT, will be about joining up with local authorities, the local NHS, charities and other partners to improve care and support in the community, meaning:

- Greater self-care and independence
- More support and care locally
- Hospital care reserved for those who need it

The philosophy of *time matters* will be brought to life through an approach which makes the core business of serving patients as efficient as possible. The clinical model is structured around single specialty teams operating across all sites. The single team will be defined in each service or specialty by:

- A unified clinical and operational leadership and governance structure with a single clinical lead with accountability for services across all sites
- A unified approach to managing a single specialty waiting/patient tracker list
- A unified specialty approach to audit, training, research and innovation

Integrating clinical services through merger will strengthen and sustain them in the short-term whilst creating the capacity for future transformation.

1.7.3 Corporate operating model

The role of corporate services is to support the clinical services using a new operating model that stratifies the activities of the corporate functions in three ways:

- **Transactional processes:** giving staff the technology and tools that equal those in their private lives to automate transactional processes that often rely on multiple manual interventions
- **Professional services/business partnering:** giving professional corporate staff more time to support their customers where their professional advice and expertise is needed most
- **Strategic management:** focused on the delivery of the trust's vision and aims through the alignment of planning, investment and operational activity

1.7.4 Enablers

There are six key enablers:

- **Fully integrated organisation:** Integrated culture, systems and structures
- **Streamlined processes:** Standardised care and harmonised ways of working
- **Portals and service desks:** Resolving the majority of issues before reaching professional teams
- **Investing in people:** Providing career pathways and enhanced learning opportunities, supporting equality and diversity
- **Data tracking and analytics:** Putting in place systems and processes to improve flow
- **Maximising scale:** Exploiting scale to improve efficiency and outcomes and to maximise value for money

1.7.5 People and organisational development

Ensuring that the transition from two organisations to one is managed smoothly for all staff is a priority. Robust arrangements for resolving organisational structures, filling of new roles, transfer of staff, aligning terms and conditions and establishing new teams, will be essential to a smooth go-live.

1.7.6 A new faculty of education and training

The faculty will aim to:

- Raise the quality, consistency and scope of the education and training available to all staff
- Develop a culture of lifelong learning, with a goal of all staff in education or training throughout their career
- Position the new organisation as a preferred destination for staff in the east of England
- Create strong partnerships with universities, medical schools and other existing education providers
- Become accredited to provide qualifications in due course

1.7.7 Capacity and capability for change

The trust will build the capacity and capability in four key areas that will enable large scale change to meet future health and social care challenges:

- Quality improvement
- Research and innovation
- Transformation and change management
- Logistics management

1.8 Financial case

Section 6 of the document details the financial case for the merger and the financial benefits to be derived. The modelling undertaken demonstrates that neither CHUFT nor IHT are likely to be financially sustainable in their current form.

Financial modelling for merger shows that by merging the financial integration benefits of £28.5m (gross) and £21.9m (net) are delivered, as shown in Table 1-2. These are benefits and financial savings in addition to the forecast CIP plans for ESNEFT.

Table 1-2 Integration Benefit Synergy Schemes

Merger Benefits (£m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Clinical integration benefits	3.1	5.8	9.8	11.8	11.8	11.8
Corporate benefits	2.1	3.8	7.7	8.5	8.8	8.8
Capital Scheme benefits	1.4	2.6	4.7	5.7	6.9	6.5
Non-operating changes from merger benefits	0.2	0.2	0.7	1.1	1.0	1.4
Total gross synergies	6.8	12.4	22.9	27.1	28.5	28.5
<i>Profile of synergies (%)</i>	24%	44%	80%	95%	100%	100%
Total recurrent cost associated with synergies	(0.9)	(1.9)	(3.9)	(6.6)	(6.6)	(6.6)
Net merger synergy benefits	5.9	10.5	19.0	20.5	21.9	21.9

Even with this level of benefits, modelling identifies that ESNEFT will be operating a deficit each year of the five-year period. The level of the deficit of ESNEFT forecast for 2013/24 will be £27.7m (£50.2m normalised) compared to the combined deficits of CHUFT and IHT of 49.7m (£72.1m normalised).

Measures to return ESNEFT to organisational financial balance will be taken as part of the development of the full clinical strategy and further work on the development of the corporate operating model.

In the context of the STP plan, the merger will deliver the financial benefits expected of the partnership, and as such will contribute significantly to delivering the overall STP control total.

1.9 Programme governance and timeline

A robust structure of governance reporting to the CHUFT and IHT boards has been used throughout the development of the partnership leading up to this FBC, post transaction integration plan (PTIP) and LTFM.

As the two trusts progress toward merger the focus of programme governance is moving to Day One readiness and the actions to implement the PTIP. Arrangements for the establishment of the shadow board and a joint executive team are progressing, to be in place in May 2018.

The FBC and supporting documentation will be submitted to NHSI following the CHUFT and IHT boards' approval of the plans.

1.10 Communication and engagement

There has been an extensive programme of meetings, briefings and displays to ensure that staff, patients, carers and stakeholder partners are able to understand and then contribute to the development of plans for ESNEFT.

The key public concern about the merger relates to travel, with anxiety that, as a merged trust, the distances and time taken to access services may be greater.

An overall travel impact assessment has been completed. The clinical model in the FBC does not propose any significant changes to services which would have any notable transport or travel implications or impact on specific services or treatments, population or staff groups, or geographies. There is a firm commitment that any such changes proposed in future would be subject to a travel impact assessment in line with best practice. Options to improve transport for staff and the public between the main sites are being explored with external agencies.

An equality impact assessment on the planned merger has also been undertaken. This has not highlighted any significant areas of concern and will be used to help focus the implementation delivery phase and inform future planning within ESNEFT.

1.11 Conclusions and recommendations

As separate organisations, CHUFT and IHT are unsustainable due to a combination of population growth, rising needs stemming from ageing and deprivation, continued workforce pressures, and the complexity and cost of meeting ever-rising health care standards.

Without the merger, quality and access to services, as well as the trusts' financial deficit will continue to deteriorate.

Coming together as a single organisation offers important opportunities to sustain and develop the range and quality of services available to the local population. The scale of clinical services and the increased range of services available to patients through ESNEFT will create further opportunities for improvement.

The time matters philosophy will reduce stress for patients, carers and families. The new corporate services model will release time for patients and staff, which will increase capacity and give corporate staff more time to support transformation in clinical services.

There will be significant reductions in the cost of administrative and agency staff, releasing funding to support clinical services.

Recommendation:

That the Board approve the Full Business Case and that it can now be submitted to NHSI.

2 Introduction

2.1 Purpose of the Full Business Case

The Full Business Case describes the case for the merger of Colchester Hospitals University NHS Foundation Trust and The Ipswich Hospital NHS Trust to form a new organisation to be known as East Suffolk and North Essex NHS Foundation Trust.

2.1.1 Business case framework and timeline

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

A programme of work was set up to develop joint working between CHUFT and IHT. This programme is following the stages of the business case process as recommended by HM Treasury¹ and the NHS Improvement transaction guidance.^{2,3}

The stages of the programme followed are shown in Table 2-1.

Table 2-1 Business case stages for the partnership programme

Business case stage	Purpose	Timescale
Strategic Outline Programme (SOP)	<ul style="list-style-type: none"> Determine strategic fit Secure agreement and commit resources to develop the SOC 	Completed October 2016
Strategic Outline Case (SOC)	<ul style="list-style-type: none"> Develop and shortlist the scenarios Recommend preferred scenario(s) Secure agreement and commit resources for Outline and Full Business Case development 	Completed January 2017
Outline Business Case (OBC)	<ul style="list-style-type: none"> Identify the preferred scenario Determine value for money (VFM), affordability, funding requirements Planning for the FBC phase External scrutiny/assurance as required 	Completed August 2017
Full Business Case (FBC)	<ul style="list-style-type: none"> Development of the detail of the preferred scenario with supporting LTFM and PTIP Both Trust Boards approve the FBC 	Anticipated March 2018

¹ Public Sector Business Cases: Using The Five Case Model, HM Treasury (2015)

² Supporting NHS providers: guidance on transactions for NHS Foundation Trusts, Monitor [now NHS Improvement] (2015)

³ In November 2017, NHS Improvement published revised guidance (*Transaction guidance – for trusts undertaking transactions including mergers and acquisitions*, NHSI, November 2017). The trusts have sought advice from NHSI on how the revised guidance should be addressed given the progress on the transaction under the previous guidance. NHSI has confirmed that the process and expectations in relation to the FBC phase under the 2017 guidance are consistent with the 2015 arrangements so should not, of themselves, affect the FBC arrangements.

2.1.2 Strategic Outline Programme

The Strategic Outline Programme agreed by the boards of both trusts described the work that would be undertaken in the subsequent Strategic Outline Case stage to identify a range of scenarios that could provide a viable future through a Partnership between the trusts.

2.1.3 The Strategic Outline Case

The purpose of the SOC was to develop and shortlist one or more scenarios for how the partnership between CHUFT and IHT could achieve its ambition and objectives. The scenarios described organisational forms or approaches that the partnership could take in order to realise the benefits of working together. The SOC evaluated eighteen scenarios, informed by a number of sources including the *Dalton Review*⁴, models emerging from the acute care collaboration vanguards⁵, and examples provided by NHS Improvement.

Three scenarios for the partnership were approved by the boards to be explored further in the 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].

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

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

Acquisition implies that there would be full clinical integration.

2.1.4 The outline business case

The OBC described:

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

⁴ *Examining new options and opportunities for providers of NHS care: the Dalton Review*, Department of Health (2014)

⁵ See www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/acute-care-collaboration/

Appendix 1 describes the process undertaken at SOC and OBC stages to refine the long-list at SOC to the shortlist and recommend option described in the OBC.

The OBC concluded with a recommendation to the boards of both trusts to approve the preferred scenario of merger of the trusts with full clinical integration and to progress with the actions to develop a full business case, implementation plan, and development of an operating structure and culture for the combined organisation, to enact the recommendation.

2.2 Agreeing the OBC and the preferred form of transaction

At a joint meeting of the boards, held in public, on 24 August 2017 the Boards of CHUFT and IHT met together to discuss the recommended way forward. The boards then separated and each took the decision to proceed with the development of the FBC for a merged organisation with full clinical integration.

This Full Business Case takes forward that recommendation.

In October 2017, both Trust Boards formally considered options and a recommendation of the form of the transaction based on legal advice and discussions with NHSI.

It was confirmed by both boards that their preferred form of transaction was an acquisition, under s.56A of the NHS Act 2006, of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust.

2.3 Structure of this document

The FBC is organised into the sections shown in Table 2-2.

Table 2-2 Sections within the FBC

Section	Contents
3. Background	<ul style="list-style-type: none">• Overview of the two trusts, the background to the partnership• The context of the Suffolk and North East Essex STP and the sustainability and transformation plan• A summary of the competition case
4. Case for change	<ul style="list-style-type: none">• The strategic case for the merger in the in the context of the key drivers for change:• Changing clinical models of care• Recruitment and retention challenges• Financial viability• Challenges of delivering transformational change• Challenges presented by the changing demography• Challenges presented by advances in clinical and other technologies• An assessment of why remaining as two organisations is not sustainable

Section	Contents
5. The New Organisation	<ul style="list-style-type: none"> • The vision and ambition of ESNEFT • The proposed governance arrangements • The proposed clinical model of integrated services and how this will be beneficial to patients • The proposed corporate operating model • The enablers to support the delivery of the new operating models including how these will help to deliver improved quality of services to patients and staff, optimise modern automated processes and improve efficient and effective delivery of care • The vision for the workforce, bringing together a culture supporting life-long learning through • A consistent approach to quality improvement, innovation, research and transformational change • A summary of the benefits to be achieved by the merger
6. Financial case	<ul style="list-style-type: none"> • The financial strategy based on the LTFM to deliver a financially sustainable future for ESNEFT
7. Transaction and Integration	<ul style="list-style-type: none"> • The proposed transaction form for the merger • The programme governance • The post-transaction integration plan • Risk management
8. Communications and engagement	<ul style="list-style-type: none"> • The communications and engagement carried out with partners, patient groups, staff and other stakeholders in developing the FBC • Equality and travel impact assessments • The longer-term approach to engagement as implementation takes place
9. Conclusions and recommendations	<ul style="list-style-type: none"> • Summary of the main recommendations to progress to merger

2.4 Arrangements for the oversight and development of the FBC

2.4.1 Programme governance

The programme governance arrangements to develop the FBC have been designed to ensure robust internal governance and accountability to both Trust Boards, supported by appropriate engagement with patients and carers, staff, clinicians, commissioners and wider stakeholders. The governance arrangements are shown in Figure 2-1.

The roles and responsibilities within this overall programme governance structure are described in more detail in Section 7.

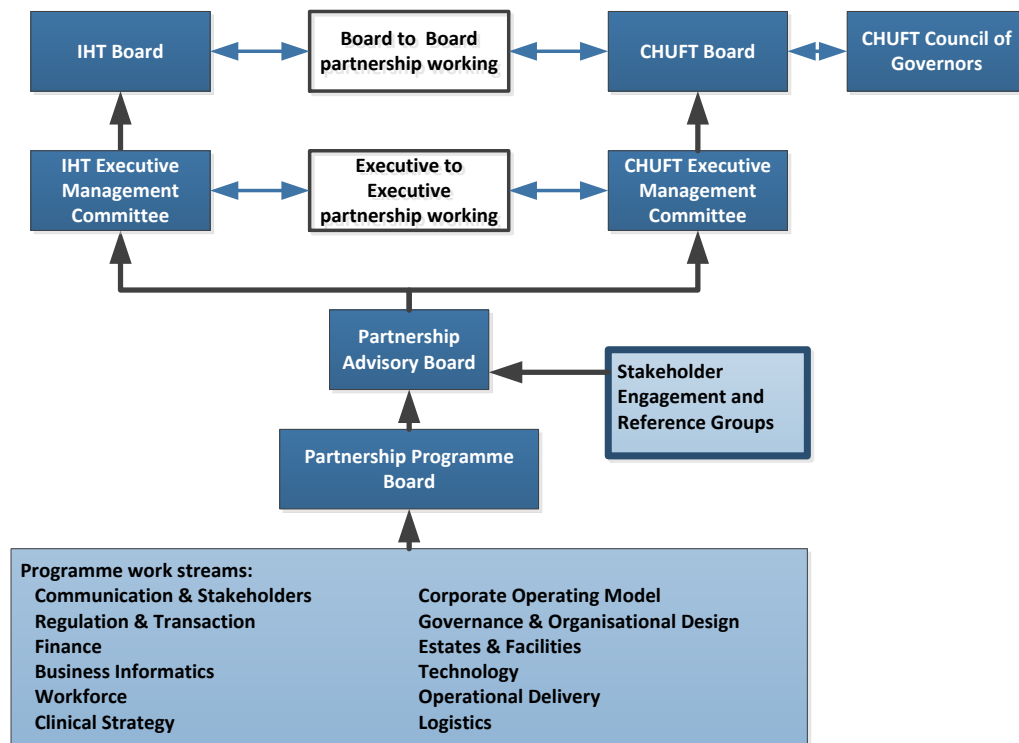


Figure 2-1 Programme governance structure

3 Background

3.1 Background to CHUFT and IHT

The two trusts are similar, particularly in respect of the population served, number of beds, and number of employees. The main differences are the provision of community services by IHT that are not provided by CHUFT, the CQC ratings of the two organisations, and the NHSI single oversight framework rating. Table 3-1 contains a high-level comparative overview of the two organisations.

Table 3-1 Overview of both trusts

	CHUFT	IHT
Profile	District General Hospital (DGH)	DGH and community services provider
Beds (General and Acute)	560	541
Turnover (2017/18)	£291.2m	£292.8m
Catchment population	380,000	390,000
Employee headcount (Dec 2017)	4,689 persons	4,759 persons
Specialist areas	Vascular surgery Radiotherapy	Spinal surgery Radiotherapy Gynae-oncology
Latest CQC rating	Requires Improvement (Oct 2017)	Good (January 2018)
NHSI Single Oversight Framework: segmentation⁶	“3 – Mandated Support: The provider has significant support needs and is in actual or suspected breach of the licence (or equivalent for NHS trusts), but is not in special measures.”	“2 – Targeted Support: Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or NHS Improvement considers formal action is not needed.”
Vision	Delivering great healthcare to every patient, every day	To be an outstanding provider of health services for the population

3.2.1 Colchester Hospital University NHS Foundation Trust

Colchester Hospital University NHS Foundation Trust was authorised as a foundation trust by Monitor from 1 May 2008. The trust provides acute, predominantly hospital-based, services mainly to the populations of Tendring DC, Colchester BC, and the eastern part of Braintree DC (Halstead and the Colne Valley). The local services catchment population is approximately 380,000⁷. In addition to hospital services the trust provides community based midwifery and specialist children’s services.

The trust hosts some specialist services drawing on a wider catchment population: this includes vascular services, where the hospital hosts the major arterial surgery centre to the population of NE Essex and Ipswich & East Suffolk CCGs. In oncology, Colchester Hospital provides radiotherapy services to the population of NE Essex and Mid Essex CCGs. The trust also is a partner in a consortium providing sexual health services in Essex, leading in particular on the medical manpower component of the service.

The trust provides services predominantly from the Colchester General Hospital (CGH) site. It currently provides a range of services from the Essex County Hospital (ECH) in Colchester, but these services will be transferring to the CGH or adjacent Colchester Primary Care Centre sites by August

⁶ NHS Improvement has segmented trusts based on the level of support they believe is required. Segmentation is based on performance data and other information. Score from 1 (best) to five (most challenged).

⁷ Source ONS Mid-year ward based population estimates

2018 as part of a plan to improve the physical estate for patient care and to release the ECH site for sale and redevelopment. The trust provides outpatient services from community hospital sites in Clacton, Harwich and Halstead, and from a number of community clinic locations in north Essex.

CHUFT has been subject to a number of regulatory interventions, arising primarily from issues identified by the CQC. These resulted in Monitor placing the trust in 'Special Measures' in November 2013.

Following further CQC concerns and regulatory interventions the trust remained in special measures until October 2017 when NHSI, acting in the light of a CQC inspection in July and August 2017 which had shown significant improvement across all areas of concern, removed the trust from the special measures regime. The trust's current CQC status is 'Requires Improvement'. The CQC quality report⁸ summarised in Figure 3-1 was published on 2 November 2017.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	Good	Good	Requires improvement	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Figure 3-1 CQC Ratings for Colchester Hospital, 2 November 2017

3.2.2 The Ipswich Hospital NHS Trust

The Ipswich Hospital NHS Trust provides hospital and community services to the population of Ipswich BC, Suffolk Coastal DC, and eastern parts of Babergh DC and Mid Suffolk DC. The local catchment population is approximately 390,000.

Changes in the model of delivery of community health services in Suffolk, in October 2017, resulted in IHT taking responsibility for a seven-year contract for the delivery of a range of community health services to the population of Ipswich & East Suffolk CCG, within an alliance of partners comprising IHT, Norfolk & Suffolk NHS Foundation Trust (mental health provider), Suffolk County Council and the Suffolk GP Federation. This is the first step towards fully integrating care and providing local people with simpler, seamless services.

⁸ Colchester Hospital University NHS Foundation Trust Quality Report, Care Quality Commission (November 2017)

The trust provides services principally from the Ipswich Hospital site, but also manages services in community hospital sites in Ipswich, Aldeburgh and Felixstowe, and from a large number of community clinics and health facilities in towns and villages.

IHT provides services to a wider catchment population including: spinal surgery, where the trust leads a network covering the whole of the Suffolk and NE Essex STP footprint; gynaecological oncology, including provision of complex procedures to NE Essex residents; and in oncology, radiotherapy services to parts of the west Suffolk area.

IHT has a CQC rating of 'Good', following inspection between August and October 2017 with the CQC quality report summarised in Figure 3-2 published on 18 January 2018⁹.

Ratings for Ipswich hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↓ Jan 2018	Good ↓ Jan 2018	Good ↓ Jan 2018
Medical care (including older people's care)	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018
Surgery	Requires improvement Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015
Critical care	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015
Maternity	Good Jan 2015	Good Jan 2015	Good Jan 2015	Requires improvement Jan 2015	Good Jan 2015	Good Jan 2015
Services for children and young people	Requires improvement ↔ Jan 2018	Good ↑ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018
End of life care	Good ↔ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018
Outpatients	Good Jan 2015	Not rated	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015
Overall*	Requires improvement ↔ Jan 2018	Good ↑ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Overall*	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018

Figure 3-2 CQC Ratings for The Ipswich Hospital and community services, 18 January 2018

3.2.3 Clinical services offered by each trust

Table 3-2 provides an overview of the major clinical services offered by each of the trusts. This table shows that there is close alignment between the two trusts in terms of services provided. There are

⁹ The Ipswich Hospital NHS Trust Quality Report, Care Quality Commission (January 2018)

some examples of services which operate as clinical networks between the trusts already. For example, vascular surgery where major operations are carried out only at CHUFT but outpatient and ambulatory surgical procedures are conducted at both trusts.

Table 3-2 Services provided by CHUFT and IHT

Service	CHUFT	IHT
General Surgery	✓	✓
Vascular Surgery	✓	✓
Breast Surgery	✓	✓
Urology	✓	✓
Orthopaedic Surgery	✓	✓
ENT	✓	✓
Ophthalmology	✓	✓
Oral Surgery	✓	✓
Orthodontics	✗ ¹⁰	✓
Emergency Medicine	✓	✓
Gastroenterology	✓	✓
Endocrinology/Diabetes	✓	✓
Respiratory Medicine	✓	✓
Cardiology	✓	✓
Endoscopy	✓	✓
Care of the Elderly	✓	✓
Stroke	✓	✓
Rheumatology	✓	✓
Neurology	✓	✓
Neuro-rehabilitation	✓	✗ ¹¹
Renal Medicine	✓	✓
Dermatology	✗ ¹²	✓
Palliative Medicine	✓	✓
Oncology	✓	✓
Clinical Haematology	✓	✓
Sexual Health	✓	✗ ¹³
Women's Health	✓	✓
Children's Services	✓	✓
Anaesthetic Services	✓	✓
Chronic Pain Services	✗ ¹⁴	✓
Imaging	✓	✓
Allied Health Professions	✓	✓

¹⁰ Orthodontics services to NE Essex patients are provided by IHT

¹¹ Community neuro-rehabilitation services equivalent to the CGH service are not currently commissioner in Suffolk

¹² Dermatology Services in NE Essex are provided by

¹³ Sexual Health Services in Suffolk are provided by Cambridgeshire Community Services NHS Trust

¹⁴ Chronic Pain services in NE Essex are provided by Anglian Community Enterprise

Pathology services are provided to both trusts (and West Suffolk NHS Foundation Trust) through a partnership arrangement (North East Essex and Suffolk Pathology Services) which is managed by CHUFT; provision of laboratory services is partially centralised at IHT.

Areas of divergence include those where the provision of services is overwhelmingly in a community setting; in these cases IHT is often provides the service whereas there is an alternative provider in northeast Essex¹⁵.

3.2.4 Background to the partnership

Following an inspection by the CQC in September 2015¹⁶, CHUFT was rated 'inadequate', the lowest rating that is awarded. Following a further inspection in early 2016, the Chief Inspector of Hospitals mandated that CHUFT find an "immediate alternative solution" to Trust Special Administration¹⁷. As a result, NHSI required that CHUFT enter into a long-term partnership arrangement with another trust and approached IHT to undertake this role.

The problems at CHUFT and the quality and performance issues between 2013 and 2016 have been well documented in CQC reports¹⁸ resulting in Monitor/NHSI regulatory interventions. Whilst the most recent CQC assessment at CHUFT in October 2017¹⁹ showed significant improvement, delivering sustainable long-term high quality care will require continued support and innovation.

Whilst CHUFT has experienced challenges with quality of patient care, as well as significant financial pressures, whilst being consistently rated as 'good' by CQC and performing well on many external measures, IHT has also faced significant financial pressures.

In considering a long-term approach to CHUFT in spring 2016 the CQC, NHSI and DH, agreed that a future model based on a long-term partnership with Ipswich Hospital represented the best option to develop and sustain services for patients in the long term.

In May 2016 the Boards of Ipswich Hospital NHS Trust (IHT) and Colchester Hospital University NHS Foundation Trust (CHUFT) committed formally into entering long-term partnership. This was built on a foundation of collaborative working that has been established between the two trusts over recent years. At this point, with the agreement of NHSI, CHUFT concurrently appointed the IHT Chief Executive and Chair, who now lead both organisations.

3.2.5 Suffolk and North East Essex Sustainability and Transformation Partnership (STP)

The partnership between CHUFT and IHT is a key part of delivering the Suffolk and North East Essex Sustainability and Transformation Partnership plan.

The NHS and local government within the STP, together with representatives of the voluntary sector, came together in March 2016. The STP has developed a five-year sustainability and transformation plan to improve the health and care of local people and bring the system back into a financially

¹⁵ Anglian Community Enterprise (ACE) Community Interest Company provides community services to the North East Essex health system.

¹⁶ *Colchester General Hospital Quality Report*, Care Quality Commission (2016)

¹⁷ *Colchester Hospital University NHS Foundation Trust Quality Report*, Care Quality Commission (2016)

¹⁸ Accessible from <http://www.cqc.org.uk/provider/RDE>

¹⁹ *Colchester Hospital University NHS Foundation Trust Quality Report*, Care Quality Commission (November 2017)

sustainable position. The system plan will deliver the vision for people across Suffolk and north east Essex to live healthier, happier lives by having greater choice, control and responsibility for their health and wellbeing. The plan will deliver against three priorities for creating a sustainable healthcare system in Suffolk and north east Essex:

- Resilient communities
- Managing demand
- Acute reconfiguration.

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

- Increases in the demand for services
- Workforce challenges
- Reduction of inequalities in health outcomes
- Key clinical priorities
- Unwarranted variation in processes and quality of care.

The overall vision, objectives and priorities of the STP are identified in Figure 3-3.

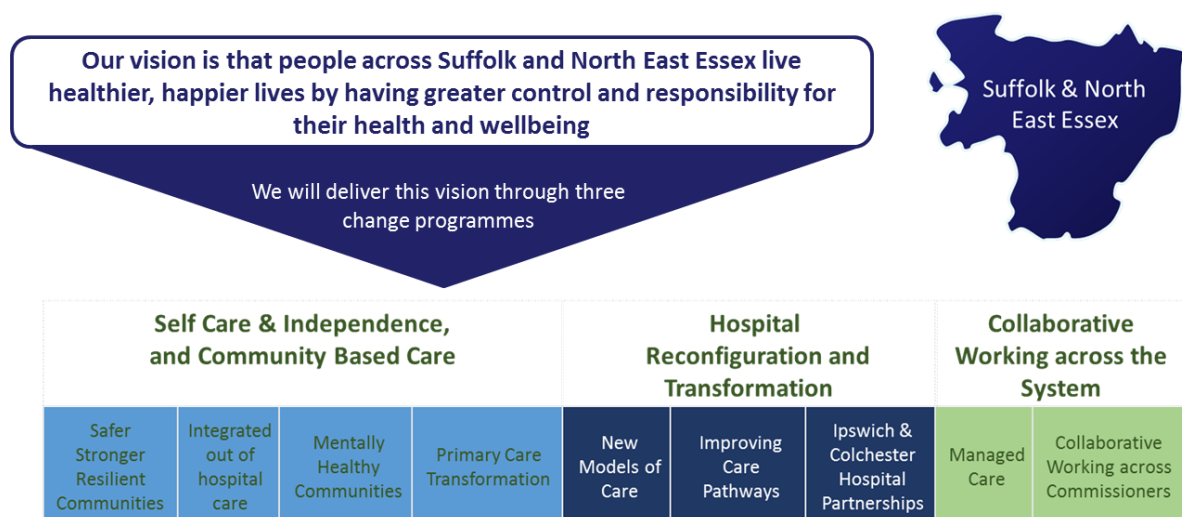


Figure 3-3 Vision, objectives and priorities of the Suffolk and North East Essex STP

3.2.5.1 Development of an Integrated Care System

Since inception the STP has developed considerably with strong relationships between partner organisations; the next stage in development is likely to be formalisation into an Integrated Care System (ICS).

The STP is planning a phased approach to develop a fully operational ICS, with a strategic commissioning function and alliance footprint, by April 2019.

The STP has carried out a large amount of work and has made good progress to date on the development towards an ICS and alliance development across the system.

In late November 2017, the STP expressed formal interest to obtain ICS wave two funding that will build on the work already carried out.

3.2.5.2 STP clinical vision

The STP has articulated the elements of its clinical vision as shown in Figure 3-4

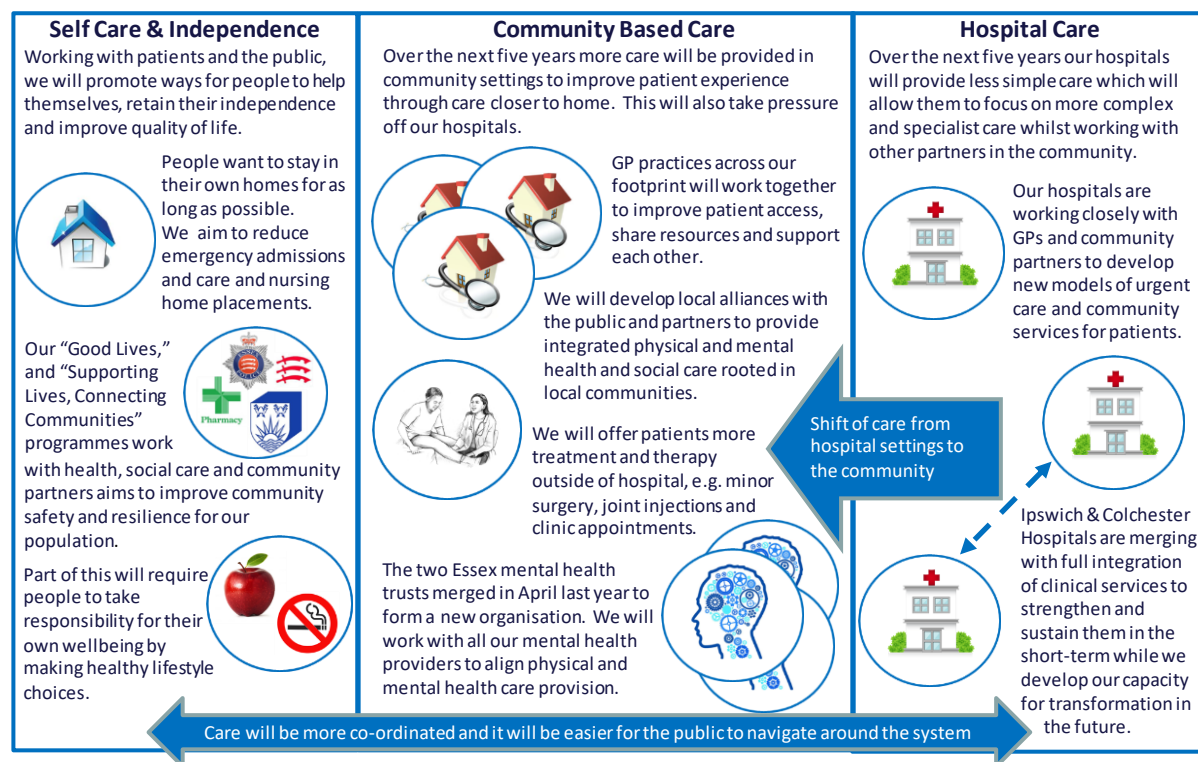


Figure 3-4 Clinical vision for the of the Suffolk and North East Essex STP

3.2.5.3 Hospital reconfiguration and transformation

The STP’s objective is to achieve viable acute hospitals across the STP through the redesign of clinical pathways around outcomes, underpinned by innovation. For CHUFT and IHT, this ambition is being met through the merger of the two trusts.

Integrating clinical services through merger will strengthen and sustain them in the short-term while the trust develops capacity and detailed plans for future transformation.

In developing the new clinical model of care, both during and after the merger, the trust will work in partnership across the health and care system in east Suffolk and north Essex to:

- Enable people to stay well through healthy living
- Support people to care for themselves at home
- Provide convenient access to services in the local community.

To support the system in planning to deliver this vision, the STP has prioritised a capital bid for the new trust to fund infrastructure improvements for urgent and emergency care and to support any future reconfiguration of clinical services that would deliver significant patient benefits identified during public, staff and stakeholder engagement (subject to support from commissioners and appropriate public consultation and regulatory approval).

Analysis undertaken during the development of the STP supporting the proposed approach to hospital services showed that:

- The local population is changing and there is a widening health and wellbeing gap.
- There are significant care and quality issues and increasing demand for services.
- It is becoming increasingly difficult to recruit and retain staff.
- CHUFT and IHT are financially unsustainable in their current form – reflecting the finance and efficiency gap.

3.2.6 Commercial and competition considerations

3.2.6.1 Geographical catchment areas covered by each trust

An examination of the geographic overlaps between the catchment areas of CHUFT and IHT was undertaken to establish the extent to which merger of the two trusts will impact on competition; specifically, the extent to which the catchment areas overlap for adult admitted patients and outpatient referrals was examined. This is shown in Figure 3-5.

The area where the catchment areas overlap provides an indication where the two trust's services are likely to be important alternatives to each other for patients and GPs. The analysis showed that overall the trusts are not commonly chosen alternatives with only 6% of IHT's and CHUFT's referrals originating from the overlapping 80% catchment area.

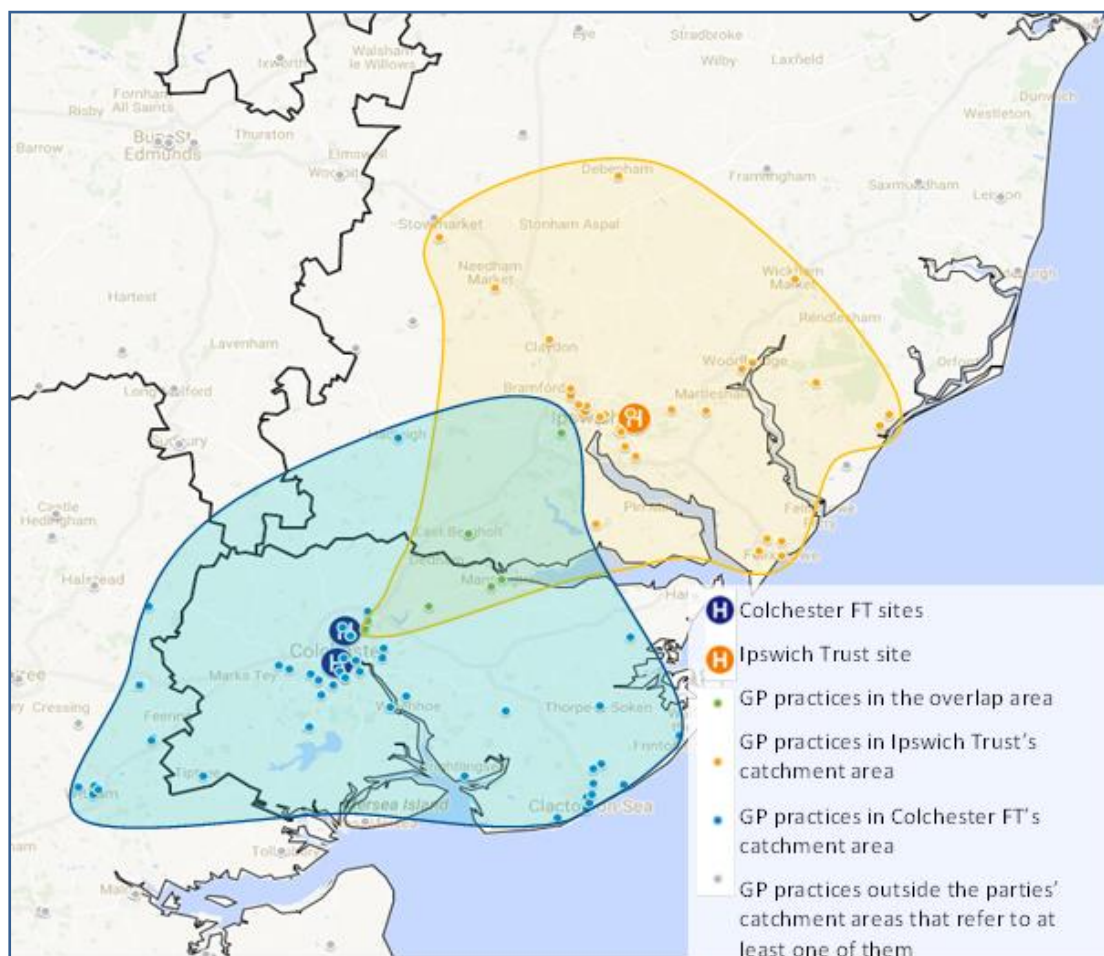


Figure 3-5 Geographic referral areas

3.2.6.2 Referral activity analysis

A GP referral analysis for all clinical services provided as outpatients, elective day-cases or elective inpatients, demonstrated that either there are alternative providers for these services or the numbers of referrals involved are small. In other words, whilst many of the services provided by the trusts are similar they are in fact provided to different but complementary catchment populations.

Further analysis of the activity patterns from the largest services has been undertaken as part of the work to produce the clinical strategy and financial model for the Full Business Case. Across all these areas of work, it has been clear that the proposed merger would not alter the current pattern of clinical service provision in any significant way, and thus there is no basis for believing that there would be changes to commissioning arrangements beyond the types of discussions already taking place via the STP (for example, about adaptation of pathways to provide greater support to patients.) Specialised services are commissioned by NHS England and no change has been notified for these services as a result of the proposed merger.

3.2.6.3 Competition and Markets Authority

On the basis of pre-notification discussions with NHSI and consideration by the Competition and Markets Authority's (CMA) Markets Intelligence Committee of a note prepared by NHSI (incorporating a competition and markets analysis based on GP referral patterns), the CMA concluded that they would not be seeking further information concerning the proposed merger. In other words, the CMA is persuaded that a '*substantial lessening of competition*' will not occur and therefore a formal competition review would serve no purpose. On this basis, and following discussion with NHSI, the Trust Boards have decided not to formally notify this merger to the CMA. The decision by the CMA not to review the merger will be confirmed four months after the merger takes place.

4 The case for change for CHUFT and IHT

4.1 The drivers for change

The OBC identified four primary drivers for change which demonstrated why the trusts in their current forms are not going to be clinically and financially viable into the future and where they are already showing signs of pressure:

- Some services are not sustainable in their current form against national guidance and new models of care
- Increasing difficulty in recruiting and retaining staff
- CHUFT and IHT are financially unsustainable in their current form
- A step change in transformation is required.

In developing a longer-term perspective on the merger through the FBC, two additional drivers have been brought into consideration:

- The impact of change in the size and structure of the population
- The impact of technology is all aspects of the delivery of health care.

In assessing the case for change from the current two-trust model to any other form of partnership or to a fully integrated single trust, these six drivers are considered in detail below using the following approach:

- Describing in more detail the driver for change
- Assessing the current situation in CHUFT and IHT and how the driver is impacting on the trusts currently
- Exploring how the driver is likely to impact on the separate trusts if no merger takes place – the counterfactual.

Section 5 of the FBC explores how and why a merger to form a new trust with fully integrated services will address the drivers for change.

4.2 Driver: Clinical models of care provision are changing

The STP clinical vision, described earlier (at para 3.2.5.2), outlines a continuum of care from self-help and independence through community-based care to hospital care, with an intention to shift care towards self-help and away from hospital care where this can be achieved safely and with high quality. The impact of this movement is that the services that will continue to be provided in acute hospital settings are going to increasingly become more complex.

In the immediate future, the district general hospital (DGH) model is likely to remain at the core of the provision of acute hospital services; however the longer-term sustainability of this way of providing services is being questioned as a consequence of a number of factors, including:

- Clinical viability of small and low volume services. Where the local catchment population does not generate sufficient demand to support the number of clinical experts or facilities required to sustain 24/7 services, patients have to travel to larger, more distant centres for

some procedures; for east Suffolk and north Essex patients this is mainly to Cambridge, London or Norwich.

- The development of increasing sub-specialisation of medical and surgical services. With a move away from 'generalist' services, there is less ability for specialists to cross-cover and take part in shared clinical support rotas to provide care for emergency patients.
- Evidence regarding improved clinical outcomes. For specialised procedures, larger centres undertaking a higher number of treatments often have better outcomes. This can lead to smaller units being unable to meet national standards.
- The difficulty attracting the right quality and skilled staff to sustain service delivery in many DGH settings.
- The increasing use of high cost capital assets in delivering specialist treatments, for example surgical robots, where the economics of capital investment and return are only justifiable if larger catchment populations for services are considered.
- The need to change the way in which services are provided to meet the needs of local people. This may involve delivering services closer to where people live, or in alternative settings.

The consequence of the above is an increasing focus in hospital settings on complex and emergency work requiring the 24/7 levels of expertise to maintain consistent, safe services. This requires clinical services at sufficient scale to sustain a range of sub-specialist expertise, staff emergency rotas and invest in modern facilities and equipment. In the long-term, whilst the forecast growth in the population of the catchments serviced by the two trusts are significant, in the context of the other drivers, the current model of provincial DGHs operating in isolation is not likely to be economic or able to deliver consistent quality care.

4.2.1 Current challenge to the two trusts

All of the above factors are demonstrable to a greater or lesser extent at CHUFT and IHT. Some services at both trusts currently manage small patient cohorts due to their specialised nature, experience difficulty in sustaining 24/7 specialty cover, have difficulty attracting and retaining high calibre clinical staff, and in some cases are not meeting national guidance on minimum volumes. Changes in service provision are therefore required to meet requirements for high quality care, now and in the future.

For some services the existing hospital-focussed pathways are no longer appropriate, and the move of services into the community (and self-care) empowers and delivers a better experience for patients and releases specialist capacity for more complex work.

The design and layout of both main sites currently does not enable some of the latest technologies and models of care, and significant capital investment will be required to address this. Failure to do so could impact the clinical accreditation of some services, for example, endoscopy.

4.2.1.1 Getting it right first time

The national 'getting it right first time' (GIRFT) programme²⁰ offers insight into the opportunities to reduce variation in quality and productivity across 30 medical and surgical specialties. Both trusts are

²⁰ <http://gettingitrightfirsttime.co.uk>. 'Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered

participating in this programme. At the date of this report, initial feedback from local GIRFT reviews is still being received. However, GIRFT reports will identify gaps in the trusts' services, where patients and carers have to travel long distances for some or all of their treatment because the trusts are unable to offer them working at their current scale. GIRFT reports are also likely to identify improvements to the quality of services, which could be achieved through consolidation of some procedures into larger units; this may also offer future-proof compliance with national standards. One example of this is the recently published national GIRFT report into vascular surgery services²¹ which recommends that all vascular surgery units operate in a hub-and-spoke model.

4.2.1.2 *The Carter review and model hospital programme*

Lord Carter's review into productivity and performance in hospitals²² examined variation in productivity and efficiency. It identified significant, unwarranted, variation in clinical, support and administrative services. The *Model hospital* programme²³ is a digital information service designed to help NHS providers improve their productivity and efficiency. The trusts have used this data, along with detailed, independent benchmarking reviews over the last two years to identify services which can improve their efficiency, in line with top performing NHS hospitals. However, at the trusts' current scale, there are still services that will not be able to achieve high levels of efficiency, particularly in some aspects of administrative services.

4.2.2 *What is likely to happen if no change is made?*

The trusts have already experienced the risk of losing local vascular surgery services; this was due to changes to national standards which required these services to treat a higher number of patients to achieve the best outcomes. In 2012 the two organisations agreed a local solution to centralise complex surgery to one site in order to preserve a local service, compliant with national standards.

Some clinical specialist services at both CHUFT and IHT manage smaller numbers of patients due to the specialised nature of their practice. In some cases, these services are not meeting, or are likely not to meet in the future, minimum national guidance. For example, this might be minimum numbers of cases seen per year or number of staff in post. Change in provision of these services is therefore required to adapt to the rising clinical standards and improve the quality of care. Some specific examples of services likely to be affected by change in the future are:

- Radiotherapy – and the impact of the National Radiotherapy Review²⁴ on low volume tumour sites
- Hyper Acute Stroke Units – where national advice is to increase the scale of these services to cover larger populations
- Services which are fragile²⁵ due to low overall staffing numbers, such as:

across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings'

²¹ http://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/02/GIRFT_Vascular_Surgery_Report-March_2018.pdf

²² *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, Carter Review, DH (2015)

²³ <https://improvement.nhs.uk/resources/model-hospital/>

²⁴ *Modernising Radiotherapy Services – Developing Proposals for Future Service Models*, NHSE (October 2016)

²⁵ 'Fragile' services are ones where the delivery of consistent levels of staffing and service are difficult to maintain. Often this is due to the small size of the team which can mean that vacancies or staff leave/absence have a disproportionate impact on service capacity or capability

- Foot and ankle surgery (both trusts)
- Oncology for less common tumours (both trusts).

Other services are subject to external accreditation or reaccreditation, often to increasingly stringent standards. An example of this is in endoscopy. CHUFT does not currently have a unit that meets the design and operational standards required for accreditation by the Joint Advisory Group on Gastro-intestinal Endoscopy (JAG). IHT does have JAG accreditation, but there is a possibility that this may not be maintained in the future as the facilities no longer meet the latest specification.

Accreditation is important to ensure high quality patient care but also to attract and retain the right staff.

Attempting to sustain some of these low volume and fragile services is likely to prove unfeasible if they remain at their current scale. The consequence of them not being provided locally will be longer travel and access difficulties for these patients.

Taken together, the scope of these challenges means that neither trust alone is likely to be clinically sustainable in providing a comprehensive range of DGH services in the medium-to-long-term.

4.3 Driver: Recruitment and retention challenges

It is becoming increasingly difficult to attract and retain staff in all sectors of the health service.

The experience locally is consistent with that being reported nationally²⁶, where it is projected that across the NHS, with no action an additional 190,000 staff will be required by 2027, but with current rates of recruitment, only 72,000 will be recruited.

The NHS planning guidance for 2017-18 reconfirmed the commitment towards seven-day working²⁷. To provide this in the current configuration of acute services as a seven-day model would require a 14% increase in the workforce across both trusts²⁸.

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

4.3.1 Current challenge to the two trusts

Across both CHUFT and IHT several clinical and clinical-support specialties are already experiencing long-term recruitment challenges. This affects medical, nursing and allied health professional staff in a number of specialties (including acute medicine, emergency medicine, gastroenterology, endoscopy, respiratory medicine, radiology, pathology and care of the elderly). Many of these staffing shortages are likely to worsen over the next five years. The workforce for many services will be unsustainable and care to patients will be under threat unless the model of service delivery is

²⁶ *Facing the facts, shaping the future – a draft workforce strategy*, NHSE (September 2017)

²⁷ *NHS operational planning guidance 2017/18-2019/20*, NHS England (2016)

²⁸ *Suffolk and North East Essex Sustainability and Transformation Plan* (2016)

changed; this must be underpinned by training and the development of new roles to change the skill-mix of staff.

The current levels of vacant posts and reliance on temporary staff are shown in Table 4-1.

Table 4-1 Current vacant posts at CHUFT and IHT by category (at 31 December 2017)

Employment metrics	CHUFT		IHT	
	WTE	% of posts vacant	WTE	% of posts vacant
Vacant posts				
Consultant vacancies	28	12.9%	10	4.2%
Junior doctor vacancies	40	13.0%	14	6.7%
Registered nurses/midwives	177	13.4%	108	7.5%
Non-registered nursing	42	7.3%	12	2.6%
AHP vacancies	93	10.3%	29	8.1%
Overall vacancies	504	11.0%	318	7.3%
Temporary Staffing				
Long-term locum consultants	NHS: 13 Agency: 6		NHS: 7 Agency: 1	
Agency use (Registered nurse/midwife)	6.2%		1.7%	
Agency use (Non-registered nurse)	1.6%		0.6%	
Annual turnover of posts				
Overall turnover rate	11.7%		9.9%	

These relatively high levels of vacant posts exist despite extensive efforts from both trusts to fill these posts, including:

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

4.3.2 What is likely to happen if no change is made?

The workforce will be unsustainable and patient care under threat unless the model of service delivery is changed. As providers neither trust will be able to sustain smaller specialty 24/7 rotas, and as neighbours the trusts will compete for the same pool of local staff. The two smaller trusts will be less able to offer recruits a broad variety of training and development experiences, and will be less able to attract the best trainees on deanery approved training schemes.

4.4 Driver: Financial viability

4.4.1 Current challenge to the two trusts

In common with the wider NHS, both CHUFT and IHT reported deficits in 2016/17 and in the previous two years. The deficits were reduced in 2016/17 compared with 2015/16, in part due to the receipt of £16.5m sustainability and transformation funding (STF). The forecast outturn for both trusts for 2017/18 is for the deficit position to continue, with a slight worsening in the underlying position at IHT but an improvement at CHUFT.

The combined forecast deficit for CHUFT and IHT in 2018/19 is expected to be £22.4m, increasing to £49.7m by 2023/24. This forecast deficit is a 'Do Nothing' position and assumes that both organisations continue to operate as standalone entities (the counterfactual proposition). The forecasting has incorporated the impact of STF incentive and both trusts are in receipt of increased STF to support their financial positions and, despite this, are not projecting a return to break-even within the next five years.

The North East Essex and Suffolk STP plan^[1] details the wider system challenges. During 2016/17 the STP income for health was £1.8bn which comprises CCG allocations spent within the system and provider income generated from outside of the system.

In 2016/17 the STP normalised deficit sat largely with the acute providers - £35.8m at IHT, £10.2m at WSH^[2], and £40.3m at CHUFT - with a further £4.8m within the Mental Health Trusts. In 2017/18 forecasts this position remained largely unchanged. IHT (£33.5m) and CHUFT (£34.7m) still have the largest underlying deficits followed by WSH (£12.6^[3]).

STP health funding (excluding STF) is mainly derived from CCG allocations and is expected to grow at a rate of between 2.6-4.3% each year in the planning period. This growth in allocation is not expected to be sufficient to address the cumulative impact that inflation and increased demand are expected to generate year-on-year, with an expectation that without a plan to address this shortfall the 'do nothing' provider deficit position of the STP will progressively increase from £84m (2016/17) to an estimated £248m by 2020/21.

4.4.2 What is likely to happen if no change is made?

Financial modelling for a do nothing scenario for the Two trusts remaining as separate entities suggests an ongoing deterioration in the financial position of both trusts. The forecast position for CHUFT in 2018/19 is a net deficit of £12.1m (normalised deficit of £25.0m) deteriorating to 31.2m (£43.7m) in 2023/24. For IHT the equivalent in 2018/19 is £10.1m (£20.3m normalised) deteriorating to £22.4m (£32.4m) in 2023/24. These forecasts assume that full CIP is delivered year on year, which, if achieved as separate entities, would leave organisations vulnerable with resilience. Capital will remain constrained and opportunities for the improvement of estate will be limited.

More detailed information on the historic and forecast positions of the trusts in future years as standalone organisations and as a merged trust can be found in Section 6.

4.5 Driver: Delivering transformational change

The NHS *Five Year Forward View*²⁹ identified three gaps which must be closed:

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

^[1] Suffolk and NE Essex STP Implementation Plan (October 2016)

^[2] West Suffolk Hospital NHS Foundation Trust, Annual Accounts 2016/17

^[3] West Suffolk Hospital NHS Foundation Trust Board Report (February 2018)

²⁹ NHS *Five Year Forward View*, NHS England (2014)

New models of service delivery and organisational integration are expected to be developed to meet these. This was reaffirmed in *Next Steps on the NHS Five Year Forward View*³⁰. This explained that, whilst some progress had been made in addressing the gaps, there was further work to be done.

The Sustainability and Transformation Partnerships³¹ introduced in 2016/17 offer a wider area for collaboration and increase the potential for partnerships between acute hospitals. The Suffolk and North East Essex STP has developed an ambitious plan and programme of delivery, which, in relation to acute reconfiguration, aims to create viable acute hospitals that have fully integrated patient pathways. This will be achieved through the redesign of clinically-led patient pathways to improve outcomes, underpinned by innovation.

The *Dalton Review*³² considered the options for provider sustainability and identified seven possible organisational forms for acute trusts. The *Carter Review*³³ identified efficiencies available from collaboration between NHS organisations (and other public services) with an expectation that trusts will significantly reduce their overheads.

In order to deliver change on this scale and at pace, the acute providers will need to embrace new ways of working within the wider health and social care system.

4.5.1 Current challenge to the two trusts

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

At CHUFT, the *Every Patient Every Day* (EPED) initiative³⁴ has sought to refocus the whole organisation on providing safe, compassionate care to patients both as an organisation and as individual members of staff, each and every day, in a consistent and caring way.

CHUFT's updated vision - *Delivering great healthcare to every patient, every day* - was approved at the Board in October 2016. The vision is underpinned by three corporate objectives: acting in the best interests of every patient, every day; supporting the workforce to look after every patient, every day, and achieving clinical, operational and financial resilience.

The CHUFT strategy aligns with the vision; it focusses on delivering the right care in the right place at the right time; ensuring a positive patient-centred culture; and, creating clinical, operational and financial resilience.

EPED is a cross-cutting quality improvement approach that has been instrumental in delivering the quality improvements acknowledged by the CQC in their November 2017 report³⁵, and by NHSI in their decision to remove CHUFT from the 'special measures' regime.

³⁰ *Next Steps on the NHS Five Year Forward View*, NHS England (2017)

³¹ *Planning, assuring and delivering Service Change for Patients*, NHS England (2015)

³² *Examining new options and opportunities for providers of NHS care*, Dalton Review, DH (2014)

³³ *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, Carter Review, DH (2015)

³⁴ This includes issues identified by the CQC: *Colchester Hospital University NHS Foundation Trust Quality Report*, Care Quality Commission (July 2016)

³⁵ *Colchester Hospital University NHS Foundation Trust Quality Report*, Care Quality Commission (November 2017)

IHT has recently refreshed its strategy; in January 2017 the IHT Board approved a five-year organisational strategy *Writing the next chapter ...:Trust Strategy 2017 – 2022* which is built around delivering four organisational goals – Deliver a great care experience; Be recognised as a leading innovator in healthcare nationally; Financially secure; and, Improve the experience of working in healthcare – each goal being underpinned by a number of supporting strategic objectives and key measures of attainment.

The EPED approach at CHUFT and the five-year strategy at IHT will be important underpinning in developing the longer-term transformation strategy of the new organisation.

4.5.2 What is likely to happen if no change is made?

Developing the capability and capacity to sustain transformational change is a challenge for all trusts. Whilst the current initiatives like *Every Patient Every Day* are delivering good results, embedding long-term change and maintaining the resource to support a change culture embodying quality improvement, research and innovation and change management as two separate trusts will be demanding.

4.6 Driver: Demographic factors

Population projections and housing growth plans in the catchment area of ESNEFT are significant. The growth is especially significant in the numbers and proportion of the population aged 65+ and 85+.

ESNEFT will serve a catchment population, shown in Figure 4-1, of over 750,000; this includes large towns (Colchester and Ipswich), significant rural populations and smaller market towns, traditional coastal resorts, significant port facilities, universities and large armed services garrisons.

The main population served is drawn primarily from six local authority areas, shown in Table 4-2.

Table 4-2 Population of principal catchment Tier 2 local authority areas

Population (000s) ³⁶	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

The new trust will be the predominant focus for acute care for these local authority areas, although there is some outward flow to Norfolk providers³⁷ in the north, West Suffolk Hospital in Bury St Edmunds, to the west, and Broomfield Hospital in 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.

³⁶ *Health Profiles 2017*, Public Health England

³⁷ The Norfolk & Norwich Hospital NHS Foundation Trust in Norwich and the James Paget Hospital NHS Foundation Trust in Gorleston, Great Yarmouth



Figure 4-1 Map showing the local area to be served by ESNEFT including main and community hospital sites

Appendix 2 includes a more detailed analysis of the characteristics of the local population and the particular challenges this may present to the new enlarged organisation.

A number of key issues that will affect the future challenges and development of the new organisation are evident from the local demographic data and intelligence.

- **Impact of a growing population:** The population served by the new trust is forecast to grow in official population estimates³⁸ by an additional 100,000 (12.2%) by 2036. These projections may be revised upward to take into account the expected housing growth identified in the borough and district Local Plans³⁹ with over 80,000 new dwellings planned to be in place by the mid-2030s.

³⁸ ONS local authority population projections (2014 based)

³⁹ 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)

- **Impact of an ageing population:** The population served by the new trust is diverse with disproportionately skewed age structures tending towards a larger population of older people in the rural and coastal areas. The older population, as a proportion of the total population is forecast to increase significantly overall with particular impact on the over 85 age cohort to 2036⁴⁰.
- **Economically inactive populations:** Linked to the overall growth of the population, higher than average dependency scores particularly reflect the higher proportion of economically inactive members of the population – both children and older people.
- **Life expectancy and underlying morbidity:** There are significant variations in life expectancy, linked to the levels of deprivation. The PHE Health Profiles show that in Tendring in particular there are significant underlying factors impacting on overall health outcomes.
- **Deprivation:** The levels of deprivation in some parts of Tendring and Ipswich in particular are amongst the worst in the country; these groups require more sophisticated strategies to engage them in preventative health care and wellbeing.
- **Minority ethnic groups:** The 2011 census identifies lower than national average numbers of people for minority ethnic groups in the local population: Colchester and Ipswich have ethnic minority populations closer to the national average. The trusts recognise that their services must become more responsive to the needs of black and minority ethnic (BME) groups.
- **Rurality and transport challenges:** The rural catchment area creates specific issues for some members of the population in accessing health care.

4.6.1 Current challenge to the two trusts

Both trusts experience significant periods where peak emergency acute pressures affect the organisation's ability to sustain both elective and emergency care. Population growth, particularly in the older (and generally more frail) population will exacerbate these pressures due to the higher proportion of these patients needing care and their higher level of acuity (medical need).

There are limited opportunities for smaller organisations to innovate to respond to population pressures in relation to, for example, seven-day working solutions, as they do not operate at the scale to make the solutions viable.

The lower proportion of economically active residents also presents challenges in recruitment of health care workers from the local area. Better offers to staff in terms of training, education and career development are required as well as more sophisticated recruitment practice; these are harder to achieve at the scale of either trust separately.

Initiatives to respond flexibly in elective or emergency care to help deliver national access standards are less easy to deliver as separate organisations.

Early experience in east Suffolk, where IHT has recently also become the community services provider has allowed greater integration with, and strengthening of, community care. This has supported changes to patient pathways to reduce or avoid the need for acute care. This model can act as a test case for how effectively this shift of care can be delivered.

⁴⁰ Op cit

4.6.2 What is likely to happen if no change is made?

The impact of these demographic challenges means that without significant change to the way in which the acute health care model operates the numbers of acute emergency admissions will continue to rise, consequently requiring more beds, staff and hospital-based infrastructure. This model is not sustainable without significant additional investment in staff and facilities. Recruitment costs will remain proportionately higher and opportunities to develop stronger education and training offers to staff will remain limited. Partnerships with local education providers will remain relatively small-scale, at a low level of influence, reducing the pace at which new roles can be developed to close current and future workforce gaps.

4.7 Driver: Impact of technology

New technology has the potential to have huge impacts on clinical care, diagnosis and treatment, and on the systems and processes of communication that support clinical care.

Technology development is transforming all aspects of life, but particularly health care. Recent developments in medical care that are likely to impact on how treatment and care is provided include:

- A range of new therapeutic techniques for cancers such as biological therapies⁴¹ and immunotherapy⁴².
- Increasingly sophisticated imaging techniques (e.g., PET-CT⁴³, SPE-CT⁴⁴ and computer-assisted analysis of radiology images⁴⁵).
- The burgeoning range of minimal access interventions such as complex laparoscopic surgery, interventional radiology and thrombectomy for stroke.
- Machine learning ('artificial intelligence') to support the early diagnosis and treatment of disease such as acute kidney injury⁴⁶.
- Robots in medical and personal care, such as robotic surgery and robotic exoskeletons to assist neuro-rehabilitation⁴⁷.

This trend will accelerate as even more sophisticated diagnostic and therapeutic approaches become standard such as genomics⁴⁸, stem-cell treatments⁴⁹, computer-assisted cancer treatment planning⁵⁰.

New technologies now form an integral part of how people live their everyday lives, these technologies ranging from complex clinical robotics and generic-engineering to relatively simple smartphone applications will increasingly play a significant role in how healthcare is provided.

⁴¹ <http://about-cancer.cancerresearchuk.org/about-cancer/cancer-in-general/treatment/targeted-cancer-drugs>

⁴² <https://www.cancerresearch.org/we-are-cri/what-is-immunotherapy>

⁴³ Positron Emission Tomography

⁴⁴ Single Photon Emission Tomography

⁴⁵ <https://deepmind.com/blog/applying-machine-learning-mammography/>

⁴⁶ <https://deepmind.com/applied/deepmind-health/working-nhs/how-were-helping-today/royal-free-london-nhs-foundation-trust/>

⁴⁷ <http://www.imperial.ac.uk/human-robotics/research/hand-rehab/>

⁴⁸ <https://www.genomicsengland.co.uk/the-100000-genomes-project/understanding-genomics/>

⁴⁹ For example Parkinson's disease, haemophilia a, diabetes

⁵⁰ <https://www.microsoft.com/en-us/research/project/medical-image-analysis/>

The NHS operates within a wider social and technological environment and can, at times, be seen as slow and inconsistent in how it adopts new consumer facing technologies⁵¹ that are well established in other sectors. Members of the public increasingly expect to interact with services using personal digital technology - typically email and apps - and the NHS systems have been slow in adapting their patient-facing transactional systems to these technologies.

At the same time, increasing NHS demand and complexity of care is focussing providers on looking at ways in which services, particularly those in back-office functions, can be delivered at lower cost and with greater productivity. In this context, the *Carter Review*⁵² identified efficiencies available from collaboration between NHS organisations (and other public services) with an expectation that trusts will significantly reduce their overheads.

4.7.1 Current challenge to the trusts

In relation to clinical innovation and research, both trusts have pockets of excellence and have some services with national reputations, for example research in diabetes care in IHT, laparoscopic surgery and ophthalmology in CHUFT and in cancer/haematology at both trusts. Investment in research is becoming harder to secure and favours larger centres.

Both trusts currently have constraints in diagnostic capacity, particularly in the imaging disciplines. This has inhibited their ability to meet waiting-time standards and to develop new interventions. Diagnostic equipment is often high cost (multi-million pound investment) and therefore the ability for the trusts to invest in this separately is limited.

Neither trust has been able to develop a sustainable, cost effective, business case for significant investment in surgical robotics.

As separate trusts CHUFT and IHT have been constrained in their ability to generate a high profile for education and research to develop stronger partnerships with universities and industry. Innovation activity has been relatively low-key compared to other hospitals in the region and the trusts have not fully exploited grant funding opportunities due to the limited capacity in these services as separate trusts.

Capacity, capability and investment in technology to transform administrative and support services for patients and staff is limited at the scale of the trusts operating separately.

4.7.2 What is likely to happen if no change is made?

Both trusts face similar challenges in justifying significant investment in complex clinical technologies for relatively small catchment populations. Technologies like surgical robotics have a high capital cost and need to be fully exploited by a team of competent surgeons in order to secure a rate of return on the capital investment.

Nationally funded research is likely to continue to diminish and smaller trusts are likely to see their funding decline more quickly. As separate trusts the capacity to engage with commercial research

⁵¹ *Technology in the NHS: Transforming the patient's experience of care*, Liddell A et al., The King's Fund (2008)

⁵² *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, Carter Review, DH (2015)

partners will be a significant constraint and therefore the trusts will be less able to respond to this changing funding environment. This will mean fewer patients benefitting from access to clinical trials and research.

Both trusts lack a well-developed and well-resourced innovation function and will struggle to develop this independently. Therefore, securing increased investment in innovation will be difficult and home-grown innovation will be less well exploited to improve care for patients.

The scale of the trust's capital plans, as separate organisations, will severely limit the ability to invest in the infrastructure and IT systems which are required to make a step-change in services which improve the experience of, and responsiveness to, patients, carers and staff.

4.8 System risks if the merger does not proceed

The wider impact on the STP health and care system if the merger does not proceed is also important. Table 4-3 summarises a number of risks to the wider system of not proceeding.

Table 4-3 Risks of not proceeding with the merger

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

4.9 Conclusion

In common with many trusts of similar scale, CHUFT and IHT face a number of pressures on their ability to deliver the current range of clinical services, consistently and at high quality. In particular,

continued challenges in some key groups of staff, rising needs in a growing and ageing population and the increasingly complex and costly requirements of modern healthcare mean that the current scale of the trusts is not sustainable.

By coming together, the new organisation will take advantage of its new scale and shared resources to:

- Improve the recruitment and retention of highly skilled staff, through improved training, education and career development
- Create larger clinical services which are more able to meet service standards, offer 24/7 services, sustain and improve the range of services to meet the needs of patients
- Create sustainable partnerships with community services, to support more self-care and community-based care
- Invest in innovation, research and technology to transform the services for patients and staff
- Adapt flexibly and attract investment to meet the changing needs of the population.

5 The new organisation

5.1 Introduction

In May 2016, within the context of the wider STP, the trusts agreed the following four objectives that should be delivered by CHUFT and IHT working in partnership:

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

These overriding objectives are still valid and in developing the plan for ESNEFT, further work has been undertaken to establish an organisational mission, vision, organising philosophy and operating framework to support their delivery.

In preparing the FBC, an outline trust strategy has been developed which forms the basis for the ESNEFT clinical and corporate operating models and approach described in this section. This outline strategy will be fully developed with patients, staff and system partners once ESNEFT has been established.

5.2 Mission, vision and philosophy

5.2.1 *The mission*

In 2018, the year of the 70th anniversary of the establishment of the NHS, the mission for ESNEFT reflects that of the NHS at its foundation and is to continue to follow the principles of the NHS identified in 1948. This means providing health care and services that meet the needs of everyone, free at the point of delivery and based on clinical need.

5.2.2 *The vision*

ESNEFT's vision is simple – to provide the communities served with excellent healthcare and build a better future for east Suffolk and north Essex.

5.2.3 *Time Matters: the ESNEFT philosophy*

Dealing with ill health is stressful, both for the individual affected and for those caring for them. There is the *necessary* stress of the illness and the emotional effort of caring. However, too often the complexity of the health and care systems adds *unnecessary* stress. At the heart of this is time. Time is important to everyone whether as patients, families, carers, or as staff delivering care. The philosophy of ESNEFT will be that time matters. Together the trust and its staff will improve services to make every moment count.

ESNEFT 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.

This focus on using time to best effect is underpinned by:

- Doing things right first time saves time, stress and frustration for patients, families and staff.
- By using time effectively, staff will have more time to use their expertise where it makes the most difference - with patients.
- Seeing patients at the right time, helps keep them well for longer or make them better quicker.

The principle that time matters will be developed further with staff and the public to create a final trust vision that provides a valuable unifying principle to maximise the potential offered by the new organisation.

That time matters is demonstrated in the way ESNEFT has developed its proposed clinical and corporate operating model.

5.3 Organisational objectives

In May 2016, four objectives for the partnership between CHUFT and IHT were identified:

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

These remain as the overall objectives of the merger and are designed to respond to the challenges identified by the STP and reiterated in the case for change (see Section 4), as shown in Table 5-1.

Table 5-1 Link between the case for change challenges and merger objectives

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

5.4 How ESNEFT will operate as a single organisation

In developing the plans to merge, the trusts have recognised that, as two established district general hospitals operating at 22 miles separation (circa 35 minutes travel time by car⁵³), and with community services provision only in the east Suffolk catchment, there is potential for the merger to happen ‘in name only’ without delivering the full benefits for patients. A clear plan for organisational integration is therefore required.

The existing trusts have developed cultures and their own ways of working. It will be important for the ESNEFT to establish its own culture, values and vision, and to promote these across all aspects of its operations.

Bringing together two organisations with 4-5,000 staff each and at the same time, introducing a new culture, vision and values will present significant challenges; research suggests that changes to culture take time and sustained effort to embed⁵⁴.

To move the organisation forward rapidly a number of design principles have been established for the clinical and corporate operating models; these support a unified approach to delivering services on multiple sites.

At the heart of how the organisation will be structured are the clinical operating model (Element 2 below) and the corporate operating model (Element 3 below). To support delivery of these two models are a number of enablers and supporting infrastructure. Together, there are eight key elements that describe how the new organisation will operate. These are shown in Figure 5-1. How each element will work in the new organisation is described in this section.

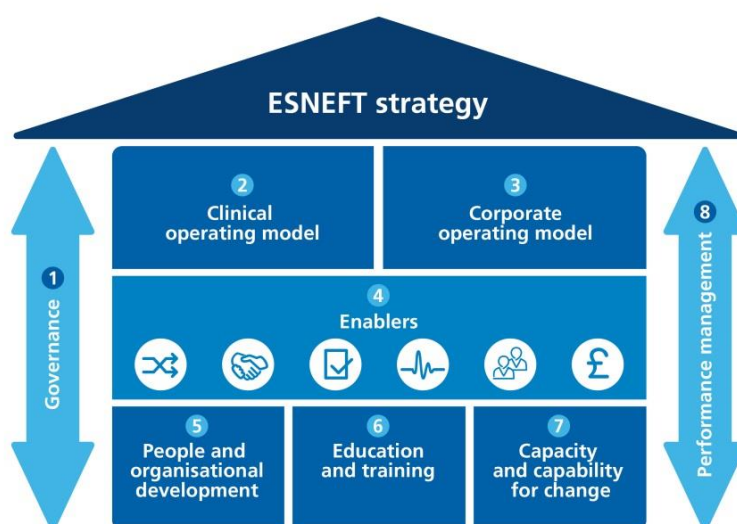


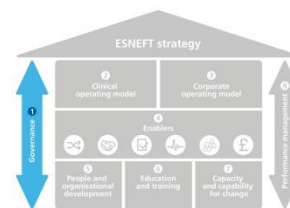
Figure 5-1 ESNEFT organisational construct

⁵³ Colchester General Hospital to Ipswich Hospital by car: 25 minutes off-peak, 40 minutes peak-time; CHUFT to IHT by public transport: 80 to 90 minutes

⁵⁴ *Mergers in the NHS: lessons learnt and recommendations*, Cass Business School/Monitor (2016)

5.5 Element 1: Governance

As an NHS foundation trust (FT), the organisation will be regulated under arrangements described in the Health and Social Care (Community Health and Standards) Act 2003, as amended⁵⁵, by NHS Improvement. The FT has an agreed licence, and conditions therein, and will be supervised by NHS Improvement, as described in the Single Oversight Framework (SOF)⁵⁶.



Fuller details of the governance structures in ESNEFT are included in the PTIP. These are briefly summarised below.

5.5.1 Foundation trust governance structure

The FT governance structure balances the responsibility of the board for the overall operational leadership and performance delivery of the trust with local accountability to the Council of Governors and, through the governors, to the membership and wider local population, shown in Figure 5-2.

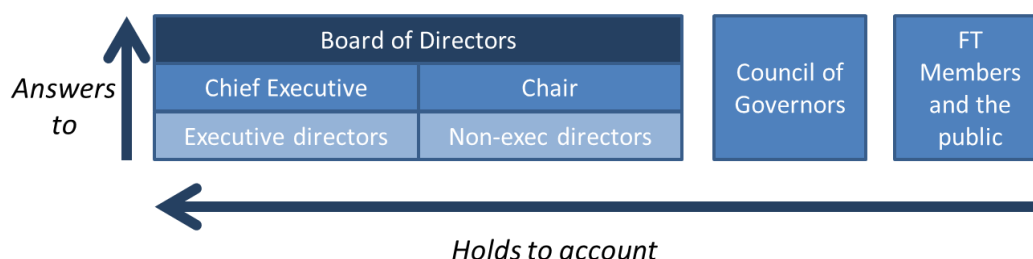


Figure 5-2 Foundation trust governance accountability model

5.5.2 The foundation trust constitution

The proposed constitution for the new organisation (Appendix 3) follows the model FT constitution. This shows how the trust will be accountable to the local population through the membership. The constitution provides the governance framework within which the trust will operate, supported by a number of corporate governance documents including the standing orders, standing financial instructions, the register of matters reserved to the board, and the scheme of delegation.

5.5.3 Membership

The FT membership includes staff and public constituencies which are defined in the constitution. The staff constituency includes all members of staff directly employed by the FT, together with registered volunteers.

Any person whose normal place of residence is in the counties of Essex, Suffolk or south Norfolk, including any residents of unitary authorities falling within this geography, is eligible to apply to join the public constituency.

⁵⁵ By the National Health Service Act 2006; Health and Social Care Act 2012

⁵⁶ *Single Oversight Framework*, NHS Improvement, November 2017

5.5.4 The Council of Governors

The council is responsible for holding the non-executive directors, individually and collectively, to account for the performance of the board. The new council will comprise:

- 18 elected public governors⁵⁷
- six elected staff governors⁵⁸
- nine nominated governors from sponsoring organisations⁵⁹.

The structure of the council will reflect the balance of public, staff and stakeholder representation across the geography served by the new trust.

Elections for the new governing body are planned to take place during May and June 2018, with members being able to vote for governors to represent their constituency.

At the transaction date the new council will take over the responsibilities of the CHUFT council and the CHUFT council and governors will fall away.

5.5.5 The Board of Directors

The Board of Directors is responsible for the strategic leadership and direction of the trust.

The ESNEFT board will comprise the chair and seven non-executive directors, the chief executive and six voting executive directors, shown in Figure 5-3. The number of voting non-executive members of the board will always exceed the number of voting executive members.

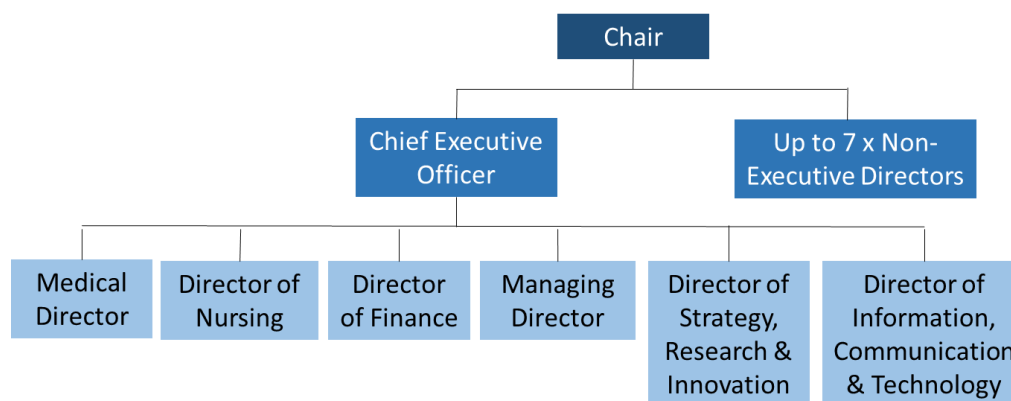


Figure 5-3 ESNEFT Board of Directors

5.5.6 Transitional board arrangements

For a period of up to six months from the transaction date, the trust may have up to 10 non-executive directors (excluding the chair). If not already reduced by the first anniversary of the

⁵⁷ Elected by public members organised in four constituencies based on the geographic areas of Colchester BC (four governors), Ipswich BC (four), the rest of Essex (five), and the rest of Suffolk and South Norfolk (five). The constituencies are described in detail in the proposed ESNEFT constitution.

⁵⁸ Elected by staff members organised in two staff constituencies – Colchester (three governors) and Ipswich (three).

⁵⁹ The sponsoring organisations nominating governors will be: Tendring District Council & Colchester Borough Council (one joint nomination); Ipswich Borough Council & Suffolk Coastal District Council (one joint); Essex County Council (one); Suffolk County Council (one); University of Essex & Anglia Ruskin University (one joint); University of Suffolk (one nomination); Colchester Garrison (one nomination); Essex Healthwatch (one); Suffolk Healthwatch (one)

transaction date, on that anniversary the maximum number of non-executive directors (excluding the chair) shall reduce to a maximum of seven non-executive directors.

5.5.7 Board committees

The Board will establish three statutory committees to support its work. These are the Audit Committee (monitoring and reviewing the integrity of financial and other systems and processes), the Remuneration Committee (managing the terms and conditions of service of executives) and the Nominations Committee (managing appointments to the board - jointly with the council of governors in the case of non-executive appointments).

The Board will also establish three assurance committees, designed to support board scrutiny of detailed operational and strategic performance. The proposed assurance committees will be the Quality and Patient Safety, Finance and Performance and Workforce committees.

The Board will have a Charity Committee to exercise its statutory responsibilities as corporate trustees for the management of charitable funds.

5.5.8 Executive leadership team

The executive leadership of ESNEFT is shown in Figure 5-4.

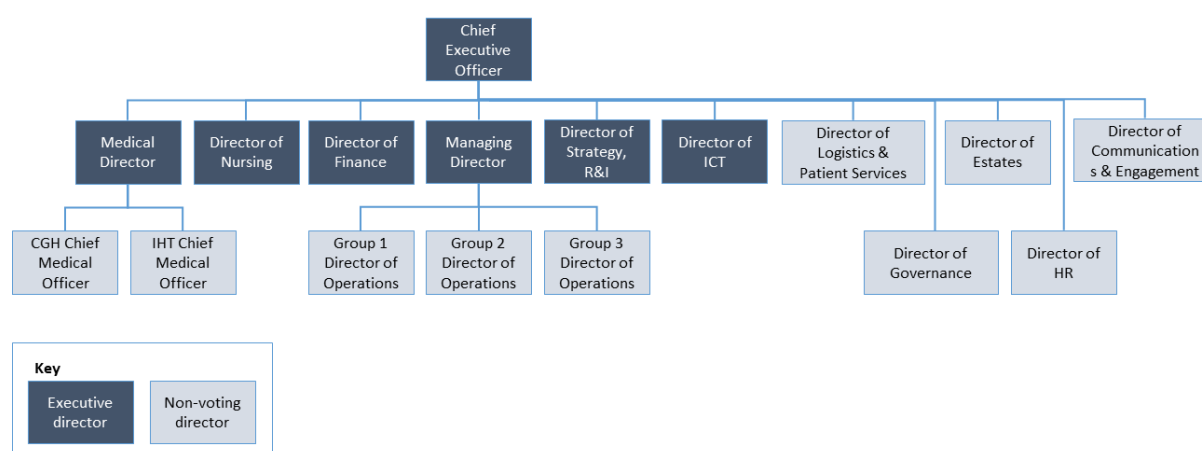


Figure 5-4 Executive leadership roles

ESNEFT will maintain leadership presence on the CGH and IH sites with all executive directors working at times on one site or the other. There will be trust offices facilities on both sites and technology; for example, teleconferencing will increasingly be used to support communication and meetings in a virtual environment.

The location of meetings of the Board, Council of Governors and executive team will take into account the need for visibility and presence on both main hospital sites.

5.5.9 Director of Operations roles and responsibilities

The operational divisional structure for the new organisation will have three director of operations roles. These posts will be pivotal in having two key functions: site responsibilities and clinical division responsibilities.

The directors of operations will each have site specific responsibilities, for Colchester General Hospital, Ipswich Hospital and the community hospitals and services respectively. Each director of operations will also have responsibility for executive level co-ordination of a grouping of the clinical divisions and clinical services (see 5.5.10).

The dual roles and cross-cutting responsibilities will need the directors of operations to work closely as a team in managing, for example, emergency system pressures, flexing capacity and responding to opportunities and challenges across the whole trust.

5.5.10 Clinical divisional structure

Clinical Services will be managed by a single leadership team working across all sites and will be organised into three clinical groupings (see Table 5-2), each under the oversight of a director of operations.

Table 5-2 Clinical leadership and management arrangements: Divisions and clinical delivery groups

Group 1	Group 2	Group 3
Medical Division <ul style="list-style-type: none"> Emergency Medicine CDG General Medicine CDG Specialist Medicine CDG 	Orthopaedic & Specialist Surgery Division <ul style="list-style-type: none"> Musculoskeletal CDG Specialist Surgery CDG 	Integrated Care Division <ul style="list-style-type: none"> General Community CDG Specialist Community CDG Integrated Therapies CDG
Cancer and Diagnostics Division <ul style="list-style-type: none"> Cancer CDG Pathology CDG Medical Imaging CDG Pharmacy CDG 	General Surgery Division <ul style="list-style-type: none"> General & Vascular CDG Gastro & Urology CDG Theatres & Anaesthetics CDG 	
	Women & Children's Division <ul style="list-style-type: none"> Women's Services CDG Children's Services CDG 	

Each grouping includes one or more clinical divisions. Each clinical division will be led by a Divisional Director (clinical), a Head of Operations and a Head of Nursing. The divisional leadership team will also include senior finance, workforce and informatics business partners and a clinical governance manager. Divisional teams will include other leaders as appropriate tailored to the scope of the individual division's functions.

Each division will manage a number of Clinical Delivery Groups (CDGs). The CDGs will be the basic business units, led by a Clinical Director, General Manager and Matron. CDGs, depending on the size of the services included, will manage one or more clinical specialties and functions.

Groups, Divisions, CDGs and specialties will cover services on all sites and locations. The performance management and accountability framework arrangements will reflect the divisional CDG and specialty structures, see performance management (Element 8) for further details.

5.5.11 Corporate structure

Each professional corporate function will operate as a unified service working across the organisation with a single leadership team.

Over time, corporate systems and processes will be aligned to deliver consistent ways of working across these services, including developing patient services and staff services models with the use of a single point of contact and an online self-service portal, which will deal with routine administrative interactions with corporate functions.

5.5.12 Harnessing technology to support unified governance

Whilst CHUFT and IHT have developed their own approaches to IT and in particular to the deployment of clinical systems, work over the last year has established a baseline of where the approaches differ, where they are similar and how over time these can be brought into alignment.

The focus for Day One will be to deliver an IT service at that provides the organisation and all staff with:

- Federated network interoperability to allow former CHUFT or IHT systems to be accessed from any trust site
- Shared email, calendar, instant message infrastructure
- A single point of access to an IT service desk operating extended hours
- Shared telephony extension infrastructure to support cross-organisational dialling
- Shared Desktop Alerting Infrastructure to support communications
- Trust-wide IT business continuity and on-call standard operating procedures
- A joint e-Health governance structure
- Internal, external patient and staff communications infrastructure support.

Travel between sites is wasteful of staff time so the new trust will take advantage of the use of technology to join up team members across sites. During partnership work to date the use of video conferencing has been a successful way of supporting this and whilst some face-to-face contact will be important, enabling alternative communication methods will support closer working irrespective of site.

5.5.13 Optimising the estate and facilities

A significant resource in the delivery of transformation in health care is the trust's estate. Creating an effective, efficient, high quality patient and staff environment providing a platform for modern healthcare delivery is important to ESNEFT. An enabler for ESNEFT to support change will be a unified estates strategy for both hospital sites and community services, which aligns with the STP plan and adopts the principles of the One Public Estate⁶⁰ objectives where possible.

The ESNEFT estates strategy will detail how the trust will plan, procure, construct and maintain its estate portfolio using innovative designs to deliver patient and staff environments that are flexible,

⁶⁰ *One Public Estate* is a national programme jointly run by the Cabinet Office Government Property Unit and the Local Government Association, bringing together public sector bodies in a locality or region to work in partnership to identify and implement projects to help manage assets more effectively.

adaptable and use the latest technologies. A key design principle will be to inspire confidence, reduce anxiety and induce calmness for patients receiving care and treatment. At the same time the designs will increase functional suitability, optimise space, maximise clinical effectiveness and reduce wasted time for staff delivering care to patients.

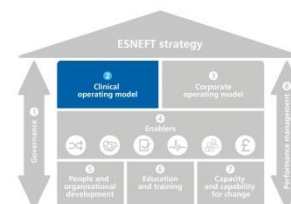
The impact of agile working upon the built environment by the introduction of new technologies through the e-Health and clinical strategies will assist in rationalising the estate on the main hospital sites to provide less non-clinical space and more flexible clinical space where required.

On both hospital sites there is a continuing need to address back-log maintenance liabilities, ensure a compliant estate and mitigate any risks and financial impact upon the organisation. The ESNEFT estates and facilities directorate will produce robust master control plans for both hospitals which reflect their 20-year vision for the use of the estate. Potentially both sites may have surplus land for either disposal or redevelopment. The disposal of land could produce a capital receipt for reinvestment, or redevelopment could provide residential care or intermediate care facilities or key worker and student accommodation amongst other options. Providing key worker accommodation in particular would improve recruitment and retention for key clinical staff from nurses through to consultants and other specialists, consistent with the Naylor⁶¹ review.

Estates and Facilities will also implement a standardised approach across both acute and community hospitals for 'soft FM' services which are provided to patients and staff to ensure consistent, high quality services are delivered whilst providing value for money at all times. Working intrinsically with the logistics division (see 5.11.4), estates and facilities will deliver a range of 'soft FM' services (catering, cleaning, porters, security, car parking, retail, etc.) which enhance the patient experience, reduce stress and anxiety and enables staff to release time to reinvest into clinical service delivery.

5.6 Element 2: Clinical operating model

The aim of the new organisation is to see patients at the right time, provide the latest treatments locally and attract the best staff. The new organisation will invest more in its frontline services by cutting waste and the cost of running the two organisations.



To achieve these aims needs a change in culture, adopting the ESNEFT philosophy that *time matters*. This will be done through focussing on harnessing the enablers that will help deliver efficient and effective patient care. These are:

- **Fully integrated organisation:** Integrate culture, systems and structures both in and the hospitals and in the community.
- **Streamlined processes:** Standardise care and harmonise ways of working to reducing unwarranted variation.
- **Portals and service desks:** Ensure the majority of issues are resolved before reaching professional teams.
- **Investing in people:** Providing career pathways and enhanced learning opportunities

⁶¹ NHS property and estates: why the estate matters for patients, The Naylor Review, DH (March 2017)

- **Data tracking and analytics:** Put in place systems and processes to track and schedule to improve flow.
- **Maximising scale:** Exploit scale to improve efficiency and outcomes and to maximise value for money.

Details of how the clinical model will be achieved are below, with further information on the enablers under Element 4. The clinical model is based on following three premises:

5.6.1 Integrating clinical services

In recent years both trusts have struggled to see patients on time, within core capacity on both elective and emergency care pathways. As a result, not only are patients waiting longer than they should but also unsustainable methods are being relied upon to provide the additional capacity.

Integrating clinical services will enable early access to emergency pathways and match elective capacity to demand. In the new organisation improvements in access times for patients will be achieved in two ways:

1. **Improving access to urgent and emergency care** through investment in infrastructure and sharing resources. This will enable early delivery of sustainable seven-day services. This will be achieved by extending best practice ways of working across both sites. There will also be opportunities to share access to some emergency theatre lists to spread capacity and establish new emergency rotas across the sites for appropriate services. This would reduce waiting times for emergency surgery and support the provision of a 24/7 emergency service across both sites.
2. **Improving access to elective care** by combining services and matching elective capacity to demand across both sites. In the new organisation there will be the opportunity to combine and review the elective capacity across the sites, comparing elective productivity and throughput where appropriate, whilst looking to increase or adjust capacity in relation to demand where required.

5.6.2 Combining the resources and skills of the two trusts

Combining the resources and skills of the two trusts will strengthen and sustain services in the short-term and enhance them in the future. This will be achieved by:

1. **Integration with community:** *The Five Year Forward View*⁶² has encouraged efforts to deliver more healthcare out of hospitals and closer to home, with the aim of providing better care for patients, cutting the number of unplanned bed days and reducing net costs. The new organisation will treat patients across a large geographical footprint. Although there are clear benefits of scale from the combining the two trusts, 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.
2. **Sustaining local services:** Although Colchester and Ipswich hospitals are centres for a range of specialist services, patients still have to travel long distances for some sub-specialty treatments.

⁶² Five Year Forward View, NHS England. (2014). <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

There is a national drive to increase the quality and consistency of specialist services by specifying minimum numbers of cases in national standards; this will effectively reduce the number of specialist centres. The new organisation will have a higher volume of activity per service enabling the minimum numbers to be achieved and therefore keeping service delivery local.

The new organisation will also maintain early sight of any new specialist commissioning intentions and national standards to enable a robust response to be formulated in order to continue to provide the latest treatments locally.

- 3. Enhancing local services:** Colchester and Ipswich both provide a portfolio of specialist services, some of which differ. Though they refer patients to each other in some instances, there are some services which one site provides but where the other site refers to different tertiary providers due to previous clinical network arrangements. Referral patterns will be reviewed and harmonised where appropriate allowing services to be provided as locally as possible for patients, keeping travel time to a minimum for the local health population. This will also enable clinical teams to be more responsive to service configuration changes.

5.6.3 Using the scale of the new organisation

Both trusts currently experience long-term vacancies across a number of specialties leading to high use of premium-rate locum and agency staff. One of the central aims of the new organisation is to retain and attract the best staff.

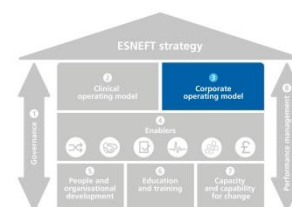
By using the scale of the new organisation it will be able to offer more opportunities for training, development and career progression. This will be achieved in several ways:

- 1. Cross-site working:** Many clinical teams in the new organisation will have the scale to cross cover, increasing the robustness of rotas and reducing the reliance on temporary staffing. In some instances, this will also increase the capacity of the service, helping to reduce waiting times and reduce the reliance on outsourcing and running additional out-of-hours sessions.
- 2. Single teams:** Combining clinical teams into single services in the new organisation creates the opportunity for greater sub-specialisation and service development. This makes roles more interesting and attractive, enhancing recruitment and retention as well as creating more opportunities for career progression.
- 3. Streamlined recruitment:** The new organisation will be the biggest NHS employer in East Anglia and the ability to recruit as a single organisation will be stronger than as two smaller DGHs, enabling services to offer more attractive posts within a larger scale service.
- 4. Better training:** There will be better access to more training opportunities in the new organisation, with further sub-specialisation. There is also the potential for increased academic links to provide further training opportunities. Additionally, it is anticipated that the organisation will be able to draw in better candidates to undertake the training roles and will also be able to offer rotations between sites and care settings (i.e. specialised, acute and community).
- 5. Alternative roles:** There will be greater opportunity to develop alternative roles to help manage growing demand, address gaps in medical rotas and make posts more attractive in the new organisation.

6. **Key worker and student facilities:** rationalisation of the ESNEFT estate will release peripheral land with the potential to develop better facilities to support key workers and students at the outset of their careers and to attract high quality trainees.
7. **Research and innovation:** The increased scale of the new organisation will allow the trust to take part in more research and innovation. The research and innovation team will be responsible for fostering new partnerships, securing funding and overseeing research and innovation activities. This will include creating academic research posts and extending the range of clinical trials available to patients.
8. **New on-call arrangements:** A number of specialties (e.g., ENT, Urology and Cardiology) have identified the opportunity to combine on-call arrangements to mitigate gaps in existing rotas or reduce their intensity, thereby reducing the burden on staff, improving retention and making posts more attractive to future recruits.

5.7 Element 3: Corporate model

Corporate services provide professional and administrative support to the clinical teams and are essential to the effective and efficient delivery of clinical services.



There are significant opportunities to improve the way in which corporate services deliver their support. Many processes currently rely on the manual collection and analysis of information. These are often paper or spreadsheet-based and can also include the entry of the same data into multiple IT systems. This is inefficient and labour-intensive. Customers (patients and staff) of these services have a bewildering array of communication routes and IT systems to negotiate in order to get what they need. The arrangements for advice, information and change-requests are not standardised and are sometimes unpredictable in the length of time taken to respond. Cumulatively, this can lead to significant delays in processes and wasted time for patients and staff trying to find out what is happening next. This is a significant cause of avoidable stress and reduced patient and staff satisfaction with the trusts.

In contrast, customers' day-to-day experience of life outside of the hospitals includes many easy-to-use self-service systems such as online or telephone banking, web-based holiday booking and service-desks which call the customer back instead of making them wait. The corporate model for the new organisation will make better use of customers' time.

Corporate services will make a key contribution to the three organisational objectives:

- See people at the right time
- Provide the latest treatments locally
- Retain and attract the best staff.

In order to achieve this, corporate services will be delivered through a new operating model, which stratifies the activities of the functions in three ways as illustrated in Figure 5-5. This model aims to separate routine, relatively-simple processes from more complex ones. With the right self-service tools, many customers will choose to complete these simpler processes quickly and easily, without the need for corporate services staff to assist them. This will save patients and staff time and

unnecessary stress; it will also give time back to corporate services staff to offer a higher level of professional support for more complex issues.

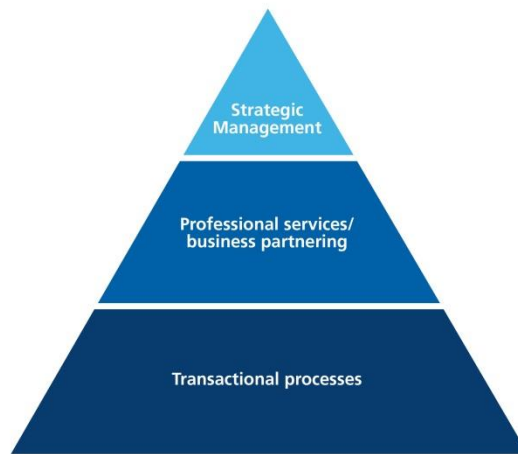


Figure 5-5 Corporate operating model

5.7.1 Transactional processes

Transactional processes are repetitive, usually frequent or high-volume and have a consistent link between inputs and outputs. This might include the updating of changes of address (for patients or staff) on multiple IT systems.

In the new organisation, corporate services will automate transactional processes that rely on multiple manual interventions, giving staff the technology and tools that equal those in their private lives⁶³. This will include increasing the opportunities for customers to meet their needs through self-service portals and service desks.

5.7.2 Professional services/business partnering

Professional services offer high levels of expertise. Freeing professional corporate staff from high volumes of transactional processes will give them more time to support customers. Corporate business partners will have more time to provide professional advice and expertise where it is needed most.

5.7.3 Strategic management

Strategic management is focussed on the delivery of the trust's vision and aims through the alignment of planning, investment and operational activity. This will include:

- Consistent and end-to-end focus on customers
- Consistent corporate behaviour, with a stronger identity and brand
- Proactive behaviour based on agreed priorities and service levels.

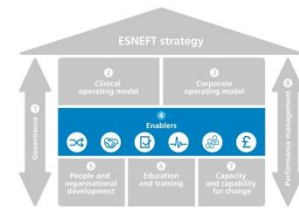
⁶³ for example self-service banking and travel apps

The corporate model will be supported through the delivery of the six key enablers (Element 4), as described below.

5.8 Element 4: Enablers

Six key enablers have been identified that will support the delivery of the overall objectives. These objectives are:

- Integrating the new organisation in all aspects of culture and governance
- Standardised and streamlined processes to save time, duplication, re-working and variation
- Using technology delivered through portals and self-service applications
- Using data and analysis to support decisions and not just for reporting
- Investing in staff to develop skills and respond to changing needs
- Maximising the benefits of the scale offered by the size of ESNEFT.



Fully integrated organisation

Integrating the culture, systems and structures across the organisation

The accountability model is based on a single leadership team – clinical and corporate – operating across the organisation. This will be delivered by:

- A unified leadership and governance structure with a single leads accountable for services across all sites
- A unified approach to performance management
- A unified specialty approach to quality and corporate governance
- A single suite of supporting IT systems



Process standardisation

Standardising and harmonising ways of working to reduce unwarranted variation.

This will be achieved across all the clinical and corporate areas by:

- Mapping workflows, with expected timings, for all core processes
- Developing one set processes, policies, and procedures that will be embedded consistently and with a focus on compliance
- Driving standardisation, simplification, automation and self-service
- Investing in robotic process automation and other innovative techniques.



Portals and service desks

Ensuring the majority of issues are resolved before reaching professional teams.

This will be delivered by:

- Most enquiries being resolved through online, self-service portals
- Service desks being supported by AI ‘virtual agents’ in time (app, web, phone, email)
- Intelligent escalation passing the issues that cannot be resolved first time directly to the right specialist team.



Data tracking and analytics

Ensuring that high quality clinical and non-clinical information is available to support decision making and system control

This will be delivered by:

- Clinical and non-clinical data analysis to provide descriptive, predictive and prescriptive insights. The objective is to improve decision making, management reporting and managing risks for patients and trusts
- Tracking and scheduling (including RFID⁶⁴) to optimise flows of patients, staff, equipment and consumables.



Investing in people

Ensuring that staff have the skills and opportunities to support or deliver high-quality care and develop their careers within the trust.

This will be delivered by:

- Engaging staff through a programme to align behaviours and values across the merged organisation
- Developing staff by identifying, attracting and building the skills and capabilities needed of the workforce in the next five years; with leadership development and succession planning in place
- Recognising staff offering a clear career pathways for all clinical and non-clinical staff with opportunities to advance
- Developing opportunities for key worker and student accommodation by the release of surplus estate near the main sites

Further details can be found under People and organisational development (Element 5) below.

⁶⁴ Radio-frequency identification



Maximising scale

Ensuring that the best value is delivered and efficiencies from scale and standardisation are achieved.

ESNEFT will be the largest trust in East Anglia, employing almost 10,000 staff with an operating budget of over £660m. The scale of the trust offers significant opportunities for operating efficiencies.

This will be delivered by:

- Defining the required level of service consistently across sites
- Identifying accountable individuals for service delivery
- Considering sourcing strategy options (internal, third party, partnerships, etc.)
- Considering scope for economies of scale and/or renegotiating existing contracts
- Considering timing and fit with existing suppliers and contracts
- Considering market testing where appropriate
- Implementation and contract management as appropriate

5.8.1 Delivering the ESNEFT objectives

The Element 4 enablers detailed above are key to delivering the objectives, as shown in Table 5-3.

Table 5-3 Objectives and delivery enablers

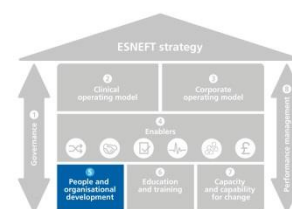
Objective	Required outcomes	Fully Integrated organisation	Streamlined processes	Portals & service desks	Investing in people	Data tracking & analytics	Maximising scale
Improved quality and patient outcomes	Increased capacity and access to care through cross-site working and single teams to deliver more effective services without additional cost [national standards]	✓	✓	✓	✓	✓	✓
	Improved patient experience through greater control of their care		✓	✓		✓	
Better value for money	ESNEFT costs match the upper quartile Carter level [estates, etc.]	✓	✓	✓	✓	✓	✓
	Reduced reliance on temporary staffing solutions in all areas [staffing]	✓	✓	✓	✓		✓
	Reduction in non-pay spend [procurement]	✓	✓			✓	✓
	Improved processes and automation reduces administrative burden [business process]		✓	✓	✓	✓	
Sustained and	Care closer to home, in line with STP strategy [community]	✓	✓	✓	✓		

Objective	Required outcomes	Fully Integrated organisation	Streamlined processes	Portals & service desks	Investing in people	Data tracking & analytics	Maximising scale
improved access to services	Greater access to a range of specialist procedures locally [tertiary]	✓	✓		✓	✓	✓
	Access to clinical trials and innovative techniques [innovation]	✓	✓				✓
	Greater volumes of activity to maintain services [sustaining services]	✓	✓			✓	✓
Sustainable, skilled workforce	Reliable, competent and consistent quality of staff	✓	✓		✓		✓
	Improved staff satisfaction	✓	✓	✓	✓	✓	✓
	Greater opportunity for training, development and career progression	✓			✓		✓

5.9 Element 5: People and organisational development

5.9.1 Introduction

At the core of the merger is the focus on creating high performing clinical, operational and support teams that achieve the best outcomes, in the quickest time and using the latest practices, for patients. This will be delivered in an environment that supports the workforce in their personal and professional development, making the trust an employer of choice both nationally and locally.



Staff are critical to making the trust philosophy of *time matters* real for patients and their families/carers and for each other, only through the commitment and efforts of its staff, will the trust improve services to make every moment count.

Focus on time matters will be enabled through delivery of an organisational development (OD) strategy and in new ways of working for clinical and corporate teams that support the model of service the trust aims to deliver. The restructured corporate functions, and a new logistics division, will support the delivery of care more efficiently and effectively.

5.9.2 Organisational development strategy

The OD strategy will be a key enabler in achieving ESNEFT's ambition and the delivering the benefits as presented throughout this business case; its implementation is crucial to the success of the new organisation and will be developed in partnership with stakeholders and staff. Once developed the OD strategy will provide:

- A shared vision, values and purpose of the organisation, embedded and understood by all that evident through a culture which respects everyone's time
- Strong board level leadership, visible and closely connected to the rest of the organisation

- Strong clinical leadership and organisational structures that deliver the vision and principles of the organisation
- Highly engaged and supportive stakeholders, including staff, patients and carers, the public and members.

A fundamental outcome of the OD strategy will be to ensure that each individual within the organisation understands how their role contributes to success of the organisation.

5.9.3 Understanding the cultural baseline

Cultural considerations are often not given enough emphasis during integrations⁶⁵, and this is cited as the most common reason why mergers fail to achieve their projected benefits. Although both organisations are fundamentally aligned to the values of the NHS, a cultural survey, conducted through desk top research and interviews, was undertaken with the senior clinical leadership teams and the executive teams found key differences in the way that each trust is organised and works in practice.

The aim of the diagnostic survey was to harness the cultural similarities of the organisations, understand the key differences and what action could be taken to mitigate risks that may result from the differences. More importantly, looking to the future, this provides a maturity analysis on the culture needed to deliver the new organisations vision.



Figure 5-6 Cultural Maturity Index: key findings from the cultural survey

5.9.4 Developing the OD strategy

The ESNEFT Board will oversee the development of the OD strategy and ensure accountability for delivery; with a vital role in shaping the culture, behaviours and values and in challenging actions and activities which do not support it.

The strategy will be developed using the principles and phases set out in the NHSI *Culture and Leadership* toolkit⁶⁶. A Phase 1 diagnostic review has been completed; the next stage of engagement activity is planned for Q2 and 3 2018/19, with staff and key stakeholders to understand what

⁶⁵ Mergers in the NHS, lessons learnt and recommendations: Cass Business School and NHSI (2016)

⁶⁶ Available at <https://improvement.nhs.uk/resources/culture-and-leadership/>

matters to them and what further needs to be done to achieve a 'right shift' in the cultural maturity matrix indices as shown in Figure 5-6.

This will enable the trust to develop and evaluate strategic ideas and options for cultural and OD change. Following a final engagement programme with key stakeholders, the final OD strategy will be completed by Q1 2019/20.

5.9.5 Equality and diversity

ESNEFT will continue the existing strong commitment of CHUFT and IHT to value equality, diversity and inclusion in service delivery, training and employment. This will be strengthened with the appointment of a dedicated lead. The new trust will develop a plan to challenge stigma and discrimination and address any under representation of staff groups with protected characteristics in middle and senior management posts.

Workforce diversity data will be collected to provide a baseline to demonstrate progress and to ensure the workforce is reflective of the communities served. Data on the current gender, age and ethnicity of CHUFT and IHT is included at Appendix 9.

5.9.6 Managing people through change

5.9.6.1 Developing organisational structures

The structure of ESNEFT will support the development of a strong leadership and accountability culture. In developing plans for ESNEFT, a number of design principles were agreed to guide and drive consistency in the development of the 'to be' organisational structure.

The organisational structure is a key element of the future operating model and the organisational design principles (in Appendix 4) are aligned with and support the overall corporate and clinical design principles.

5.9.6.2 Harmonising employment terms and conditions

Within the workforce programme actions have been identified to highlight variations in the development of terms and conditions for employees. There are inevitably some areas where for example grading of posts apparently with equivalent duties are not consistent between the old organisations. In particular arrangements for additional duty payments for example for additional sessions at weekends are different. These issues will need to be addressed early to establish a consistent approach.

5.9.6.3 Management of people transition

All organisational changes will be made through application of best professional practice and in line with the relevant employment legislation. The consultation requirements for TUPE and any potential redundancies or redeployments will be in line with the legislative requirements and the policies of both organisations. Every effort will be made to minimise any staff redundancies. Where people are displaced workforce professionals will work with them to find suitable alternative positions, including, where feasible, on the job training.

Throughout this process, there will be active and consistent partnership working with recognised Trade Unions and, where appropriate, other staff representative bodies.

5.9.6.4 *Transfer of Undertakings (Protection of Employment): TUPE*

Although in practice the two trusts are merging, with regard to the transfer of staff the requirement will be for IHT staff to transfer under the TUPE regulations to ESNEFT on their current terms and conditions of employment; CHUFT employees will also be employed by ESNEFT but contracts will not need to transfer.

5.9.6.5 *Practical Support*

Recognising that change can be challenging, all staff will continue to have access to internal and external independent support. Those leading the organisational change are being offered change management and people leadership training and development.

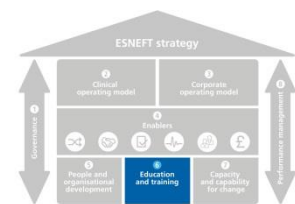
5.9.7 *Overview of the workforce benefits*

The benefits for the workforce of the merger and development of the OD strategy will be:

- The size of the new organisation will offer more dynamic and diverse roles, across sites, in bigger teams, with broader and more challenging work placements.
- A shared vision, underpinned by values and behaviours that are embedded and understood by all.
- Strong visible inclusive leadership with the board connected to the organisation.
- Highly performing workforce who understand and buy-in to their personal role in delivering the vision/strategic aims.
- Creating career development opportunities through effective talent management programme, succession planning, grow your own programmes and connections with schools and education providers across the communities.
- An understood and trusted employer brand based on high level of staff and patient satisfaction and engagement

5.10 Element 6: Education and training

Currently, responsibility for education and training is dispersed across different departments and executive portfolios within CHUFT and IHT. There are some notable areas of high quality and innovation, such as the development of physician associate training at IHT and the nursing OSCE training programme at CHUFT. However, the quality of education and training in other areas, such as junior doctor experience at CHUFT, and the lack of career progression and development opportunities reported in exit interviews at both organisations are likely to be contributors to the ongoing recruitment and retention challenges.



Key staff groups are particularly challenging for recruitment and retention, as detailed in Element 5. The creation of new staff roles and the development opportunities for staff in all groups will be important ways in which the new organisation addresses this.

The new organisation will employ over ten thousand staff and operate at a scale which permits a new consolidated approach to education and training.

5.10.1 Objectives

The new organisation will create a new faculty of education and training, with dedicated senior leadership, to support the professional and executive leadership within ESNEFT.

The faculty of education and training will:

- Raise the quality, consistency and scope of the education and training available to all staff
- Develop a culture of lifelong learning, with the goal of all staff in education or training throughout their career
- Position the new organisation as a preferred destination for staff in the east of England
- Create strong partnerships with universities, medical schools and other existing education providers
- Become accredited to provide qualifications in due course.

5.10.2 Benefits

The faculty will:

- Co-ordinate career pathways and development opportunities across ESNEFT, taking advantage of the increased number of departments, roles and specialties
- Develop the scope of education and training for an integrated health and care environment including:
 - multidisciplinary training to improve safety, quality and co-ordination of care across settings
 - developing new staff roles to meet workforce challenges
 - offering co-designed education and training to partner organisations in the STP and wider
- Improve the quality and consistency of the education and training offer to staff to increase retention
- Become a beacon for staff recruitment
- Enhance the reputation of ESNEFT as an employer and a partner in the wider economy.

5.10.3 Operating model

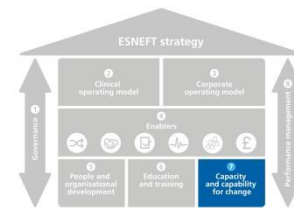
The development of the faculty of education and training is a long-term plan. The initial step is to establish a project team to develop the brand and business plans.

In the first year following merger the priority will be the successful consolidation of training and professional education programmes into the single organisation and the establishment of an education and training board to co-ordinate work. ESNEFT will create an entrepreneurial academic leadership role to grow the department and further strengthen the offer.

Over the next three years the new organisation will create a range of academic posts in partnership with universities, including post-graduate and post-doctoral training posts, part-time research posts and research posts.

5.11 Element 7: Capacity and capability to deliver change

Building and maintaining the capacity and skills to deliver change and service improvement will be key for ESNEFT as it brings teams and individuals together. The scale of ESNEFT is such that it presents significant opportunities to develop in four key areas that will support change, see Figure 5-7:



- Quality Improvement (QI) methodologies
- Research and innovation
- Transformation and change management
- Logistics.

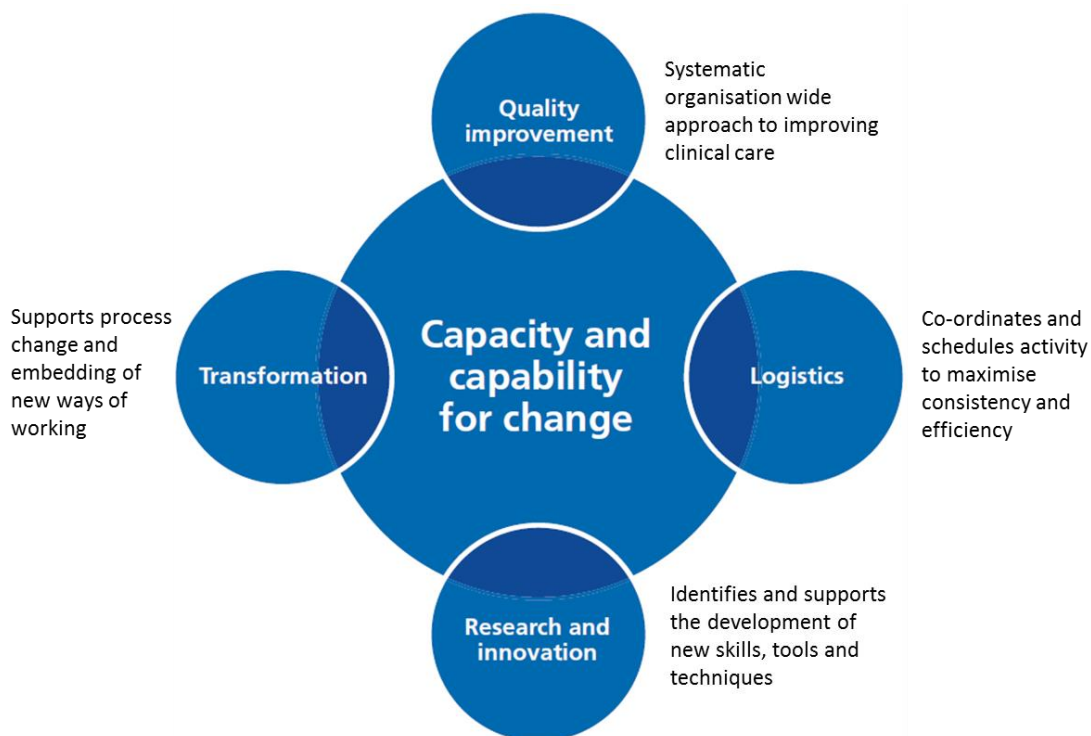


Figure 5-7 Capacity and capability for change

5.11.1 Quality improvement

In delivering the *Every Patient Every Day* programme of focussed activity at CHUFT the value of developing and implementing a consistent methodical approach to improvement was beneficial. In developing the partnership it was recognised that the nationally supported Quality Improvement (QI) programme would be a strong tool to support ESNEFT in delivering change and improvement.

QI is a systematic approach to improving health services based on iterative change, continuous testing, measurement and empowerment of frontline teams, which uses specific methodologies to enhance patient safety, outcomes and experience.

The Academy of Royal Medical Colleges has defined Quality Improvement⁶⁷ as:

- Using understanding of the complex healthcare environment
- Applying a systematic approach
- Designing, testing, and implementing changes using real-time measurement for improvement
- Making a difference to patients by improving safety, effectiveness and experience of care

QI should start with what is important to patients and not what is easier to address; staff need to be trained and supported to develop QI skills.

5.11.1.1 *Objectives and operating principles*

In the period leading up to the establishment of ESNEFT, the trusts are jointly developing an approach to QI that will create a QI Faculty (QIF) which will establish the support structure for QI development within ESNEFT from ward-to-board and in all staff groups. The faculty will support training, coaching, spreading learning, co-ordination and monitoring. This will help to develop a single QI ethos and expertise across ESNEFT.

The faculty will be multidisciplinary with clinical and non-clinical staff trained in QI methodologies. The faculty will be headed by a QI lead, medical lead and lead nurse roles and will be accountable through the medical director.

The faculty will provide:

- QI signposting to resources, coaching for teams for QI projects
- Leadership for QI education and training for staff
- Support for patient and carer involvement and engagement in QI programmes
- Oversight for capturing , monitoring and reporting QI activity
- Advice to the executive on priority QI programmes
- Links with national capability and excellence promoting initiatives including the Institute for Healthcare Improvement, the 'Q' initiative⁶⁸ and the Eastern Academic Health Sciences Network (EAHSN) quality collaborative.

In ESNEFT, QI will be an integral part of all clinical encounters. To make this happen will require:

- The spread of individual and team improvement capabilities
- Use of an agreed improvement methodology that is effective, easy for staff to engage with and learn
- An appropriate supporting structure with elements of education, training, project management and governance
- Linkages with external improvement communities and national benchmarking.

5.11.1.2 *Implementing QI*

To successful delivery the QI approach will require:

⁶⁷ *Quality improvement – training for better outcomes*, Academy of Medical Royal Colleges (March 2016) Available from <http://www.aomrc.org.uk/quality-policy-delivery/improving-quality-and-standards/quality-improvement/>

⁶⁸ <http://www.health.org.uk/programmes/the-q-initiative>

Leadership and culture

- The QI ethos will be established and embedded at all levels, from ward-to-board and with local professional educational establishments.
- Improvement activity will be aligned with ESNEFT's strategic objectives.
- ESNEFT will encourage a culture that celebrates success, with processes to facilitate sharing of results and learning spread throughout the organisation and more widely. The culture must also celebrate 'failure', understanding that negative findings offer great learning value to improvement practice.

Infrastructure

- Provision of time and support for individuals, teams and trainers.
- Alignment of QI training/activity with the college/professional education programmes.
- Ensure the executive leaders support the QIF and similarly the QIF advises, prioritises and supports the quality improvement work streams identified by the executive.

Education and Training

- Multidisciplinary team to reflect team working in real hospital environment
- Include *Human Factors* training to develop a 'safety imagination' to allow staff to better understand/deal with risks in practice
- Provide QI training from induction, not as an add-on
- Link QI activity to professional development and standards
- Embed QI in every patient encounter; for example, develop a questioning culture during ward rounds - "How could we improve care for the person in front of us?"
- Provision of time and support for individuals and teams to carry out quality improvement projects in their own workplace with real life experiential learning
- Development of a trained QI faculty with enthusiastic and skilled clinical and non-clinical staff

5.11.1.3 Patient involvement

Patients and carers will be at the centre of the QI programme; they bring their unique knowledge and experience, are expert on the experience of being a patient and often an expert in their illness.

Engagement of patients, carers and the public in quality improvement projects will include:

- Involvement in the strategic direction of quality improvement projects
- Partnership in respect of standards and outcomes to be measured
- Active participation in data collection where possible, for example, through interviews, surveys, and analysis and scrutiny of quality improvement project data
- Involvement in communications around quality improvement activity
- Involvement in quality improvement project governance.

5.11.2 Research and innovation

CHUFT and IHT have research and development departments, incorporating innovation within their remit. The majority of activity is focussed on research through the Eastern Clinical Research Network (CRNE), which supports delivery of the National Institute for Health Research (NIHR) portfolio. This is a mixture of non-commercial and, increasingly, commercial research. There is also a smaller amount of non-portfolio commercial research.

Each organisation has areas of strength with IHT recognised nationally as a leading centre for diabetes research and CHUFT for haematology. The range of specialties is different in each.

Research in CHUFT and IHT faces a number of challenges. This includes the recruitment of patients into studies, which is significantly lower at both organisations in 2017/18 compared to the previous year. CHUFT and IHT recruited 3,841 patients into studies in 2016/17, approximately 0.4% of all outpatient attendances compared to 0.65% nationally⁶⁹. In CRNE, IHT ranks 7th and CHUFT 15th in terms of number of patients recruited in 2017/18 year-to-date.

There are currently 34 principal investigators⁷⁰ (PIs) in 15 specialties at CHUFT and 67 PIs in 25 specialties at IHT. In 2016/17 patients were recruited to 76 studies at CHUFT and 93 studies at IHT.

CRNE also measures value-for-money⁷¹ and both organisations perform poorly on this measure, ranked 18th (CHUFT) and 17th (IHT) of 18. This is particularly challenging as NIHR funding for research is falling year-on-year and CRNE are increasingly linking future funding to value-for-money performance. In 2017/18 both organisations saw CRNE funding for research reduced by 5% and in 2018/19 this will reduce by a further 6.5%. CRNE expect that trusts will increase their commercial research activity to support activity.

The approach to innovation in CHUFT and IHT is more ad-hoc, again with some notable successes in recent years including the creation of a research fellowship at IHT and the Icenicentre at CHUFT⁷². However, there is a lack of systematic enablers to innovation and poor uptake of external opportunities. For example in the last year there were no bids from either organisation to the small business research initiative⁷³ (SBRI) and the uptake of the innovation and technology payment⁷⁴ (ITP) schemes is low in both. Neither organisation has taken advantage of funding through the national knowledge transfer partnership (KTP) scheme⁷⁵ which supports graduates to bring innovations into practice.

The new organisation will have a single research team and a new innovation team to give clear focus to this activity.

5.11.2.1 Objectives

The new department will:

- Maximise the number of patients offered the opportunity to be involved in clinical trials
- Extend the scope and volume of research and innovation

⁶⁹ NIHR Annual Report 2016-17. The national figures include tertiary centres which have higher levels of recruiting than general hospitals

⁷⁰ Principal investigators are the lead researcher for a study

⁷¹ This is the number of patients recruited to non-commercial studies only, divided by the CRNE investment

⁷² The Icenicentre was originally a collaboration between CHUFT and Anglia Ruskin University and focussed mainly on surgical training and education

⁷³ SBRI healthcare is administered through the academic health science networks (AHSN). NHS England states that “the SBRI healthcare programme is based on taking a two-phased development approach, projects start with initial feasibility and can then move on to more detailed product development. Phase 1 contracts for feasibility testing are valued at up to £100,000 and last for six months. Phase 2 contracts for prototype development are worth up to £1 million over two years”.

⁷⁴ NHS England <https://www.england.nhs.uk/ourwork/innovation/innovation-and-technology-payment-201819/>

⁷⁵ Knowledge Transfer Partnerships is a UK-wide programme that has been helping businesses for the past 40 years to improve their competitiveness and productivity through the better use of knowledge, technology and skills that reside within the UK Knowledge Base <http://ktp.innovateuk.org/>

- Increase the number of active researchers and innovators, creating a community of practice
- Create a culture of research and innovation which supports activity and increases the opportunities available to all types of staff
- Build partnerships with commercial research and innovation partners to ensure sustainable activity.

5.11.2.2 *Benefits*

Evidence indicates that patients involved in clinical studies tend to have better clinical outcomes⁷⁶ therefore increasing the number of patients offered this opportunity will contribute to improving the quality of care. The new organisation will offer clinical studies to patients in 35 specialties, supported by over 100 active PIs. This will enable the new organisation to grow its recruitment of patients to levels equivalent to, or exceeding, some of the highest recruiting organisations in CRNE.

Innovation and research will provide ESNEFT with further opportunities for quality improvement and cost-efficiency through better processes and the introduction of new technology.

The reputation of ESNEFT will be enhanced, being recognised as a research-focused and innovative healthcare provider, through:

- Increasing performance against the NIHR high-level objectives for research, including the recruitment of a higher proportion of patients into clinical studies
- Successful bids for innovation funding
- Strong partnerships with industry and universities to increase the volume of innovation and research.

Research and innovation are intrinsically rewarding activities, offering a strong sense of personal satisfaction to staff involved as well as the opportunity to advance knowledge and improve the quality of care. Increasing the opportunity to be involved in these activities will contribute to staff satisfaction and improve the recruitment and retention of staff.

Income from research and innovation will be sufficient to sustain and grow the activity of the department.

5.11.2.3 *Operating model*

The new organisation will adopt a strategic focus on research and innovation as key drivers for quality improvement and transformation. This will develop a culture that supports staff, increases opportunities to participate, and recognises and celebrates research and innovation activity.

There will be a combined research team supporting all its researchers. A clinical director for research will lead the team and co-ordinate research activity across the new organisation.

A new innovation team will focus on increasing the identification of innovation and exploiting innovations from elsewhere. The Iceni Centre at CGH will expand its role to support innovation in the broadest sense and building on its links with industry. The innovation team will become self-sustaining within two years.

⁷⁶ *Research Activity and the Association with Mortality*. Ozdemir BA, Karthikesalingam A, Sinha S, et al. in Chalmers JD, ed. PLoS ONE. 2015;10(2):e0118253. doi:10.1371/journal.pone.0118253

The new organisation will develop partnerships with its local universities to drive innovation and develop opportunities for further transformation. This will include:

- Implementing a programme of internships in automation which will engage university students to rapidly build capacity and capability for these new approaches in the new organisation. This will also create a good opportunity to identify talented individuals when recruitment opportunities arise.
- Securing one or more KTP to support the innovation agenda, particularly in the transformation of clinical and corporate models.

5.11.3 Transformation

5.11.3.1 Introduction

Both Colchester and Ipswich hospitals have transformation teams who support the operational teams in transforming the delivery of services to patients.

5.11.3.2 Scope of the transformation programme

The current programmes of work are principally focused on the transformation of clinical services. In order to successfully deliver the FBC this will be broadened to include the design and implementation of the corporate model.

The work streams that will be established to deliver the FBC are:

- Logistics and corporate transformation
- ICT including automation
- Informatics
- Culture and organisational development
- Quality Improvement
- CIP

The transformation agenda also covers ongoing support to deliver business as usual operations and system working with partners (through the Ipswich & East Suffolk alliance and the North East Essex alliance). Other work streams within the transformation programme are therefore:

- Emergency care
- Elective care
- I&ES alliance integration
- North East Essex alliance integration

5.11.3.3 Transformation resources

To deliver the significant change agenda ahead will require investment in:

- An internal transformation team: The existing transformation teams will be brought together under one head of transformation, reporting directly to the managing director. Given the maturity of the relationship with I&ESCCG the team will consist of a minimum of 12WTE from the two hospitals plus additional support from I&ESCCG Transformation team seconded to ESNEFT, currently estimated to be between 5-10WTE.

- External capacity and capability: In the financial planning provision has been made for a budget to procure specialist expertise where skills and capabilities are not required in the organisation over the long term e.g. for the detailed design of the corporate model.
- Non pay budget: Provision has also been made to fund innovative ICT tools and technologies.

5.11.4 Logistics

The way in which the NHS interacts with patients is inefficient and highly complex. The use of technology is outdated when compared to how people interact with organisations in other sectors.

At the heart of the philosophy of time matters, is the ambition to remove stress from the process of accessing healthcare. CHUFT and IHT, along with the wider NHS, are currently using cumbersome approaches which are paper-based and time intensive, for example, in finding out the results of diagnostic tests, booking and changing outpatient appointments, being discharged from treatment. Opportunities to support patients to self-care are missed as the trusts do not have the technology infrastructure in place to communicate remotely and receive data from different devices and systems.

For staff, data is held in multiple locations requiring paper forms to be completed – for example new joiners, change of address, accessing training.

Key to delivering the organisation-wide approach is the creation of a new Logistics function.

5.11.4.1 The role of the Logistics function

The logistics function will be responsible for stitching the processes of the organisation together so that patient and staff interactions are efficient, effective and technology-enabled. Ensuring the right information, equipment and appropriately accessible space is available to optimise the time spent on delivering patient services. This will entail:

- Lifting out of how any one service works and looking at systems and processes between teams
- Creating the automated tools to aid flow and interactions
- Focusing on flow and the scheduling and tracking of assets throughout the organisation
- Using real time data to support timely decision making to vary capacity, enabling us to more effectively manage services to meet patient expectations and deliver financial balance
- Focus on standardising and streamlining ways of working.

This will enable the trust to limit the delays caused by administrative processes.

5.11.4.2 Scope of logistics

The scope of logistics will grow over time as processes are transformed. Initially, the focus will be on:

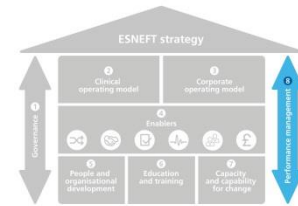
- Running and transforming the outpatient services to introduce greater automation and better technology to internal processes.
- Designing and building a patient portal to improve access to a range of self-service activities including appointment booking, viewing tests and submitting test results.
- Transforming how technology is used across the organisation to support real-time bed state information to enhance the Operations Centres, bed and site management teams.

- Working with the external patient transport providers to improve the booking and scheduling processes to improve the timeliness of patient discharges.
- Sterile Services Department and the introduction of track and traceability.
- Leading a RFID programme across the organisation (with ICT).
- Provision of real time management information to empower clinical and operational decision making to enable positive patient experience (with the Informatics Team).
- Detailed design of the corporate model for transactional processes including the design of one service desk and one staff portal for the organisation.

5.12 Element 8: Performance management

5.12.1 Performance and accountability framework

It is crucial that the ESNEFT board and executive team are clearly sighted on the performance management through the transition, and as the new trust mobilises from Day One.



Since May 2016 CHUFT has progressively introduced an approach to performance management and accountability that mirrored that established in IHT. The benefit of this is that culturally, as ESNEFT comes together, these systems are in place and well-embedded, but will need to be realigned for the new divisional reporting structure.

The model in use in both trusts demonstrates the rigor of an effective performance system; it is not stand alone, but instead is applied consistently across the trust and is integrated into the overall cycle of business.

ESNEFT will build on the existing performance management approach in CHUFT and IHT consisting of the following elements:

- Monitoring arrangements that accumulate data and produce reports to the boards, the Finance and Performance Committee (F&P) and the divisional boards and corporate departments that track the current position 'as is'.
- Board and board committee 'dashboard' reports that use a balanced scorecard approach to select key indicators from four organisational quadrants (quality, external, financial and workforce) together with a brief narrative.
- Performance reviews and performance improvement plans that concentrate on key areas of work where improvement would contribute significantly to trust performance or to improved service user outcomes.

Underpinning this will be the accountability framework, which includes indicators that enable monitoring of performance against national measures (set by NHSI, CQC), commissioner measures (for example, CQUIN, quality schedule key performance and quality indicators) and internal measures.

The accountability framework and reporting arrangements enhance the understanding and subsequent management of risk. Where performance against key performance indicators is not compliant with the required standard, this is escalated through the dashboard and the responsible

executive director is required to produce an improvement plan to outline the remedial action to be taken and set the trajectories for return to compliance.

The PTIP contains more detail of the approach to performance management that will operate in ESNEFT.

5.12.2 Quality and assurance compliance – front line service to board

ESNEFT's approach to quality assurance and compliance through the performance management and accountability reporting systems will, as at present in CHUFT and IHT, be replicated at all levels of the organisation.

Although the commonly used term is 'ward-to-board', to be inclusive of community services, ESNEFT is planning to use the term 'front line service to board'. Figure 5-8 illustrated this bottom up model of reporting and escalation.



Figure 5-8 ESNEFT quality assurance – front line service to board

5.12.3 Board assurance

The reporting structure is designed to ensure that, through the board assurance committees, the board is sighted on any non-compliance issues.

Figure 5-9 shows how the reporting information flows to support this.

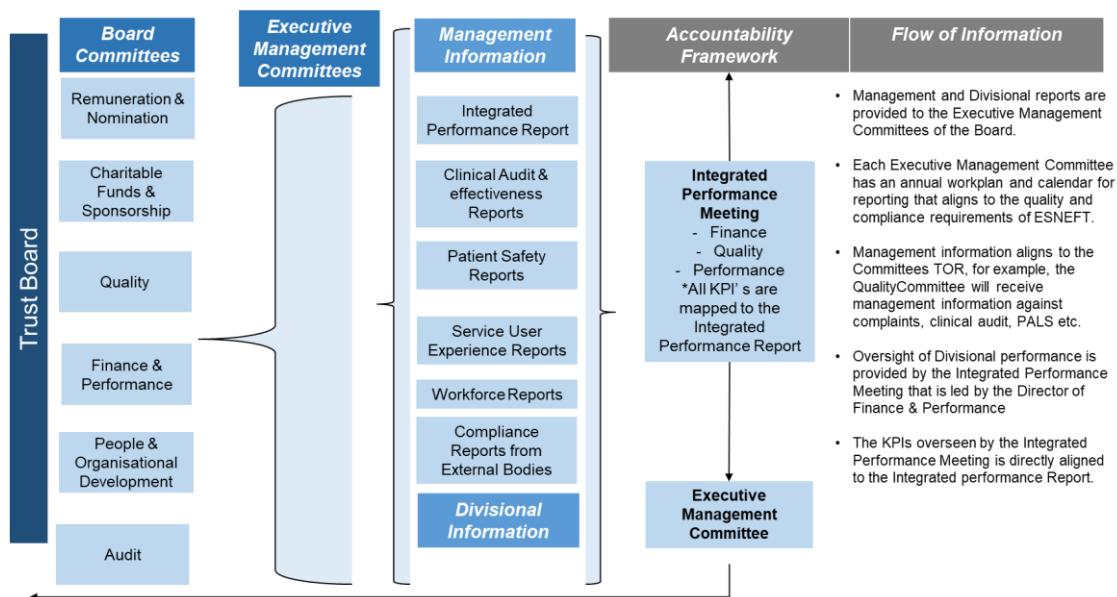


Figure 5-9 ESNEFT Matrix Reporting Structure

5.13 Benefits

Delivering the four objectives above is integral to ESNEFT delivering on an overall ambition to be rated as 'outstanding' or 'good' on all indicators in future CQC assessments, and to achieve an NHSI Single Oversight Framework segmentation rating of '1' or '2'.

Throughout the FBC a number of areas of benefit to patients, staff and the wider health system will be derived as a result of proceeding with the merger.

In considering the benefits these have been categorised against seven main criteria:

- Patient outcomes
- Patient experience
- Clinical sustainability
- Workforce sustainability
- Financial sustainability
- Alignment and strategic fit
- Execution risk

For each criterion, a select number of indicator measures have been identified with a planned date for attainment.

Sitting below these identified measures are a wide range of performance indicators, compliance with which will contribute to attaining the overall measure. These contributory measures will be managed through the granularity of the trust's performance management and accountability framework.

Table 5-4 details the overall mapping the benefits of the merger.

Table 5-4 Benefits tracking and targets

Criteria	Description	Indicator/measure	Target
Patient outcomes	Plans support the patient's clinical needs and deliver improved outcomes wherever possible.	CQC Safe and CQC Effective domain ratings	CQC Safe and CQC Effective: Good or Outstanding
		Mortality (SHMI)	SHMI within expected range from end of Y1 with a reduction over 3-5 years
		Morbidity (Sepsis)	Effective sepsis screening and time to intravenous antibiotics for red flag patients - 90% within 1 hour by end Y1
		Delayed Transfer of Care (DToC)	NHS DToC <1.0% by end Y2
		GIRFT responding to recommendations	Set a strategy that responds to GIRFT by the end Y1
Patient experience	Plans improve the experience of patients, their families and carers matching capacity to demand at their preferred location(s) for care where practicable.	CQC Caring domain rating	CQC Caring: Good or Outstanding
		Time matters – composite patient time loss indicator	Patient time lost indicator – under development
		National Patient Survey	Top 20% for Patient Survey by Y5
		Friends & Family Test (FFT)	FFT recommended by 97% of patients by Q2 Y3
Clinical sustainability	Plans improve clinical sustainability and support the delivery of acute and emergency services across 7-days. Moreover, plans should ideally contribute to innovation, research, education and training and provide regional competition for the delivery of excellent healthcare thereby helping the new trust to retain and attract the best healthcare professionals.	CQC Responsive domain rating	CQC Responsive: Good or Outstanding
		Time matters – composite staff time lost indicator	Staff time lost indicator – under development
		National Access Standards	Deliver trajectories as agreed with NHSI
		Compliance with accreditation standards	Ongoing compliance
		7-Day Services Standards	Deliver key four 7-day standards by end Y1 Deliver all 7-day standards by end Y2
		Research	Increase the number of patients benefitting from enrolment in NIHR portfolio and other research by 50% by end Y2 Top quartile of Clinical Research Network (CRN) recruiting trusts by end Y2
Workforce sustainability	Plans improve workforce sustainability and support the delivery of acute and emergency services across	CQC Use of Resources domain rating	CQC Use of Resources: Good or Outstanding
		National Staff Survey	Top 25% for National Staff Survey by end Y5

Criteria	Description	Indicator/measure	Target
	7-days. Plans should contribute to the delivery of excellent healthcare thereby helping the new trust to retain and attract the best healthcare professionals.	Vacancy factor and staff turnover	Vacancy factor of less than 6% by end Y3 Staff turnover less than 10% by end Y3
Financial sustainability	Plans contribute to the development of a financially sustainable health economy (using consistent quantitative analysis).	CQC Use of Resources domain rating	CQC Use of Resources: Good or Outstanding
		ESNEFT Control Total	Achievement of Control Total Annually
		Reduction in corporate costs	Benchmarked in top 10% for corporate efficiency cost compared to peer by Year 5
		Agency Cap	Achievement of agency ceiling annually
Alignment/strategic fit	Plans align with the STP's clinical vision and has the support of commissioners. Plans take account of compatibility with emerging national policy (such as the integration of health and social care and delivery of care that is convenient to access) and anticipated developments in healthcare.	CQC Well-Led domain rating	CQC Well-Led: Good or Outstanding
		Trust Strategy approved by STP Board	Trust Strategy approved by STP Board by end Y1
		Delivery of relevant milestones in the STP Plan	STP milestones met on time
Execution risk	Plans must be assessed for likelihood of organisation being able to maintain effective performance management and meet all regulatory and statutory requirements.	Achieve and maintain Segment 2 (or better) of NHSI Single Oversight Framework.	SOF Segment 2 by Q1 Y2
		No legal or regulatory action as a result of the transaction.	Zero actions at Q3 Y1

6 Financial Strategy

6.1 Introduction

The merger of CHUFT and IHT is a key part of the STP plan to achieve financial balance and achieve a financially sustainable position for the acute services within the area. The merger will result in gross financial savings of £28.5m per annum by 2023/24 (£21.9m net savings 2023/24).

This position includes anticipated gross capital investment of £69.2m to enhance infrastructure, support the improvement on the emergency care pathway and elective case. A capital business case has been submitted to the STP which continues to support the schemes as the highest priority on its overall capital investment plans.

The Trusts are developing plans to achieve cost improvements over the five-year period of £109.6m, equating to an average of 2.6% per annum. Given the historic level of CIP achieved by both Trusts this is a challenging target and the merger will provide additional opportunities to identify schemes to deliver the target.

The importance of achieving a financially sustainable organisation is a priority for ESNEFT, and in addition to the CIP the merger benefits identified above are significant steps in achieving this. The enlarged organisation is still forecasting an underlying deficit position of £27.8m after STF and post-merger benefits identified by 2023/24. The remaining deficit needs to be addressed through delivery of the benefits of clinical integration. Detailed plans will be developed as part of the ESNEFT clinical strategy, and the benefits modelled in the annual planning process. Figure 6-1 shows the overall bridge chart to arrive at a break even position in 2023/24.

As part of the STP, ESNEFT will continue to progress the development of system control totals with commissioners which will support the ethos of STP risk/gain share.

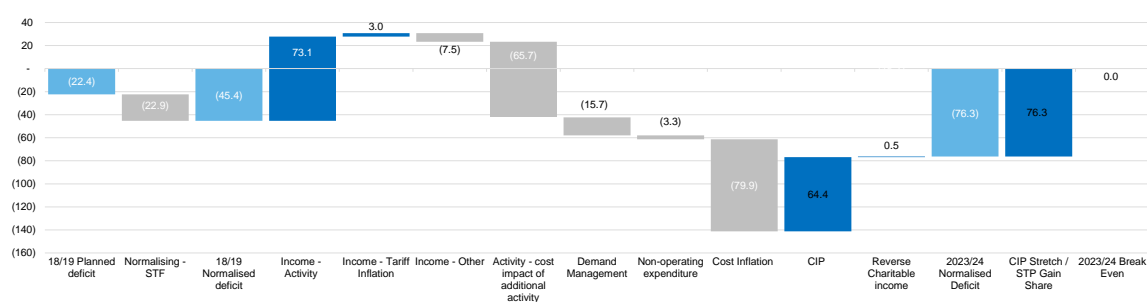


Figure 6-1 2018/19 to 2023/24 break-even bridge

6.2 Overview

In common with the wider NHS, both CHUFT and IHT reported deficits in 2016/17 and in the previous two years. The deficits were reduced in 2016/17 compared with 2015/16, in part due to the receipt of £16.5m sustainability and transformation funding (STF).

The forecast outturn for both trusts for 2017/18 is for the deficit position to continue, with a slight worsening in the underlying position at IHT but a significant improvement at CHUFT.

The combined reported forecast deficit for CHUFT and IHT in 2017/18 is expected to be £22.4m, increasing to £49.7m by 2023/24. This forecast deficit is a 'Do Nothing' position and assumes that both organisations continue to operate as standalone entities (the counterfactual proposition). The forecasting has incorporated the impact of STP support to both providers. Both trusts are in receipt of increased STF to support their financial positions and, despite this, are not projecting a return to break-even within the next five years.

The STP funding has been assumed to be non-recurrent and therefore the underlying deficit is higher. The forecast combined underlying deficit for CHUFT and IHT in 2017/18 is £45.3m, which increases to £76.3m by 2023/24. The deterioration is driven by planned cost improvements being lower than cost inflation impact by £15.5m. The key difference in the assumed being a 10% (£12.5m) annual impact of CNST. In addition, the trusts have modelled the impact of demand management cautiously with income being removed at 100% and cost being reduced at the marginal rate of 70% resulting in deterioration £15m over the forecast period.

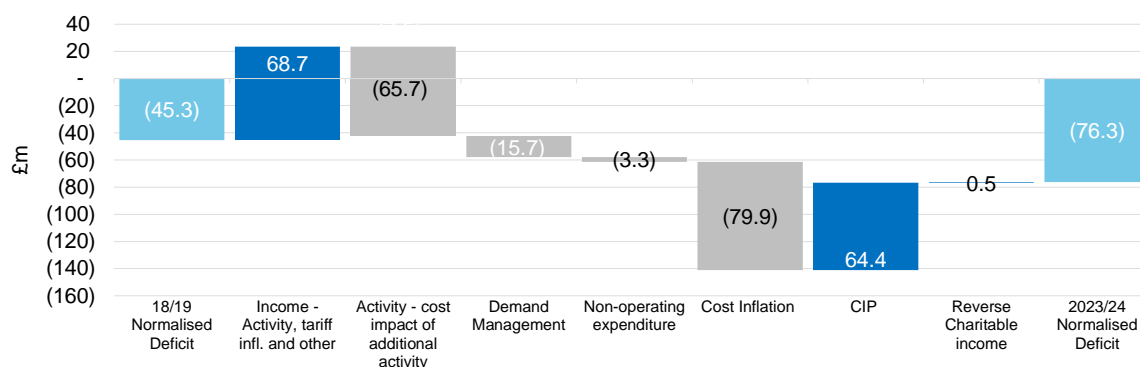


Figure 6-2 Combined 2018/19 to 2023/24 'Do Nothing' bridge – the counterfactual

As a consequence of running significant deficits for a number of years, both trusts have difficult cash positions; the year on year deficits have led to significant accumulated levels of debt, leading to ongoing problems with liquidity.

This financial case reflects work that can progress immediately to deliver the ESNEFT clinical and corporate models. The implementation of these, together with the requested capital investment to support merger will result in around half of the underlying deficit of the organisations being addressed by 2023/24.

In the longer-term the ability of ESNEFT to achieve a standalone balanced financial position will depend on making transformative changes to the ways in which clinical services are provided and

further discussions with commissioners about how the sharing of gains from demand management activities may be addressed through the new system control arrangements.

Work to address these two key issues is taking place and the trusts are continuing to identify the additional potential benefits (both quality and financial) that can be achieved by merger.

The ambition in the long-term, through service developments and reconfiguration is for ESNEFT to achieve a break-even position.

6.3 Key developments since the OBC

Since the OBC was approved by the boards in August 2017, work has continued in planning for the future financial model with staff, commissioners, the wider STP and NHSI. In this period the key areas of development relevant to the financial case have focused on:

- **Capital funding business case:** this was submitted to NHSE in January 2018 and is a key element to the success of the merger. The capital funding has been given the highest priority by the STP to enable the hospital reconfiguration to support clinical strategies post-merger and consultation and the business case has now been submitted for approval.
- **Development of stretch of clinical and corporate benefits case:** further work has been completed to develop the investment requirements and resulting benefits from the clinical and corporate models.
- **Updated 2018/19 control total:** the trusts have agreed the 2018/19 control totals and the March 2018 annual planning submissions are included within the financial case. STF has been modelled and for the purpose of this case have been assumed to be received through to 2023/24.
- **Completion of financial due diligence (FDD):** Financial due diligence has been undertaken by both trusts and considered as part of the preparation of the FBC. No adjustments have been made as a result of the FDD to the baseline figures. Where appropriate, risks have been considered as part of the downside modelling.

6.4 Historic trust performance and STP context

6.4.1 North East Essex and Suffolk STP

The North East Essex and Suffolk STP plan⁷⁷ details the wider system challenges. During 2016/17 the STP income for health was £1.8bn which comprises CCG allocations spent within the system and provider income generated from outside of the system.

In 2016/17 the STP normalised deficit sat largely with the acute providers - £35.8m at IHT, £10.2m at WSH⁷⁸, and £40.3m at CHUFT - with a further £4.8m within the Mental Health Trusts. In 2017/18 this position remained largely unchanged. IHT (£33.5m) and CHUFT (£34.7m) still have the largest underlying deficits followed by WSH (£12.6⁷⁹).

⁷⁷ Suffolk and NE Essex STP Implementation Plan (October 2016)

⁷⁸ West Suffolk Hospital NHS Foundation Trust, Annual Accounts 2016/17

⁷⁹ West Suffolk Hospital NHS Foundation Trust Board Report (February 2018)

STP health funding (excluding STF) is mainly derived from CCG allocations and is expected to grow at a rate of between 2.6-4.3% each year in the planning period. This growth in allocation is not expected to be sufficient to address the cumulative impact that inflation and increased demand are expected to generate year-on-year, with an expectation that without a plan to address this shortfall the 'do nothing' deficit position of the STP will have increased from £84m (2016/17) to an estimated £248m by 2020/21.

The plan to achieve financial balance for the STP includes both cost avoidance and cost reduction measures with the proposed merger of CHUFT and IHT being a key cost reduction element but also as an enabler to higher cost avoidance. Figure 6-3 summarises the STP plan to achieve a breakeven position.

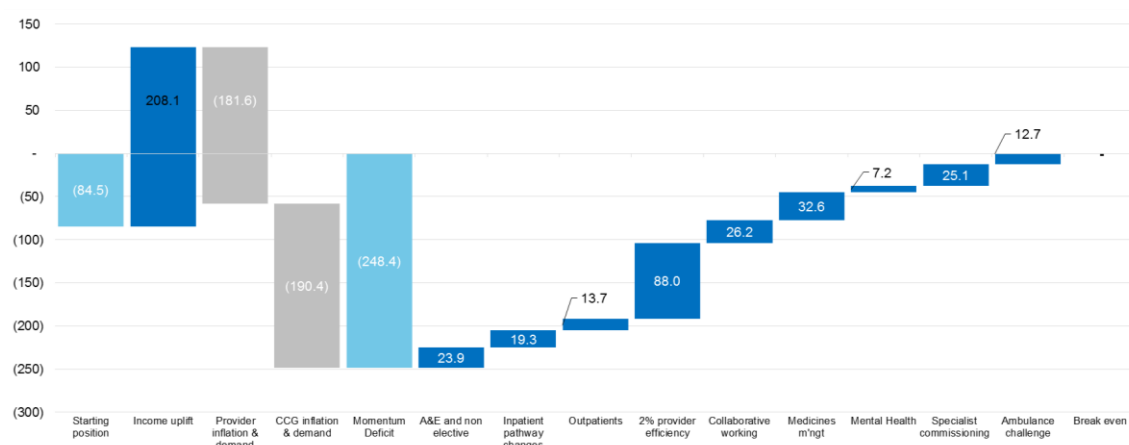


Figure 6-3 STP plan to breakeven

6.4.2 CHUFT historic performance

CHUFT first reported a deficit in 2013/14 (£2.4m) which significantly increased in 2014/15 and 2015/16 (£38.9m), as shown in Figure 6-4. Key drivers contributing to the downturn in the financial position were the tariff reduction, significant additional expenditure on agency/interim, and the costs of responding to the findings of Keogh review in 2013 as well as Trust identified risks.

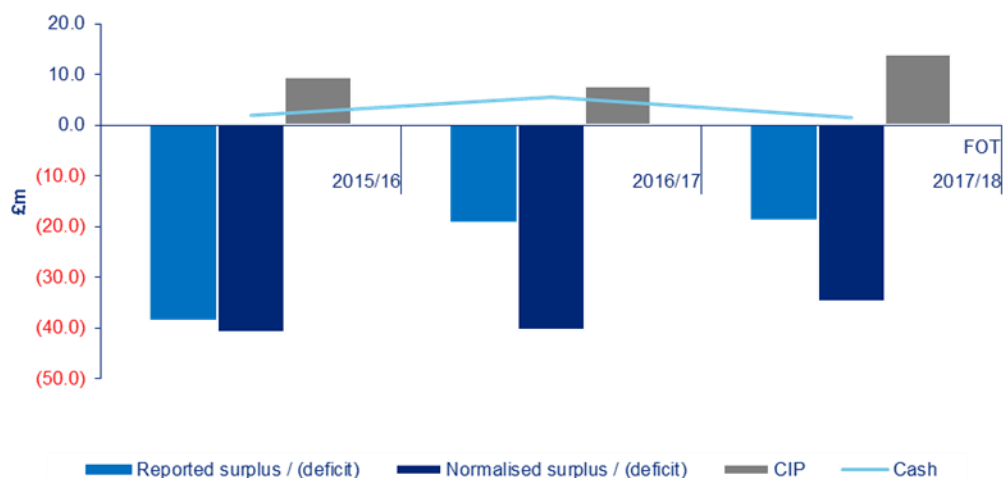


Figure 6-4 CHUFT historical performance

CHUFT stabilised its financial position in 2016/17 and in 2017/18 has improved both the reported and normalised position.

Trust specific control totals were first issued by NHSI in 2016/17, with CHUFT delivering against its target in 2016/17 of £31.7m. This was supported by £14.4m of STF of which £5.5m related to additional incentive funding for managing national pressures.

In 2016/17 a large proportion of CHUFT's income was also assured by a guaranteed income contract (GIC) with North East Essex CCG for emergency care.

The Trust expects to meet its 2017/18 control total of £22.1m and deliver an improvement in its normalised deficit of around £5.6m from 2016/17. There are two key factors to this:

- Improved income settlement with commissioners. The national tariff currency and prices were updated to HRG4+ in 2017/18 and resulted in a large increase in income due to the Trust. The Trust agreed a guaranteed income agreement with its clinical commissioning groups which although did not reflect this benefit in full did result in an improved funding settlement.
- Reduction in costs through improved CIPs delivery. The Trust is expecting to achieve £14m CIPs in 2017/18 compared to £7.7m in 2016/17.

The Trust is cash constrained and relies on DH facilitating access to cash through loan arrangements which has placed limitations of the ability of the Trust to invest in capital.

Table 6-1 CHUFT historic CIP performance

	2015/16	2016/17	2017/18
CIP target (£m)	10.8	9.1	17.0
CIP actual/FOT (£m)	9.4	7.7	14.0
CIP target (%)	3.6%	2.9%	5.0%
CIP actual/FOT (%)	3.1%	2.5%	4.1%

Table 6-1 shows that CHUFT achieved cost improvements between 2% and 3% in 2015/16 and 2016/17 and is forecast to deliver around 4% in 2017/18; this has been a key driver to the improved financial position. The Trust has achieved in excess of 80% of its CIP target in the last three years with a record of achieving almost all CIP by recurrent schemes (2016/17- 82%, 2017/18 - 94%).

6.4.3 IHT Historic Performance

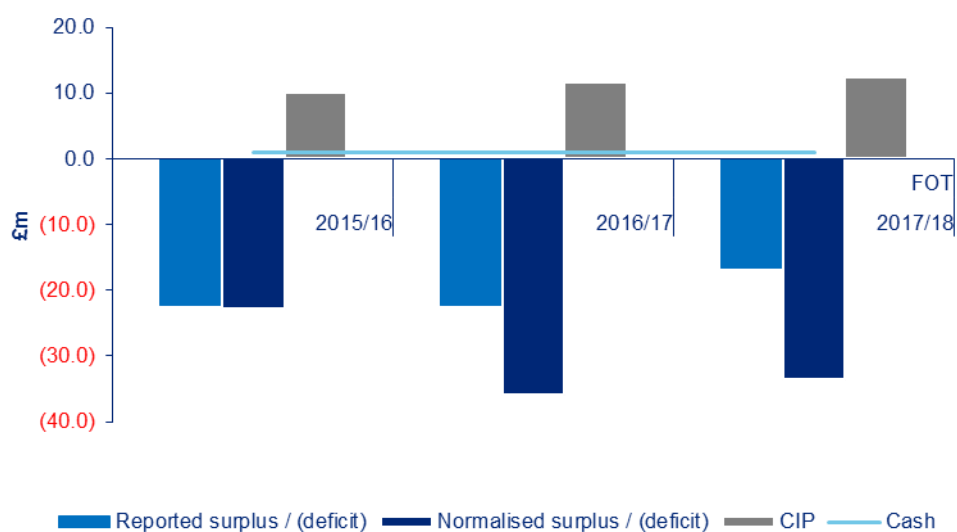


Figure 6-5 IHT historical performance

IHT has reported a deficit since 2014/15, although the reported surplus position prior to this was achieved with non-recurrent support from commissioners. The trust's financial performance since 2014/15 has deteriorated with reliance on income growth rather than reducing costs and cost control.

In 2016/17, IHT over-achieved against its control total. This was in part due to support of £9.3m STF, of which £2.7m was the additional incentive monies for managing national pressures.

The majority of the Trust's income in 2016/17 was confirmed because of a GIC with Ipswich and East Suffolk CCG.

The reported deficit position has shown an improvement from £22.3m in 2015/16 to £16.7m in 2017/18 (forecast) however this is underpinned by additional non-recurrent STF (£10.0m). The normalised position of the Trust continues to deteriorate increasing from £22.8m in 2015/16 to £33.5m in 2017/18 (forecast) with the Trust underachieving against its CIP targets and historical reliance on non-recurrent means beyond STF. This deterioration is linked to a number of factors, including the compounding impact of the non-delivery of recurrent CIPs, cost inflation (notably in relation to areas such as CNST and clinical supplies).

Table 6-2 IHT historic CIP performance

	2015/16	2016/17	2017/18
CIP target (£m)	9.8	12.0	15.8
CIP actual/FOT (£m)	10.1	11.6	12.3
CIP target (%)	3.5%	3.8%	4.8%
CIP actual/FOT (%)	3.6%	3.7%	3.7%

Table 6-2 shows that IHT has delivered CIPs of 3.5% or higher for the past three years, although this is a combination of income growth and cost reductions. The level of CIP delivered in 2015/16 exceeded the target. However, in the past two years CIPs have fallen short of the target (96% of target in 2016/17 and 80% forecast in 2017/18); this has contributed to the worsening financial

position. Over the three years the Trust has delivered around 80% of CIP plans with recurrent schemes.

Areas where the Trust has not been able to deliver the level of CIP it had planned for in 2017/18 include sustained bed management efficiencies that were envisaged over the winter period and Pathology Partnership re-organisation savings. The additional element of CIP that has not been delivered effectively related to the 'stretch' in control total advised to the Trust by NHSI. Commissioners have agreed to fund costs of delivering care non-recurrently in year

6.5 Forecast methodology

In completing the long term financial model (LTFM) the trusts have followed a structured staged process shown in the diagram below. (Figure 6-6)

This is derived from the individual long term financial models (LTFMs) for the existing trusts on a standalone basis. These models have been combined to arrive at the ESNEFT LTFM before applying synergies and integration costs.

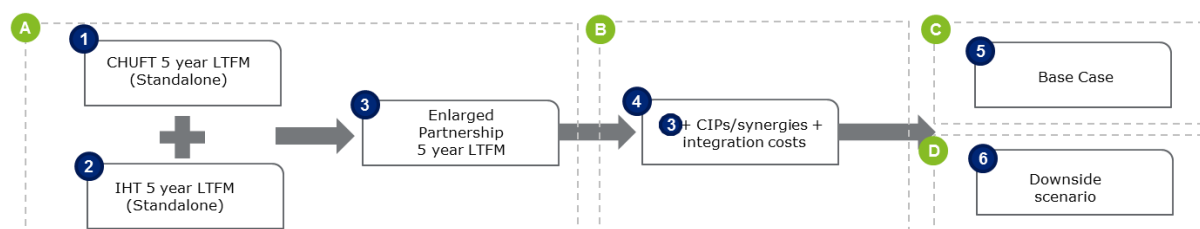


Figure 6-6 LTFM modelling stages

6.6 Standalone positions (Step 1 and 2)

6.6.1 Key assumptions

Separate trust 2018/19 plans were submitted to NHSI on 8 March 2018. These are designed to deliver the agreed control totals (CHUFT £12.1m deficit, IHT £10.3m deficit).

The control totals are considered extremely challenging and while accepted, the trusts have highlighted the risks to achievement of the plan. The combined planned deficit includes £22.9m of non-recurrent items with £22.4m related to STF income.

The NHSI 2018/19 plan guidance has been used to forecast the position through to 2023/24, the only significant difference to these being the growth inflation of CNST being modelled at 10% per annum due to the volatility of historic premiums. A summary of the key assumptions is set out in Table 6-3.

Table 6-3 Baseline Assumptions for future years modelling

Assumption	Comment
Starting year	<p>The outturn year of modelling is 2018/19 as this is the year of anticipated merger. The 2018/19 forecasts match the plans submitted to NHSI on 8 March 2018.</p> <p>The notified STF has been assumed to be fully received in 2018/19 and the same figure has then been assumed for each year through to 2023/24.</p>
Control total	<p>Financial targets (control totals) have been advised by NHSI but while accepting these the trusts have highlighted key factors that will potentially affect ability to deliver being:</p> <ul style="list-style-type: none"> • Transition arrangements for the new organisation • Consequence of non-recurrent transition costs to realise the expected benefits • Scale of CIP required to achieve the control total for 2018/19 based on previous experience and the current significant period of change.
Cash	The trusts will continue to rely on interim revenue support from DH.
Financing	<p>A rate of 1.5% is assumed as the cost of servicing the interim cash support.</p> <p>Depreciation has been modelled on the five year capital plans currently produced by each organisation and is in line with our accounting policies.</p> <p>The additional net capital expenditure of £64.4m has only been assumed in the merger modelling.</p>
Strategic change and service developments	The impacts from currently known strategic business cases and service developments for the individual trusts have been included.
Service reconfiguration and organisation changes	The modelling does not include any further service reconfigurations or organisational changes other than those already identified above.
Inflation and efficiency	<p>NHSI published cost inflation (2.1%) has been used to derive the forecast changes in cost base.</p> <p>Efficiency requirements of 2% for the purpose of long-term modelling in line with NHSI advice has been assumed.</p> <p>An assumption of 10% increase for CNST has been applied based on previous impacts to the Trusts.</p> <p>Clinical income uplifts of 2.37% based on expected settlements from commissioners have been applied to future years. These expected settlements are based on the level of funding commissioners are expected to receive through their national allocations.</p>
Workforce	Changes in activity within the LTFM will adjust workforce costs. The financial impact of these changes has been calculated and will flow through the demand, capacity, workforce modelling.
Demand management	Demand management values are based on STP modelling.

6.6.2 CHUFT Standalone

Table 6-4 summarises the anticipated financial performance for CHUFT to 2023/24. These include the income and expenditure position pre- and post-CIP, balance sheet (including capital investment plans) and cash forecast.

Table 6-4 CHUFT Standalone Summary Forecast to 2023/24

(£m)	2018/19 Plan	2019/20 Forecast	2020/21 Forecast	2021/22 Forecast	2022/23 Forecast	2023/24 Forecast
Income	341.3	349.9	348.7	351.2	345.0	352.3
Operating expenditure	(350.4)	(358.8)	(363.8)	(368.4)	(368.2)	(378.8)
EBITDA	(9.1)	(8.8)	(15.1)	(17.2)	(23.2)	(26.5)
Non-operating expenditure	(3.0)	(3.2)	(3.6)	(3.9)	(4.3)	(4.7)
Net surplus/(deficit) <i>Note 1</i>	(12.1)	(12.0)	(18.7)	(21.0)	(27.5)	(31.2)
Normalised items <i>Note 2</i>	(12.9)	(16.0)	(12.4)	(12.4)	(12.4)	(12.4)
Normalised net surplus/(deficit)	(25.0)	(28.0)	(31.1)	(33.5)	(39.9)	(43.7)
<i>CIPs modelled</i>	17.3	7.1	7.2	7.3	7.2	7.2
<i>CIPs as % of cost base</i>	-4.9%	-2.0%	-2.0%	-2.0%	-2.0%	-1.9%
<i>CIPs cumulative</i>	17.3	24.4	31.6	38.9	46.1	53.3
Normalised net surplus/(deficit) pre-CIP	(42.3)	(52.5)	(62.7)	(72.4)	(86.1)	(97.0)
EBITDA %	-2.7%	-2.5%	-4.3%	-4.9%	-6.7%	-7.5%
Net surplus %	-3.5%	-3.4%	-5.4%	-6.0%	-8.0%	-8.9%
Normalised net surplus %	-7.3%	-8.0%	-8.9%	-9.5%	-11.6%	-12.4%
Net assets	32.9	20.9	2.2	(18.8)	(46.3)	(77.5)
Cash	1.5	1.5	1.5	1.5	1.5	1.5
Drawdown of loans	17.2	17.8	18.9	21.3	27.8	31.5
Total loans <i>Note 3</i>	(119.7)	(136.2)	(153.7)	(169.6)	(196.0)	(226.2)
Capital investment	(13.6)	(13.9)	(7.8)	(9.6)	(7.9)	(8.0)
Finance Score	3	3	3	3	3	3

Notes:

Note 1: The net surplus/(deficit) for 2018/19 is based on the plan submitted to NHSI on 8 March 2018. The plan includes an element of costs and benefits of merger on the assumption it will proceed. An adjustment to the planned surplus has been made in the table below for the implementation costs related to the merger. The benefits identified of £5m which relate to Year 1 of the merger have been retained as it is assumed that if the merger did not proceed this element of the benefits could still be achieved through closer working relationships between the trusts as opposed to a full merger.

Note 2: The significant normalised item is STF of £12.4m which has been assumed throughout the forecast period. The remaining adjustments in 2018/19 and 2019/20 relate to non-recurrent charitable income for cancer campaign.

Note 3: Year-end loans outstanding after repayments during the year (£1.4m per annum)

The CHUFT standalone position includes some non-recurrent costs and income. If these were excluded the normalised deficit would be worse by 2023/24 as shown in Table 6-5. This is because a large element of Non recurrent income support for STF is lost.

Table 6-5 CHUFT standalone adjustment from plan

(£m)		2018/19 Plan	2019/20 Forecast	2020/21 Forecast	2021/22 Forecast	2022/23 Forecast	2023/24 Forecast
Net surplus/(deficit) in submitted plan	Note 1	(12.1)	(12.0)	(18.7)	(21.0)	(27.5)	(31.2)
Adjustments:							
Remove implementation cost budget	Note 2	4.0	4.0	4.0	4.0	4.0	4.0
Adjusted surplus/(deficit)		(8.1)	(8.0)	(14.7)	(17.0)	(23.5)	(27.2)
Normalised items		(12.9)	(16.0)	(12.4)	(12.4)	(12.4)	(12.4)
Adjusted normalised net surplus/(deficit)		(21.0)	(24.0)	(27.1)	(29.5)	(35.9)	(39.7)
CIPs modelled		12.3	7.1	7.2	7.3	7.2	7.2
CIPs as % of cost base		-3.5%	-2.0%	-2.0%	-2.0%	-1.9%	-1.9%
CIPs cumulative		12.3	19.4	26.6	33.9	41.1	48.3
Normalised Net surplus/(deficit) pre-CIPs		(33.3)	(43.4)	(53.7)	(63.4)	(77.0)	(88.0)

Notes:

Note 1: The plan submitted to NHSI includes an assumption that £5m of the merger benefits will be achieved in 2018/19. The Trust has not excluded this from the standalone modelling as the expectation would be if the merger did not proceed the Trusts would continue to work together to achieve savings.

Note 2: CHUFT have built into their base plan a £4m budget for implementation costs. If the merger did not proceed these costs would not be required and therefore should be removed from the standalone position providing a £4m per annum benefit

The movement in the normalised deficit is shown in Figure 6-7.

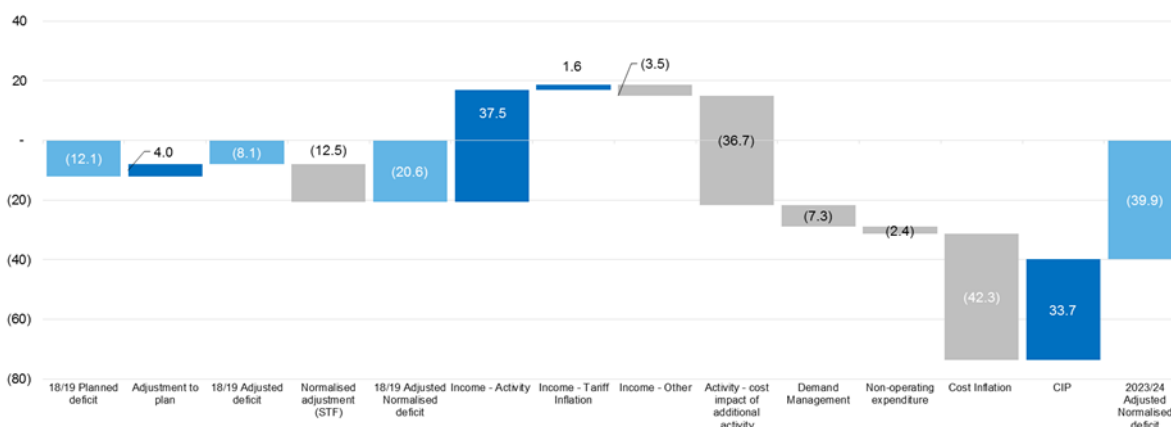


Figure 6-7 CHUFT 2018/19 to 2023/24 normalised deficit

6.6.2.1 Income and expenditure

The forecast pressures to the trust over the period would result in a normalised deficit position of £88.3m by 2023/24 prior to the achievement of a total CIP of £48.4m over the period.

A key factor to the worsening position is the demand management requirements. The underlying income growth of 2.37% (including tariff changes) is offset by the demand management impact. This is having a negative impact on the financial position as it is being assumed that only influential costs of 70% can be reduced. The negative impact is around £7m by 2023/24.

Additional key impacts include:

- Cost inflation (2.1% excluding CNST) which results in a £35.6m pressure by 2023/24
- CNST is expected to be a significant additional pressure to the Trust equating to an additional pressure of circa £6.5m by 2023/24

- The cost of servicing the additional borrowing to fund the forecast deficit will add a further (circa) £2m pressure by 2023/24.

The trust has a CIP plan for 2018/19 of £17.3m (see Table 6-4) which equates to around 5% of the trust cost base. As noted in the table the 2018/19 plan includes an assumption that £5m of the merger benefits will be achieved. This has not been removed from the standalone model as it is assumed that should the merger not proceed the trusts will continue to seek to deliver this level of efficiency. The impact of excluding this is to reduce the 2018/19 CIP to £12.3m (3.5% of the Trust cost base).

From 2019/20 to 2023/24 the trust has modelled a 2% per annum recurrent CIP based on the NHSI forward assumption. The trust has made significant efficiencies in previous years and is at a position where as a standalone organisation the ability to achieve ongoing recurrent efficiencies in excess of this level is not considered sustainable. Further details of the current CIP plans are provided at section 6.6.4.

The cumulative CIP assumption of £48.4m by 2023/24 is insufficient to offset the pressures faced by the trust and therefore the normalised position is forecast to increase from a £21.0m deficit (2018/19) to £39.8m deficit (2023/24).

6.6.2.2 *Balance Sheet and Cash*

Due to the current cash position of the Trust and the ongoing deficit, the Trust will continue to rely on DH facilitating access to cash through loan arrangements. The Trust is forecasting it will require an additional £134.5m of support over the period to 2023/24 to maintain a positive cash balance. The financing costs (interest only) associated with this borrowing places additional pressure to the Trust's bottom line.

The cash position is putting a limitation on the capital investment by the Trust but the current plan forecasts investment of around £60.8m over the forecast period which is mainly funded by internally generated sources but also by assumed sale proceeds and a small amount of commercial funding for energy efficiency and front of house developments.

6.6.2.3 *Finance Score*

Achievement of the 2018/19 plan would result in a finance score of 3. The capital servicing capacity and liquidity position of the Trust is the key driver to the score. While borrowing continues to increase further impacting the capital servicing capacity and the I&E margin deteriorates, it is not sufficient to adversely move the score to a 4.

6.6.3 *IHT Standalone*

Table 6-6 summarises the anticipated financial performance for IHT to 2023/24. This includes the income and expenditure position pre- and post-CIP, balance sheet (including capital investment plans) and cash forecast. Further details of the forecast financial performance is shown in Appendix [X] which includes a detailed I&E statement, balance sheet and cash flow statement.

Table 6-6 IHT Standalone Summary Forecast to 2023/24

(£m)		2018/19 Plan	2019/20 Forecast	2020/21 Forecast	2021/22 Forecast	2022/23 Forecast	2023/24 Forecast
Income		319.5	322.9	322.5	320.5	316.3	323.0
Operating expenditure		(326.2)	(332.7)	(334.4)	(332.3)	(332.2)	(340.6)
EBITDA		(6.6)	(9.8)	(11.9)	(11.8)	(15.9)	(17.6)
Non-operating expenditure		(3.7)	(3.8)	(4.1)	(4.3)	(4.6)	(4.9)
Net surplus/(deficit)	Note 1	(10.3)	(13.6)	(16.0)	(16.1)	(20.4)	(22.4)
Normalised items	Note 2	(10.0)	(10.0)	(10.0)	(10.0)	(10.0)	(10.0)
Normalised net surplus/(deficit)		(20.3)	(23.6)	(26.0)	(26.1)	(30.4)	(32.4)
CIPs modelled		23.2	6.6	6.6	6.6	6.6	6.6
CIPs as % of cost base		-7.1%	-2.0%	-2.0%	-2.0%	-2.0%	-1.9%
CIPs cumulative		23.2	29.8	36.4	43.0	49.6	56.2
Normalised net surplus/(deficit) pre-CIPs		(43.5)	(53.4)	(62.4)	(69.1)	(80.0)	(88.6)
EBITDA %		-2.1%	-3.0%	-3.7%	-3.7%	-5.0%	-5.4%
Net surplus %		-3.2%	-4.2%	-5.0%	-5.0%	-6.5%	-6.9%
Normalised net surplus %		-6.4%	-7.3%	-8.1%	-8.1%	-9.6%	-10.0%
Net assets		31.2	17.6	1.5	(14.6)	(35.0)	(57.5)
Cash		1.5	1.5	1.5	1.5	1.5	1.5
Drawdown of loans		10.7	13.4	16.1	16.1	20.4	22.4
Total loans	Note 3	(77.6)	(91.0)	(107.1)	(123.2)	(143.6)	(166.1)
Capital investment		(7.4)	(7.0)	(6.8)	(6.8)	(6.8)	(6.8)
Finance score		3	3	3	3	3	3

The movement in the normalised deficit is shown in Figure 6-8.

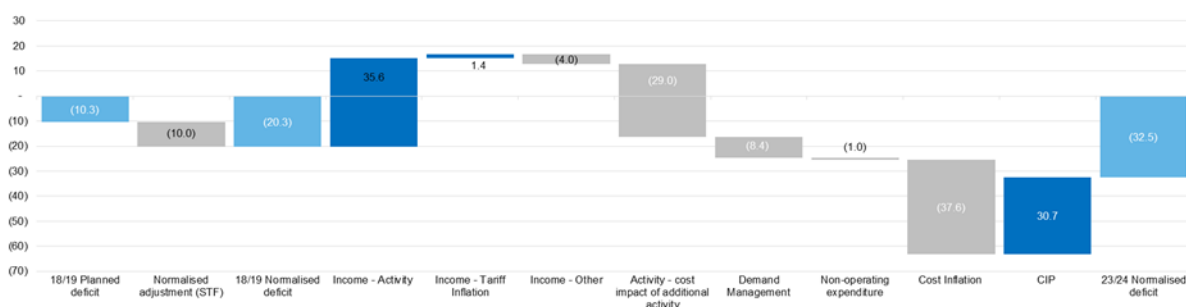


Figure 6-8 IHT 2018/19 to 2023/24 Normalised Deficit

6.6.3.1 Income and expenditure

The forecast pressures to the trust over the forecasting period would result in a normalised deficit position of £88.6m by 2023/24 prior to the achievement of a total CIP of £56.1m over the period.

A key factor to the worsening position is the demand management requirements. The underlying income growth of 2.3% (including tariff changes) is offset by the demand management impact. This is having a negative impact on the financial position as it is being assumed that only influential costs of 70% can be reduced. The negative impact is around £8.3m by 2023/24.

Additional key impacts include:

- Cost inflation (2.1% excluding CNST) which results in a £31.6m pressure by 2023/24
- CNST is expected to be a significant additional pressure to the Trust equating to around an additional pressure of £6.0m by 2023/24

- The cost of servicing the additional borrowing is partially offset by reducing depreciation charges but the net impact is a further £1m pressure by 2023/24.

The trust has a CIP requirement of £23.2m in order to achieve its control total for 2018/19. This is in excess of 7% of the trust cost base and as highlighted to NHSI there is considerable risk to the achievement of this level of CIP. Going forward from 2019/20 to 2023/24 the Trust has modelled a 2% per annum recurrent CIP based on the NHSI forward assumption. This does not take into account any under achieved of CIP from 2018/19. The trust believes that as a standalone organisation the ability to achieve ongoing recurrent efficiencies in excess of this level is not considered realistic or sustainable. Further details of the CIP plans are provided at section 6.6.4.

The cumulative CIP assumption of £56.1m by 2023/24 is insufficient to offset the pressures faced by the trust and therefore the normalised position is forecast to increase from a £20.3m deficit (2018/19) to £32.5m deficit (2023/24).

6.6.3.2 *Balance Sheet*

Due to the current cash position of the trust and its ongoing deficit, the trust will continue to rely on DH interim revenue support. The trust is forecasting an additional loan requirement of £103.7m over the period to 2023/24 to maintain a positive cash balance. The financing costs associated with this borrowing places additional pressure to the trust's bottom line.

The cash position is putting a limitation on the capital investment by the trust but the current plan forecasts investment of around £41.6m over the forecast period. The standalone trust plan appears to be eroding the level of fixed assets due to the current planned investments being at a lower level than historically delivered.

5.1.1.1 *Finance Score*

Achievement of the 2018/19 plan would result in a finance score of 3. The capital servicing capacity and liquidity position of the trust is the key driver to the score. While borrowing continues to increase further impacting the capital servicing capacity and the I&E margin deteriorates it is not sufficient to adversely move the score to a 4.

6.6.4 *CIP Plans*

CHUFT's CIP is summarised in the table and chart below. The Trust has worked with external advisors to develop a detailed plan for 2018/19 with in excess of 60% of the £17m target having already been identified. All CIPs are intended to be recurrent. Work is continuing to identify the remaining elements of the plan and to begin work in developing plans to meet the annual 2% targets through to 2023/24.

Table 6-7 CHUFT 2018/19 CIP Plan Themes

(£m)	2018/19 Plan
Workforce	4.3
Pathology	3.0
Estates & Facilities	0.9
Procurement	0.5
Hospital Medicine and Pharmacy	0.2
Other	2.0
Identified	10.9
Unidentified	6.4
CIP target	17.3
% of cost base	5%

The Trust has a track record in the achievement of recurrent CIPs. The CIPs have been agreed by multi-disciplinary teams and all budget holders within each division, supported by external consulting advisors.

The plans have been, or will be, subject to a QIA review by the medical director and director of nursing. They have been presented to weekly CIP committee chaired by the finance director and performance is reported to the board by the finance assurance committee.

The Trust has achieved significant CIP savings in the past 3 years and is planning to achieve a further 5% in 2018/19. The assumption of 2% per annum from 2019/20 to 2023/24 is in line with NHSI published guidance. The ability to achieve a higher level of savings is considered limited without undertaking significant organisational and transformative change.

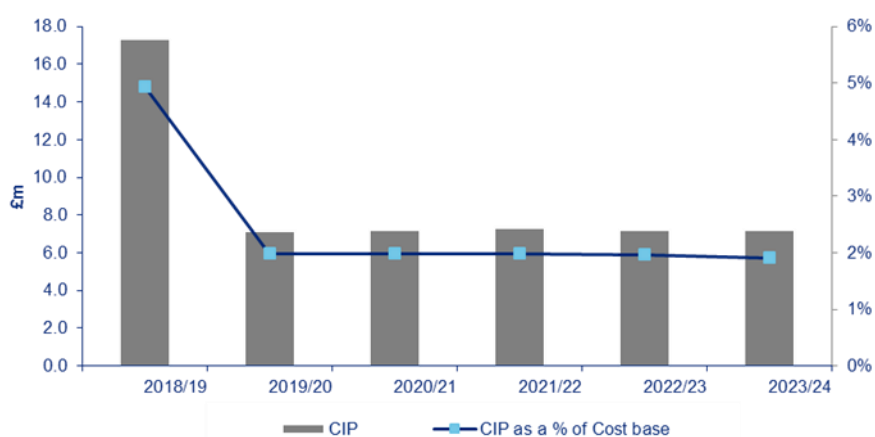


Figure 6-9 CHUFT CIP targets 2018/19 to 2023/24

IHT's approach to the CIP process is summarised in the table and chart below. The Trust has a significant CIP target as a result of the 2018/19 control total and to date has identified recurrent schemes of around 40% of the total target.

The trust has a robust process for the development of CIPs shown in Figure 6-10.

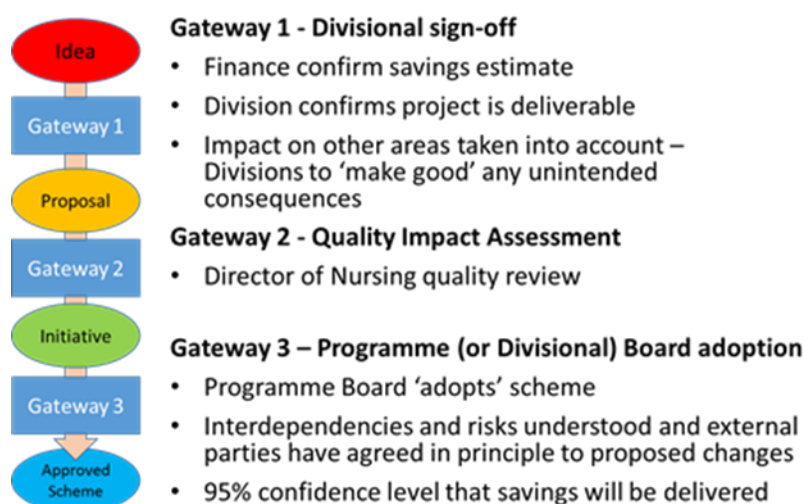


Figure 6-10 IHT CIP development process

Work is ongoing within the operating divisions of the trust to identify schemes to ensure the full target can be achieved. All CIPs are intended to be recurrent.

Table 6-8 IHT 2018/19 CIP Plan Themes

(£m)	2018/19 Plan
Medicine	3.0
Surgery	2.8
Women and Children/Oncology	0.4
Corporate	1.2
Other	1.0
Identified	8.4
Unidentified	14.8
CIP target	23.2
% of cost base	7%

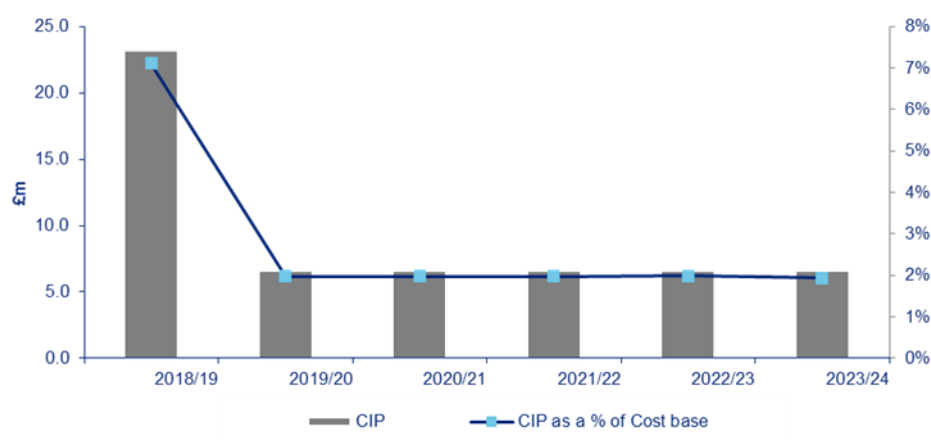


Figure 6-11 IHT CIP targets 2018/19 to 2023/24

6.7 ESNEFT before adjustments (Step 3)

The CHUFT (adjusted) and IHT standalone models have been consolidated to produce an ESNEFT model prior to any adjustments for any one-off integration or transaction costs, and transaction-related synergies.

Table 6-9 shows the projected income and expenditure position pre and post CIPs, balance sheet (including capital investment plans) and cash forecast for ESNEFT, and is also shown in Figure 6-12.

Table 6-9 Consolidated (pre-adjustments) summary forecast to 2023/24

(£m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Clinical income	595.5	604.0	606.3	606.9	596.5	610.4
Other income	65.3	68.8	64.8	64.8	64.8	64.8
Total income	660.8	672.8	671.1	671.7	661.3	675.2
Pay	(404.5)	(412.1)	(414.5)	(414.1)	(411.8)	(421.0)
Non-pay	(268.1)	(275.4)	(279.7)	(282.6)	(284.6)	(294.4)
Total expenditure	(672.6)	(687.5)	(694.2)	(696.7)	(696.4)	(715.3)
EBITDA	(11.8)	(14.6)	(23.0)	(25.0)	(35.1)	(40.1)
Non-operating expenses	(6.7)	(7.0)	(7.7)	(8.2)	(8.8)	(9.6)
Net surplus/(deficit)	(18.5)	(21.7)	(30.7)	(33.1)	(43.9)	(49.7)
Normalised items	(22.9)	(26.0)	(22.4)	(22.4)	(22.4)	(22.4)
Normalised net surplus/(deficit)	(41.4)	(47.7)	(53.2)	(55.6)	(66.4)	(72.1)
CIPs modelled	40.5	13.7	13.8	13.9	13.8	13.8
CIPs as % of cost base	6.0%	2.0%	2.0%	2.0%	2.0%	1.9%
EBITDA %	-1.8%	-2.2%	-3.4%	-3.7%	-5.3%	-5.9%
Net surplus %	-2.8%	-3.2%	-4.6%	-4.9%	-6.6%	-7.4%
Normalised net surplus %	-6.3%	-7.1%	-7.9%	-8.3%	-10.0%	-10.7%
Net assets	63.5	37.7	2.8	(34.7)	(82.9)	(136.8)
Cash	1.5	1.5	1.5	1.5	1.5	1.5
Drawdown of loans	22.8	29.6	34.7	37.1	47.9	53.7
Total loans	(198.0)	(228.1)	(261.7)	(293.8)	(340.6)	(393.2)
Capital investment	(20.3)	(20.5)	(14.7)	(19.6)	(14.7)	(14.8)
Financial score	3	3	3	3	3	3

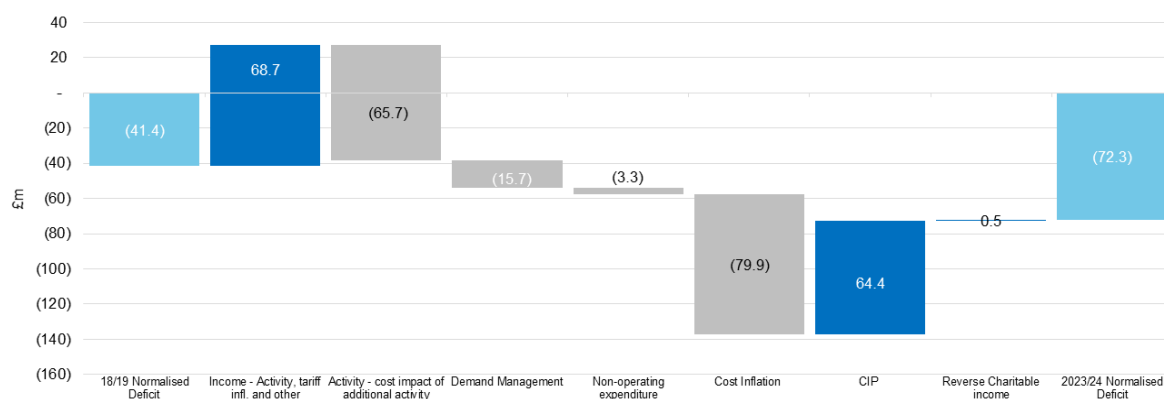


Figure 6-12 ESNEFT normalised net position (pre-adjustments) 2018/19 to 2023/24

The 'do nothing' consolidated position is financially unsustainable on an income and expenditure basis with the normalised deficit growing over the planning period from £41.4m to £72.1m.

The trusts are planning for a combined CIP of 6% in 2018/19 followed by 2% each year thereafter. By 2023/24 the cumulative CIP is forecast at £109.6m or 15% of the cost base. The trusts' ability to achieve the 2018/19 CIP plan and forward assumptions has been highlighted as a risk as two standalone organisations. It is expected that the enlarged organisation will have a greater scale to provide more confidence in the achievability of the overall CIP requirement which will not affect the resilience and sustainability of service delivery.

The identified synergies brought about by the merger will help to address the deficit position.

6.8 Merger benefits and integration costs (Step 4)

6.8.1 Merger benefits

Section 5 of the FBC describes the areas of synergies that the enlarged organisation is expecting to deliver. The savings have been quantified in Table 6-10. The impact of the merger synergies is forecast to deliver a £21.9m recurrent benefit by 2023/24. The plan is that the majority of these benefits will have been achieved by Year 3 (2020/21).

Table 6-10 Integration Benefit Synergy Schemes

Merger Benefits (£m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Clinical integration benefits	3.1	5.8	9.8	11.8	11.8	11.8
Corporate benefits	2.1	3.8	7.7	8.5	8.8	8.8
Capital Scheme benefits	1.4	2.6	4.7	5.7	6.9	6.5
Non-operating changes from merger benefits	0.2	0.2	0.7	1.1	1.0	1.4
Total gross synergies	6.8	12.4	22.9	27.1	28.5	28.5
Profile of synergies (%)	24%	44%	80%	95%	100%	100%
Total recurrent cost associated with synergies	(0.9)	(1.9)	(3.9)	(6.6)	(6.6)	(6.6)
Net merger synergy benefits	5.9	10.5	19.0	20.5	21.9	21.9

6.8.2 Clinical integration benefits

While some immediate benefits from clinical integration are forecast to be achieved due to reduction in agency costs it is expected that the development of the cross-site reporting and working, shared training pathways and combined teams will take time to realise the full benefit and therefore the majority of the synergies from clinical integration are forecast to be achieved from 2020/21 (year 3). Benefits from this have not been included in the partnership modelling but will be expected as part of the future consultation arrangements for these developments.

Table 6-11 Clinical integration benefit synergy schemes

Clinical Benefits (£m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Agency	2.0	4.0	8.0	10.0	10.0	10.0
Clinical Procurement	1.1	1.8	1.8	1.8	1.8	1.8
Total synergies	3.1	5.8	9.8	11.8	11.8	11.8
Profile of synergies (%)	26%	49%	83%	100%	100%	100%

6.8.3 Corporate operating model

The Trust has developed efficiency plans to be delivered through the revised corporate operating model. The benefits are focussed on key themes including the combined corporate function, digital enabling, improved operating model efficiencies, joint procurement and rationalisation of suppliers.

The identified benefits are spread across four key divisions being estates and facilities, finance, workforce and ICT. Whilst not actually part of the operating model review, partnership working will lead to a single board structure with associated reductions in costs at this level.

The overall corporate model is expected to produce a recurrent savings benefit to the I&E position of £8.4m by 2023/24 (£8.8m gross saving).

Table 6-12 Gross integration benefit synergy schemes

Corporate Benefits (£m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Estates & facilities	0.5	1.1	1.7	2.3	2.3	2.3
Finance	0.6	1.1	2.0	2.0	2.0	2.0
HR	0.3	0.6	1.4	1.7	2.0	2.0
ICT	0.1	0.7	2.5	2.5	2.5	2.5
Total gross synergies	1.6	3.5	7.7	8.5	8.8	8.8
<i>Profile of synergies (%)</i>	<i>18%</i>	<i>39%</i>	<i>87%</i>	<i>96%</i>	<i>100%</i>	<i>100%</i>
Total recurrent costs associates with synergies	(0.3)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)
Net merger synergy benefits	1.3	3.0	7.2	8.1	8.4	8.4

6.8.4 Capital scheme benefits

The work on clinical integration has highlighted the need for significant capital investment as a key enabler of change. A number of schemes which were identified at the OBC have generated a STP capital case submission to NHSE for a net capital investment of £64.3m. The STP supports the schemes as the highest priority on its overall capital investment plan.

The bid provides outline plans for investment on both hospital sites to provide suitable care to local patients. The bid also works in conjunction with other bids being developed by the STP and the wider health economy to ensure that suitable capacity is provided for patient care outside of the acute sector where this is clinically safe and sustainable, including the developing urgent care agenda. The STP's other high priority bids will enable more suitable provision of facilities and services, thus enabling acute sites to be re-designed for the needs of the acute patients, absorbing expected growth rates and still enabling the release of some estate at both acute hospital sites.

The case submitted to the STP provides a positive Return on Investment of 138% over a 30-year period, with a payback period of 8 years. The net benefits to the I&E position by 2023/24 is a positive £0.2m after financing costs.

The capital reconfiguration work will result in the release and sale of surplus land and a non-recurrent benefit of £4.9m is expected in 2022/23.

The financial benefits are summarised in Table 6-13.

Table 6-13 Merger related capital investment plan I&E impact

Capital Benefits (£m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Gross Benefits	1.4	2.6	4.7	5.7	11.3	6.5
Less						
Additional Capital Charges	(0.6)	(1.4)	(3.4)	(6.1)	(6.1)	(6.1)
Non-recurrent benefit	0.0	0.0	0.0	0.0	(4.9)	0.0
Total Recurrent Net Capital Benefits	0.8	1.2	1.3	(0.4)	0.3	0.4

Table 6-14 shows the overview of the capital schemes proposed directly relevant to the merger.

Table 6-14 Merger related capital investment plans

Capital requirements (£m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Emergency care pathway	3.5	6.0	5.9	0.0	0.0	0.0	15.4
Diagnostic imaging	3.3	1.6	0.0	0.0	0.0	0.0	4.3
Elective care capacity and redesign	0.0	0.0	3.9	9.7	0.0	0.0	13.6
Estate enabling work	2.8	3.4	0.0	0.0	0.0	0.0	6.2
Integrated elective care facilities	0.0	0.0	8.5	21.2	0.0	0.0	29.7
Total gross capital requirement	9.6	10.4	18.3	30.9	0.0	0.0	69.2
Land disposal	0.0	0.0	0.0	(4.9)	0.0	0.0	(4.9)
Total net capital requirement	9.6	10.4	18.3	26.0	0.0	0.0	64.3

6.8.4.1 Emergency Care Pathway / Elective Care Capacity and Redesign

With significant future population growth plans for the area (see section 4 and Appendix 2) it will be important that the ED departments are suitably equipped to deal with resulting volumes of complex patients. Significant work is planned to reduce the underlying demand for ED services across the footprint. However, given growth rates and ageing populations it is expected that there will be a move towards only the higher acuity patients attending ED. The capital requirement for the Emergency Care Pathway will significantly increase the capacity within the majors, resuscitation and assessment areas of the sites. The works will bring these areas of the department up to modern standards, enabling improved flow of patients.

6.8.4.2 Diagnostic Imaging

Current CT scanning capacity at IH is below the requirements for the needs of the service; the CT unit is a significant distance from the ED, causing delays to patient's treatment and the fluctuations in emergency care requirements of CT impacting on elective care scanning. The provision of a CT scanner adjacent to the ED will enable improved timely decision making for emergency patients and flow of patients through both emergency and elective care.

MRI facilities are also insufficient to meet the current demands for the service; mobile scanning facilities and outsourcing of scans are enabling delivery of the requirements of patients. The provision of an additional MRI scanner will alleviate the need to rely upon mobile facilities and future-proof the capacity for the rising acuity of patients and demands for MRI services, including cardiac MRI.

6.8.4.3 Estate rationalisation and enabling works

Dermatology and EEG services remain within the largely redundant buildings at IH. The investment in re-provision of these services into the main footprint of the estate will enable the release of this element of the estate in line with the Naylor and Carter recommendations whilst making significant reductions in estates running costs and mitigating the £6.1m in backlog maintenance.

6.8.4.4 Integrated elective care facilities

The current day case facilities at both CGH and IH are sub-optimal for the demands of current service delivery models, restricting the ability of both hospitals to treat more patients as day cases. The investment in day case capacity will enable a step-change in treatments, reducing reliance upon inpatient beds, and enabling patients to be treated in appropriate settings.

Early clinical strategy discussions have also identified the benefits to patients of developing some elective services on one or other site. These ideas will be developed further as part of the clinical strategy work. An allowance is contained within latter years to facilitate these opportunities.

6.8.5 Non-operating changes from merger benefits

The impact of the merger benefits is to reduce the level of cash support required by the Trust. This in turn reduces the financing costs by £1.4m by 2023/24.

6.8.6 Enlarged organisation post-merger benefits, pre-transaction costs

The impact of the recurrent merger benefits on the consolidated CHUFT (adjusted) and IHT standalone model has been overlaid to produce an enlarged ESNEFT model prior to any adjustments for any one off integration or transaction costs at this stage.

Table 6-15 shows the projected reported and normalised deficit position post-merger synergies.

Table 6-15 Consolidated (post-merger, pre-implementation costs) summary forecast to 2023/24

(£m)		2018/19 forecast	2019/20 forecast	2020/21 forecast	2021/22 forecast	2022/23 forecast	2023/24 forecast
Adjusted Net Surplus/(Deficit) CHUFT	Table 6-4	(8.1)	(8.0)	(14.7)	(17.0)	(23.5)	(27.2)
Net Surplus/Deficit IHT	Table 6-5	(10.3)	(13.6)	(16.1)	(16.1)	(20.4)	(22.4)
Enlarged organisation pre-merger benefits and costs	Table 6-6	(18.4)	(21.7)	(30.7)	(33.1)	(43.9)	(49.7)
Normalised organisation pre-merger benefits and costs	Table 6-6	(41.4)	(47.7)	(53.2)	(55.6)	(66.4)	(72.1)
Gross Merger Benefits (Recurrent)	Table 6-9	6.8	12.4	22.9	27.1	28.5	28.5
Costs of Benefits (Recurrent)	Table 6-9	(0.9)	(1.9)	(3.9)	(6.6)	(6.6)	(6.6)
Net Merger Synergies (Recurrent)		5.9	10.5	19.0	20.5	21.9	21.9
2018/19 Benefit already included	Table 6-4	(5.0)	0.0	0.0	0.0	0.0	0.0
Adjusted benefit for modelling		0.9	10.7	19.2	20.8	22.2	22.2
Enlarged organisation post-merger benefits, pre-non-recurrent costs		(17.5)	(11.2)	(11.7)	(12.6)	(22.0)	(27.8)
Normalised Items		(22.9)	(26.0)	(22.4)	(22.4)	(22.4)	(22.4)
Normalised Surplus/(Deficit)		(40.5)	(37.2)	(34.2)	(35.1)	(44.5)	(50.2)

The normalised deficit is reduced from £72.1m at 2023/24 to £50.2m as a result of the recurrent merger synergies.

6.8.7 Integration costs and one-off benefit

In addition the cost of the integration work have been recognised, including the PMO to support delivery of the successful merger and the transitional costs primarily linked to developing automation, redeployment of staff, and additional cost of staff travel. The total costs over the period to 2023/24 are estimated at £20.6m with the majority of these falling in the first two years.

A benefit of £4.4m is anticipated as a result of the disposal of surplus land peripheral to the CGH and IH sites.

Table 6-16 Non-recurrent Integration costs

Integration costs (£m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Corporate model	0.6	0.3	0.0	0.0	0.0	0.0
Capital schemes	0.3	1.1	2.3	3.9	0.0	0.0
Costs of implementation	4.0	4.0	2.0	2.0	0.0	0.0
Total non-recurrent merger costs	4.9	5.5	4.3	5.9	0.0	0.0
Non-recurrent merger benefits	0.0	0.0	0.0	0.0	(4.4)	0.0
Non-recurrent impact	4.9	5.5	4.3	5.9	(4.4)	0.0

6.8.8 Transitional Funding

As identified above, the proposed merger will deliver significant benefits, but as part of that there are non-recurrent costs associated with delivering the successful implementation of the merger.

The trusts are aware that there is no central funding available to support the transitional costs of this merger; this will place additional pressure on ESNEFT to deliver the transformation and, at the same time, achieve control totals.

The only funding that is assumed is the (currently sought) STP/NHSE capital funding requirement of £69.3m gross. If this funding is not received this will have an impact on the level of improvement to the underlying position of the trusts and the speed with which transformational change in services can be achieved.

6.9 Enlarged Partnership Post Adjustments (Step 5)

The non-recurrent integration/transaction costs have been included to give the forecast merger income and expenditure position in

Table 6-17 and Table 6-18 ESNEFT deficit post non-recurrent.

Table 6-17 ESNEFT deficit post non-recurrent

(£m)		2018/19 forecast	2019/20 forecast	2020/21 forecast	2021/22 forecast	2022/23 forecast	2023/24 forecast
Enlarged organisation post-merger benefits, pre-non-recurrent costs	<i>Table 6-15</i>	(17.5)	(11.2)	(11.7)	(12.6)	(22.0)	(27.8)
<i>Normalised organisation post-merger benefits and costs</i>	<i>Table 6-15</i>	<i>(40.5)</i>	<i>(37.2)</i>	<i>(34.2)</i>	<i>(35.1)</i>	<i>(44.5)</i>	<i>(50.2)</i>
Non-recurrent merger costs							
Corporate TOM	<i>Table 6-16</i>	(0.6)	(0.3)	0.0	0.0	0.0	0.0
Capital Schemes	<i>Table 6-16</i>	(0.3)	(1.2)	(2.3)	(3.9)	0.0	0.0
Costs of Implementation	<i>Table 6-16</i>	(4.0)	(4.0)	(2.0)	(2.0)	0.0	0.0
Total non-recurrent merger costs		(4.9)	(5.5)	(4.3)	(5.9)	0.0	0.0
Non-recurrent merger benefit (Capital)		0.0	0.0	0.0	0.0	4.4	0.0
Enlarged organisation post-merger benefits and transaction costs		(22.4)	(16.7)	(16.0)	(18.5)	(17.6)	(27.8)
<i>Normalised items</i>		<i>(22.9)</i>	<i>(26.0)</i>	<i>(22.4)</i>	<i>(22.4)</i>	<i>(22.4)</i>	<i>(22.4)</i>
<i>Normalised surplus/(deficit)</i>		<i>(45.4)</i>	<i>(42.7)</i>	<i>(38.5)</i>	<i>(41.0)</i>	<i>(40.1)</i>	<i>(50.2)</i>

Table 6-18 ESNEFT deficit post non-recurrent

(£m)	2018/19 forecast	2019/20 forecast	2020/21 forecast	2021/22 forecast	2022/23 forecast	2023/24 forecast
Clinical income	595.5	604.0	606.3	606.9	596.5	610.4
Other income	65.3	68.8	64.8	64.8	64.8	64.8
Total income	660.8	672.8	671.1	671.7	661.3	675.2
Pay	(404.8)	(408.7)	(402.6)	(399.5)	(396.5)	(405.8)
Non-pay	(252.5)	(253.7)	(255.2)	(258.5)	(254.2)	(263.9)
Total expenditure	(657.3)	(662.4)	(657.8)	(658.0)	(650.8)	(669.6)
EBITDA	3.5	10.5	13.3	13.7	10.5	5.6
Non-operating expenses	(25.9)	(27.1)	(29.4)	(32.1)	(28.1)	(33.3)
Net surplus/(deficit)	(22.4)	(16.6)	(16.1)	(18.4)	(17.5)	(27.7)
Normalised items	(22.9)	(26.0)	(22.4)	(22.4)	(22.4)	(22.4)
Normalised Net surplus/(deficit)	(45.3)	(42.6)	(38.5)	(40.8)	(39.9)	(50.2)
CIPs/synergies modelled	41.4	18.6	22.2	15.6	14.8	14.2
CIPs/synergies as % of cost base	6.3%	2.8%	3.4%	2.4%	2.3%	2.1%
EBITDA %	0.5%	1.6%	2.0%	2.0%	1.6%	0.6%
Net surplus %	-3.4%	-2.5%	-2.4%	-2.7%	-2.6%	-4.1%
Normalised net surplus %	-6.9%	-6.3%	-5.7%	-6.1%	-6.0%	-7.4%
Net Assets	74.2	67.2	68.2	78.0	59.6	31.7
Cash	1.5	1.5	1.5	1.5	1.5	1.5
Drawdown of Loans	26.7	22.3	16.1	18.4	17.5	27.7
Total Loans	(198.0)	(219.1)	(234.1)	(247.4)	(263.9)	(290.5)
Capital Investment	(30.6)	(30.3)	(33.0)	(47.3)	(14.7)	(14.8)
Finance Score	3	3	3	3	3	3

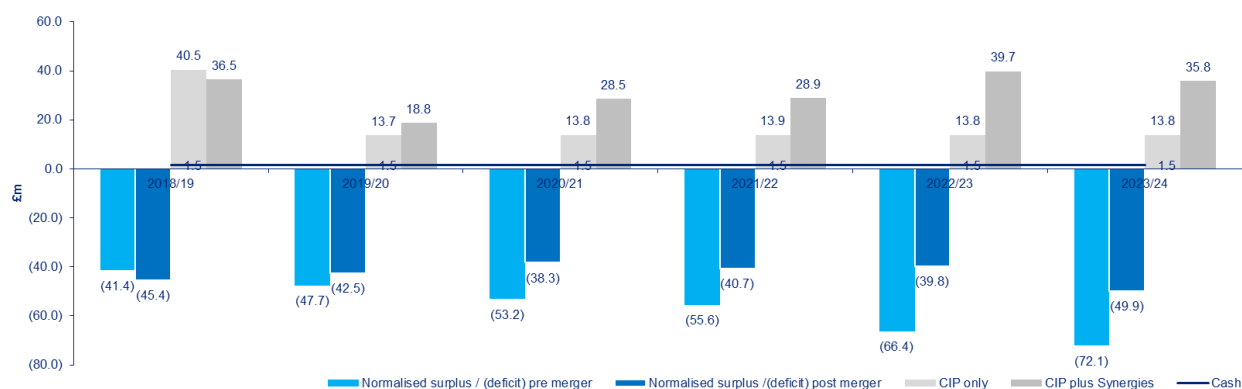


Figure 6-13 ESNEFT financial summary 2018/19 to 2023/24

As detailed above, the overall benefit from the merger without any service reconfiguration is estimated at £21.9m by 2023/24. There remains a significant level of deficit to be addressed which is considered further in section 6.11.

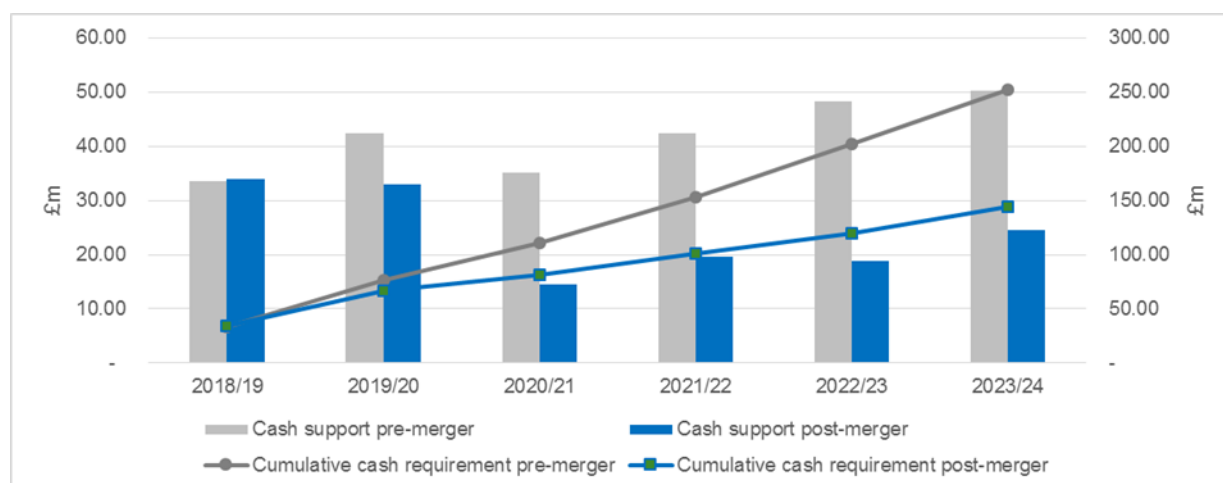


Figure 6-14 Cash impact of merger 2018/19 to 2023/24

Under the do nothing modelling the trusts would require increasing amounts of cash support over the period to 2023/24. The total level of borrowing is estimated at circa £252m. The impact of the merger benefits results in a reduced cash borrowing requirement with the total borrowing reduced by £128m to circa £123m.

6.10 Sensitivities (Step 6)

There are a number of potential risks to the financial position that have been modelled, resulting from the merger. An analysis of these risks, and the new organisation's sensitivity to them, has been undertaken and is shown in Table 6-19.

Table 6-19 Financial sensitivity

Sensitivity	Comment	Adjustment to be tested
Annual level of funding - commissioning settlements	<p>Whilst funding based on national tariff will be highlighted in the modelling, it has been assumed that commissioners will seek to cap any growth in provider income and income growth will actually be linked to the funding growth included in the allocations received by Commissioners (the assumption being that growth % uplifts or reductions will be mirrored in provider settlements).</p> <p>There is a risk that settlements will actually be lower in future depending on the wider NHS financial position.</p>	Funding is 1% per annum lower than modelled in the base case.
Marginal cost behaviour	The impact of changes in activity on expenditure have been considered in the base modelling for each Trust. Based on the latest costing information (latest reference costs 2016/17) for each organisation, cost behaviour by point of delivery has been	The cost base structure behaviour of the newly merged organisation is consistent with that

Sensitivity	Comment	Adjustment to be tested
	established and a marginal cost (%) for additional activity for elective, non-elective, outpatient, A&E, and other tariff established. Different rates have been identified for each Trust, with CHUFT reporting higher marginal rates. Given that activity has been predicted to grow at broadly the same levels for each Trust (based on relevant IHAM growth rates); this means that additional costs have been included for CHUFT relative to IHT which is a major factor as to why its deficit position deteriorates by a greater amount over the assessment period.	modelled for CHUFT, and where activity increases, marginal costs are higher than currently anticipated.
Cost inflation	<p>In line with the modelling of income, cost inflation as outlined in the National Tariff document for 18/19 has been used for all years subsequent to this as well (except for CNST - see below).</p> <p>Additional costs and pressure on the financial bottom line would result if these assumptions are understated. A key area of volatility relates to staff pay costs, and uncertainty over the pay award that potentially may be granted. If this exceeds the 1% currently assumed, and is not centrally funded, then this will adversely impact financial performance.</p>	Model pay costs at 0.5% higher than presently, and assume that no central funding is forthcoming to support this.
CIP delivery	<p>It is assumed that recurrent CIPs targets will be realised in each year for both the no merger and merger models. The total efficiency to be delivered is the 2% expected national annual requirement.</p> <p>Delivery of variable levels of efficiency should be tested.</p>	CIP delivery is actually 0.5% lower than planned for.
Corporate TOM delivery and level of savings	There is a risk that the savings that have been assumed to result from the Corporate TOM do not materialise. Because of the level of detail that supports the plans that have been produced by the corporate risks, the chances of this occurring are considered low but the impact nevertheless needs to be tested. To this end, the scenario will be tested to assess the impact of 25% over-delivery of savings and 25% under-delivery.	Corporate TOM savings to be modelled at 'only' 75% of the value included in the full clinical integration model.
Clinical integration delivery and level of savings	The financial benefit that is assumed to relate to the revised clinical models may not materialise. A number of detailed sessions have been held with specialties and their relevant clinicians and a number of innovative changes have been proposed. However continues to be progressed to ensure that detail implementation plans exist to ensure the implementation and delivery of such ideas. The current base modelling principally and simply assumes that it will be possible to achieve a significant reduction in agency utilisation as a consequence of a number of factors such as becoming a more attractive place to work, with lower attrition rates, and cross site rota cover utilisation. However, with agency spend high in areas where nationally there are staffing pressures (such as the Emergency Department), this will be challenging to achieve and so the level of risk associated with this modelling must be considered higher and therefore the stress test to be applied to the preferred option more severe.	Model the clinical savings (do not include costs to deliver) at 50% of the value included in the full clinical integration model.

Sensitivity	Comment	Adjustment to be tested
Costs to deliver transformation: both corporate and clinical	Because of the complex and innovative nature of some of the schemes proposed (such as automated and robotic working) some of the revenue costs to deliver, the Corporate TOM, clinical vision and Estate proposals are very hard to truly predict and must be considered potentially variable. It is important to gauge what the effect will be of these costs differing from those that have presently been estimated.	Model the delivery costs for the Corporate TOM, Estates reconfiguration and clinical changes at 150% of current values.

The downside financial risks have also been quantified. The values detailed in Appendix 10 represent for each risk, how the anticipated ESNEFT income and expenditure value by year would be affected if it were to materialise. Calculations have been based on the risk occurring in isolation and how it impacts the 'base' ESNEFT modelling. No attempt has been made to consider a number of risks happening in combination, but it is considered that the analysis is adequate to broadly show the extent to which each risk or multiple risks would affect the bottom line and to test the robustness of ESNEFT's plans. The summary in Appendix 10 also discusses the likelihood of each risk, and the possible specific actions that could be adopted to mitigate its impact.

In addition to the specific mitigations outlined above, Appendix 10 also includes more generalised actions the Trust would seek to implement if it became apparent that the financial position modelled was under pressure.

6.11 Closing the Gap

The trusts recognise the importance of ESNEFT being a financially sustainable organisation and the CIP plans and merger benefits identified above are significant steps in achieving this. ESNEFT is still forecasting a deficit position after the merger benefits have been identified and the remaining deficit will need to be addressed.

The trusts, working in partnership with the wider STP are considering two key strategies to support ESNEFT in achieving a financially balanced position by the end of the 2023/24:

- 1) CIP 'Stretch' – The CIP and merger benefits identified above are focussed on taking advantage of the economies of scale of the enlarged organisation. Work will continue in all areas to secure greater efficiency benefits from the merger. Clinically-led work on the longer-term clinical strategy to optimise the delivery and sustainability of clinical services will take place in 2018/19 and the financial impact and additional efficiency benefits of any changes to service models will be assessed as part of the annual planning process.
- 2) STP gain share – the LTFM is forecasting a deficit position for ESNEFT, however with the cost reduction contribution from the ESNEFT merger, the overall STP is forecasting a balanced position by 2023/24. It is proposed that ESNEFT continues to work with commissioners in adopting the STP system control total opportunities.

An indicative position of how this might be achieved is outlined below. The expectation would be that any additional stretch or the benefit from additional flows from commissioners would be achieved from Year 2 through to Year 5. A detailed plan to breakeven cannot be confirmed until any public consultation is complete.

Table 6-20 Break-even scenario (potential)

(£m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Underlying surplus/(deficit) post-merger	(22.4)	(16.8)	(16.1)	(18.0)	(18.3)	(27.9)
CIP Stretch	-	5.0	7.5	9.9	10.2	12.2
STP Gain/Share	-	-	5.3	8.1	8.1	15.7
Revised underlying surplus/(deficit)	(22.4)	(11.8)	(3.3)	0.0	0.0	(0.0)
CIP Stretch as % of operating expenditure	0.0%	0.7%	1.1%	1.5%	1.5%	1.7%

7 Transaction and integration

7.1 Organisational form of the transaction

In finalising the preferred organisational form for the merger, the trust boards have taken into account advice from their legal advisors (Hempsons) and discussion with NHSI. This advice included an assessment of the merits and drawbacks on a number of potential transaction forms.

None of the options to deliver the merger were considered to be without risk and some, although permitted at face value, are not feasible in practice.

The two most feasible options to bring the two organisations together as one are 'statutory merger' under Section 56, and 'statutory acquisition' under Section 56A, of the National Health Service Act 2006. These options differ in the complexity of implementation, particularly in the timing of formation of a new board and substantive leadership team.

In reaching a preferred form, the boards separately considered:

- The potential legal options for the transaction
- The complexity and risks of different options
- The regulator's view (NHSI) of the optimal route to transaction.

On this assessment, the statutory acquisition of IHT by CHUFT was recommended as the preferred organisational form for the transaction to both boards at their private meetings in October 2017. Both boards accepted this recommendation.

The boards have agreed that, although the legal transaction for the merger is the s56A acquisition of IHT by CHUFT, the key message from the boards is to approach the partnership as the coming-together of equals, and that the mechanism of the transaction should primarily be seen as a technical process which enables a merger into a new organisation, drawing on the best of both CHUFT and IHT.

7.2 Transaction governance

The arrangements to deliver the benefits of working in partnership, and ultimately in coming together as one trust have been in place since May 2016.

7.2.1 Programme governance arrangements

The programme governance arrangements to develop the FBC have been designed to ensure robust internal governance and accountability to both Trust Boards, supported by appropriate engagement between the boards and with patients and carers, staff, clinicians, commissioners and wider stakeholders. These governance arrangements, which build on the approach at the SOC and OBC stages, are shown in Figure 7-1.

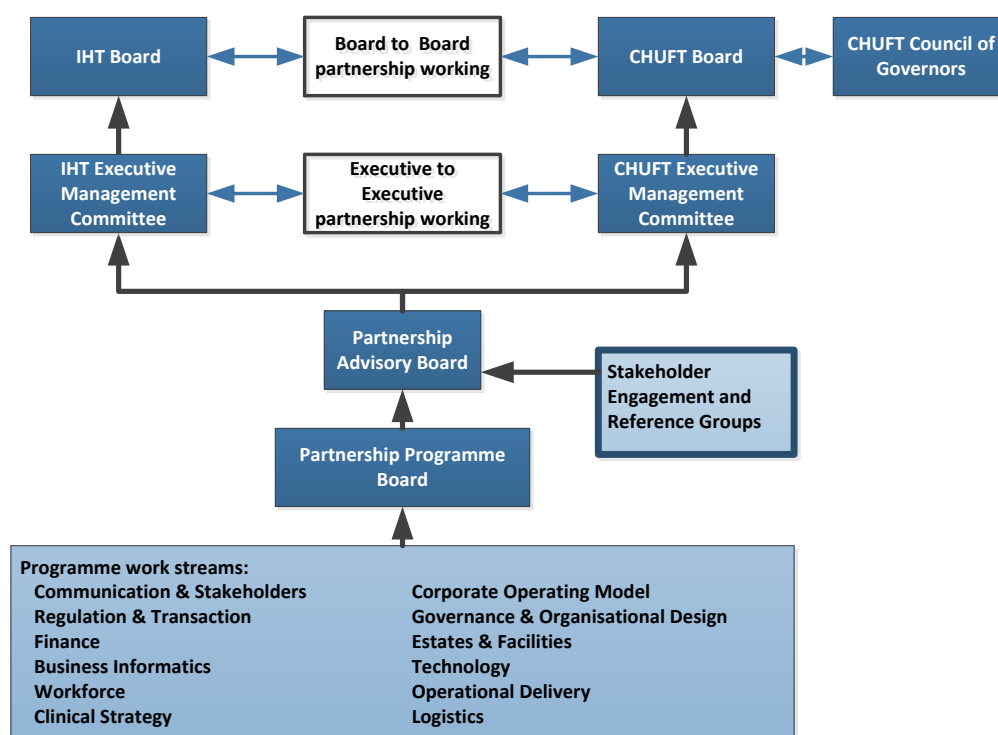


Figure 7-1 Programme governance structure

7.2.2 Roles and responsibilities within the governance structure

7.2.2.1 Trust Boards

The Trust Board is the body responsible for the management and governance in both an NHS Trust⁸⁰ and an NHS Foundation Trust⁸¹. The Trust Boards of CHUFT and IHT have led the process of partnership and have set the overall direction under which the business case and integration plan have been developed.

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

The boards have held a monthly cycle of informal board-to-board meetings since the outset of the partnership, to develop shared understanding of the challenges facing both trusts and a wider strategic view on potential arrangements.

7.2.2.2 Executive management committees of both trusts

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

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

⁸⁰ Established under the *National Health Service and Community Care Act 1990* (as amended)

⁸¹ Established under the *Health and Social Care (Community Health and Standards) Act 2003* (as amended)

7.2.2.3 *Partnership advisory board*

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

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

7.2.2.4 *Partnership programme board*

The partnership programme board (PPB) includes executive directors and senior managers from CHUFT and IHT together with commissioner representatives and external advisors and support.

PPB meets fortnightly and has overseen two distinct areas of activity: (i) delivery of the FBC and transaction, and (ii) planning and preparation for Day One of the new organisation. The PPB oversight has included:

- Development of the Full Business Case, including:
 - Development and drafting of the FBC and Post Transaction Integration Plan
 - Legal transaction form to create the new organisation
 - Competition and Markets Authority referral process
 - Engagement with regulators, commissioners and partners
 - Compliance with the confidentiality and information barrier agreement arrangements.
- Planning and preparation for the readiness of the new organisation, including:
 - Development of the transition and transformation plan for integration into a single new organisation
 - Coordination and oversight of the programme work streams
 - Assurance and scrutiny of readiness planning.
- Manage the relevant:
 - Programme risks
 - Programme milestone delivery
 - Engagement and communications

7.2.2.5 *Work streams*

In developing the plans for the new organisation, executive directors of both trusts have led a number of supporting work streams, focussed on developing the proposed operating models and detailed plans, making appropriate preparations in each area of responsibility. The key programme work streams are identified in Figure 7.1

7.2.2.6 Reference and advisory groups

The programme has been supported by a number of reference and advisory groups established to ensure broad engagement in discussions regarding the development of the partnership. The outcomes of the group deliberations are considered by the PAB. Details of these groups are included in Section 8.

7.2.3 Preparing for the new trust

Responsibility for the governance of the processes to develop the business case and the detailed arrangements for merger falls to the CHUFT and IHT trust boards, supported by the programme governance arrangements.

Concurrently, parallel arrangements to ensure the smooth transition to the new organisation have been developed to establish a shadow board of directors, to prepare for the new council of governors, and to have in place single executive leadership for the new trust.

7.2.3.1 Shadow board arrangements

The CHUFT board currently includes the chair and six non-executive directors; the IHT board includes the chair and five non-executive directors and an associate non-executive director. Some of the NED terms of office are scheduled to expire in the period leading up to the point of merger. It is proposed that, to ensure continuity of knowledge and experience, all the NEDs with unexpired terms will form the non-executive component of the shadow board leading up to the transaction completion and for the first six months of the new organisation.

7.2.3.2 Council of governors

A new ESNEFT council of governors will be elected in advance of the transaction completion. The elections and partner organisation appointments will be completed by mid-June 2018, after which the new council will operate in shadow form alongside the CHUFT council for the remaining transaction lead-in period. At the point of the transaction the CHUFT council will fall away.

7.2.3.3 Bringing together the executive leadership

Preceding the establishment of a formal shadow board, and since the establishment of the partnership in 2016, a number of permanent and temporary appointments of executive leads and senior clinical leaders to cover both trusts have been made. This is to ensure there is stability of leadership and to oversee the process of the merger, support the harmonisation of processes and to maintain the executive focus. Specifically:

- In May 2016 the Chair and Chief Executive of IHT were appointed in the same roles at CHUFT.
- In September 2016 the CHUFT Company Secretary was appointed to support IHT in the same capacity.
- In April 2017 the Chief Pharmacist at CHUFT retired; consequently the Chief Pharmacist at IHT was appointed to the joint role for both trusts.
- In May 2017 the trusts jointly appointed to a new post of Director of Communications and Engagement.
- In September 2017 the Chief Information Officer (CIO) at IHT and the Associate Director IT at CHUFT, were appointed respectively as CIO and Deputy CIO working across both trusts.

- In January 2018 both trust remuneration committees approved a number of temporary changes designed to support the focus on the new organisation, including:
 - Appointment of the CHUFT Managing Director to a new Medical Director role, working across both trusts in developing a new clinical strategy and implementation plans.
 - Appointment of the IHT Managing Director/Deputy Chief Executive to also cover the equivalent role at CHUFT.
 - Appointment of the CHUFT Director of Finance to also cover the equivalent role at IHT.
 - Appointment of the IHT Director of Workforce to also cover the equivalent role at CHUFT.

Appointment procedures for executive directors will be completed in April/May 2018

7.2.3.4 Governance in the period to the completed transaction

During the period leading up to the transaction completion, the trusts will increasingly bring together internal processes and governance arrangements to ensure a smooth transitional period. For example, in February 2018 the trusts brought together their capital plan processes to ensure that investment decisions are taken in the light of the plans for the new trust. It is anticipated that further governance meetings will be undertaken jointly as appropriate in the period leading into the merger.

7.2.4 Creation of a new trust

7.2.4.1 Transaction agreement

The transaction documents will need to be executed in order to complete the proposed transaction, and will include:

- The transaction agreement, which will supplement the Grant of Acquisition and outline the steps to be taken prior to completion and describe any other contracts to be entered into in relation to the transaction.
- The joint application made by the trusts to NHS Improvement accompanied by:
 - Evidence of approval of the transaction by a majority of the CHUFT council of governors.
 - A copy of the proposed constitution of ESNEFT amended on the assumption that CHUFT acquires IHT.
 - A letter of support from the Secretary of State.
 - The approved minutes of the Council of Governors meeting for CHUFT.
- The Grant of Acquisition made by NHS Improvement which will transfer all of the assets and liabilities of IHT to CHUFT.
- NHSE Standard Services Contract(s) for commissioning of the Transferring Services from CHUFT.

7.2.4.2 Completion of the transaction

The transaction will be effected by NHSI using its powers under sections 56A and 56AA of the 2006 NHS Act to grant the trusts' joint application for the transaction by making a Grant of Acquisition as a result of which:

- the transferring assets and liabilities will transfer to CHUFT (ESNEFT)
- the transferring employees will transfer to CHUFT (ESNEFT) in accordance with the TUPE Regulations
- CHUFT's amended constitution will take effect
- IHT will be dissolved and its establishment order revoked
- the charitable funds will transfer to CHUFT (ESNEFT) in its capacity as corporate trustee
- the new board and council of governors will take effect

7.2.4.3 Execution of the Grant of Acquisition

At the point that the Grant of Acquisition takes effect, the organisation, previously known as Colchester Hospital University NHS Foundation Trust, will be re-named as East Suffolk and North Essex NHS Foundation Trust.

7.2.5 Transaction timeline

The anticipated stages of the programme in relation to completion of the submission to NHSI and subsequent scrutiny to approval are summarised in Figure 7-2.

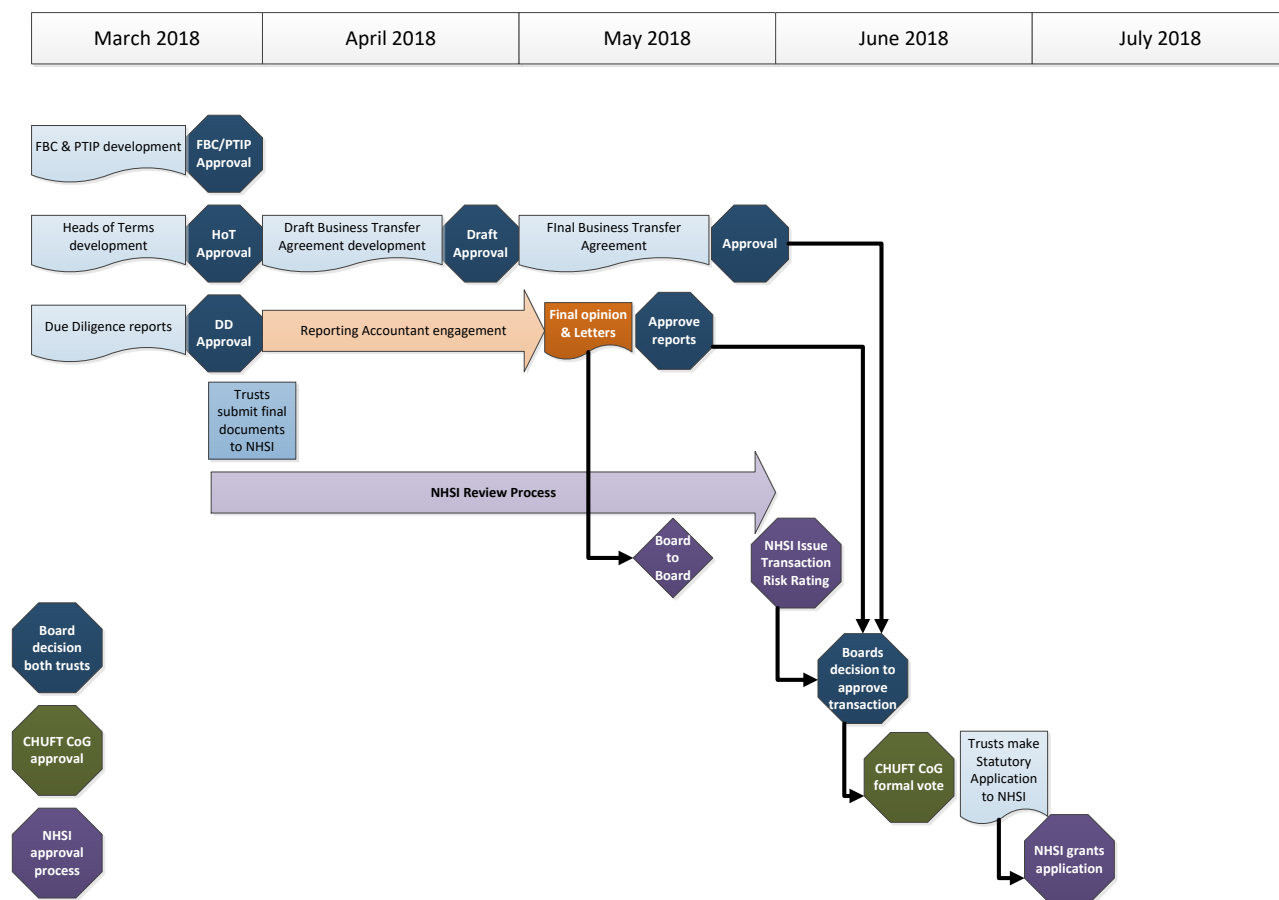


Figure 7-2 Key milestones in the timeline to successful Grant of Acquisition

This timeline is an ambitious 'best estimate' based on the NHSI transaction guidance. The time to complete the review and subsequent transaction stages will be determined by NHSI.

7.3 Post-transaction implementation

In parallel with the development of the FBC, a Post-Transaction Integration Plan (PTIP) has been developed which details the approach ESNEFT will take to implementing the merger.

The PTIP operates as a standalone document, complementary to the FBC, with distinct milestones and objectives which will be implemented through ESNEFT's governance and leadership processes, and which will form the basis for the trust's annual business and strategic planning.

7.3.1 Summary of the PTIP and milestones

The PTIP identifies the approach and actions to be taken to deliver a five-year plan of integration within ESNEFT. This will, in turn, contribute to delivering the overall ambition for the merger that by working together CHUFT and IHT will secure sustainable and high quality healthcare for east Suffolk and north Essex.

At the outset of the partnership four objectives, or success measures, were defined which align with the strategic challenges faced by the STP, these are:

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

7.3.2 Integration programme governance

The PTIP has been developed within the overall programme governance structure as outlined at section 7.2.1, it includes details how the integration programme will be governed.

7.4 Overview of key risks and mitigations

Risks have been identified and rated by the programme team assessing the combination of impact and likelihood⁸² to arrive at an overall risk score. This approach is consistent with NHS standards.

Risks have been identified in relation to three types as shown in Table 7-1.

⁸² Risks are measured using a five by five matrix assessment of Impact and Likelihood; Impact is assessed on the scale: 1 = Negligible, 2 = Minor, 3 = Moderate, 4 = Major, 5 = Catastrophic; Likelihood is assessed on the scale: 1 = rare, 2 = Unlikely, 3 = Possible, 4 = Likely, 5 = Almost Certain

Table 7-1 Risk classification

Programme risks	Transaction risks	Integration risks
Risks that could affect the boards' ability to reach a decision on the FBC	Risks that affect the completion of the transaction with NHSI	Risks that could affect the organisation post-transaction
These risks have been reported via a risk register report submitted to the partnership advisory board	These risks will be managed in dialogue with NHSI and the boards	Identified in PTIP and part of active risk management strategy up to and beyond the grant of acquisition
These risks fall away on approval of the FBC	These risks fall away on grant of acquisition	These risks will be managed using the ESNEFT Board Assurance Framework (BAF) and risk register and through the portfolio board and board assurance committees
Table 7-2 includes a schedule of the outstanding high and significant programme risks	Table 7-3 includes a schedule of the outstanding high and significant transaction risks	Table 7-4 includes a schedule of the outstanding high and significant integration risks. The PTIP includes all integration risks in a risk appendix.

Key risks with a combined Impact and Likelihood rating of 12 and above (High and Significant risks) in each of categories are shown.

7.4.1 Programme risks

Table 7-2 High and Significant rated risks to the delivery of the programme

Risks	Risk description	Controls and mitigation
Conflicting demands on scarce resources Impact 4 Likelihood 3	<p>Cause: If the programme fails to deliver key deliverables</p> <p>Effect: due to conflicting resource demands within the work streams between partnership activities and individual trusts business as usual</p> <p>Impact: will lead to delays in producing programme deliverables, which may then have an impact on FBC and PTIP being ready for review by Trust Boards, submission to NHSI and subsequently delay Day One for the new organisation.</p>	<p>Each work stream has been asked to identify where there is a requirement for additional resources.</p> <p>Key posts to have their responsibilities backfilled to create bandwidth for key resources to input to the merger. Particular teams/functions ICT, HR, finance, business intelligence, change management, operational leads</p>

Risks	Risk description	Controls and mitigation
Loss of key staff Impact 4 Likelihood 3	<p>Cause: If key staff leave both CHUFT and IHT prior to Day One due in their view to uncertainty of their role in the new organisation,</p> <p>Effect: then there will be a loss of skills and capability that will be difficult to replace in the timescales</p> <p>Impact: which means there will be a loss of capacity to deliver and potential for increase in costs due to having to backfill with agency</p>	<p>Staff communications (regular updates and engagement) - and briefings in place at both organisations.</p> <p>Management reports - turnover rates and reasons.</p> <p>Leavers exit reviews and reason for leaving.</p> <p>Staff feedback</p> <p>Engagement on organisational structure and post commenced March 2018.</p>

7.4.2 Transaction risks

Table 7-3 High and Significant rated risks to the transaction

Risks	Risk description	Controls and mitigation
Delivering long-term financial sustainability Impact 5 Likelihood 3	<p>Cause: If we are not able to present a balanced LTFM for the partnership to support the FBC</p> <p>Effect: Regulators will not be able to approve the transaction</p> <p>Impact: leading to delay or project failure</p>	<p>Work to align the financial strategies of the two trusts to articulate how sustainability could be achieved.</p> <p>Work to develop and socialise stretch ambition especially regarding corporate model</p> <p>Early discussion with senior leaders at NHSI regarding their expectations of LTFM and approach to possible transaction</p> <p>Rigorous risk-assessed evaluation of financial benefits arising from the operating model and clinical strategy</p> <p>Work to align the financial strategies of the two trusts which articulate how sustainability could be achieved</p> <p>Early discussion with senior leaders at NHSI regarding their expectations of LTFM and approach to possible transaction</p>
Savings are back-ended in LTFM Impact 5 Likelihood 3	<p>Cause: If the operating model for Day One and beyond does not realise any savings in the first two years and the majority of savings are in years 4-5</p> <p>Effect: the business case might not be approved by boards and NHSI</p> <p>Impact: the timescales for Day One will move out to later in 2018/19.</p>	<p>Corporate work stream reviewing operating model organisation design</p> <p>Integration plans from each corporate function</p>

7.4.3 Integration risks

The risks as a result of the merger should the transaction be approved, will form part of ESNEFT's risk register. These are summarised in Table 7-4. Actions and activities have already commenced to mitigate all of these risks. These will be managed by the shadow board and then the board of directors.

Risks to the achievement of successful integration, including clinical risks, legal risks, financial and commercial risks, have been identified and captured during production of the FBC, due diligence, integration planning and the early integration activities. These identified risks have been scored and added to the ESNEFT risk register. The risk register is trust-wide and populated from risk assessments carried out at all levels and across all divisions within the trust.

Integration risks are marked under the 'Integration' nomenclature and are subdivided by integration work stream. Risks are reviewed by each integration work stream; risks with a rating of 12 or above appear on the [Integration Board] risk register. All risks relating to the integration of the merged organisation will be reported to the board for the first year to give directors oversight of how the integration implementation is progressing.

To manage ongoing integration risks, to both the individual work streams and the overall integration programme, the work stream senior responsible officers will be accountable for:

- Early identification of risks and inputting detail into the risk management system (Datix) with clear accountability (i.e. who is responsible for resolving the issue) and assessment/score.
- Escalation to the relevant group as appropriate, with oversight by the Executive Risk Oversight Committee with escalation to the trust executive, board assurance committees, board of directors as appropriate.
- Timely mitigation.
- Tracking, monitoring and communicating dependencies.

Table 7-4 High and Significant rated risks to integration

Risks	Risk description	Controls and mitigation
Staff skills shortage for change management	Cause: Inadequate individual staff skills, expertise and resources to deliver major change programme at pace	Cost of change included in implementation plan Work stream executive leads have oversight of their implementation plan
Impact 4 Likelihood 4	Effect: Delay or failure to meet objectives, increased staff turnover/absenteeism/illness Impact: Changes are not fully adopted or utilised and slide back to previous state	Portfolio board will oversee implementation of all trust programmes

Risks	Risk description	Controls and mitigation
Combined Performance Impact 4 Likelihood 3	<p>Cause: If the 'combined' statutory performance for the new organisation</p> <p>Effect: results in a deterioration of performance</p> <p>Impact: then this may result in regulatory bodies invoking performance management regimes which means scarce resources will be diverted away from transformation activities to address required performance reporting</p>	<p>Both Trust's already manage statutory performance and have improvement plans in place where required.</p> <p>Continue use of accountability framework - to identify and manage areas poor performance.</p> <p>Board assurance committees in place.</p> <p>Continue portfolio board approach until integrated approach is developed.</p> <p>Experienced operational delivery teams.</p>
HR Bank Impact 4 Likelihood 3	<p>Cause: if the re-procuring a new bank provider result in changes for bank staff</p> <p>Effect: then there may bank staff disengagement and attrition</p> <p>Impact: which means temporary staff not being available when required leading to gaps in rotas and potential for increased agency spend</p>	<p>Keep existing contract arrangements in place until a full option appraisal and the risk mitigation plan has been established to address - differential payments, differential pension arrangements.</p>
Work streams have too many Day One Must Haves Impact 4 Likelihood 3	<p>Cause: If the various work streams identify too many Day One Must Haves</p> <p>Effect: then teams such as IT, Information Management, Finance and HR may not have capacity to develop all the solutions for Day One</p> <p>Impact: which means the new organisation is not ready for operation and therefore services and performance are impacted</p>	<p>Each work stream identifying what changes are required for Day One and dependency on teams such as IT, Estates, Finance and HR.</p> <p>Review of scope of work by Corp Functions and deliverability in timescales.</p>

8 Communications and stakeholder engagement

8.1 Progress and approach since the OBC

Since publication of the OBC, communication and engagement activity has continued to build further on the previous activity, approach and relationships. This has provided a solid platform from which to widen and strengthen audience reach, and introduce more interactive and intelligence-led opportunities for engagement.

During the period from publication of the OBC to submission of this document, a number of steps have been taken to strengthen engagement with staff, public and stakeholders. Highlights are included below, and a full list of activity included in Appendix 5. Whilst this summary segregates the activity by three main audiences (staff, stakeholder and public), much of the activity would have been seen by two or more of these audiences (for example, online activity, public display material or surveys) and was designed deliberately to work for multiple viewers or respondents.

Throughout this period, activity, messaging and channels have been tested and shaped by staff and public feedback and real-time evaluation has been used to refine our approach.

The communication and engagement strategy has a principal that messaging must be clear, understandable and consistent, and focus on practical information and planned benefits, not process.

Following this principle, the four objectives set out in the OBC and FBC were consolidated and adapted into three aims which focused on understandable and tangible benefits which would resonate with the widest possible audiences.

These aims are:

- To see patients at the right time
- Attract and retain the best staff
- Provide the latest treatments locally.

These were agreed after testing with staff and public, and have been used extensively to good effect throughout our engagement activity.

The approach to communication and engagement materials has been based on:

- Clean corporate style based on NHS brand
- Professional public material
- User testing of messaging by staff and public groups and online surveys
- Public engagement at libraries, town halls and patient participation meetings
- Communicating directly with stakeholders through a new *Connect* e-bulletin
- Bespoke contact with seldom heard groups
- Staff engagement through internal updates/staff meetings at all sites
- Online and social media surveys, crowdsourcing feedback.

8.2 Communication and engagement strategy

A full communication and engagement strategy (Appendix 6), including target audiences, was agreed by both boards in October 2017; key areas of the plan included:

- Recognition that any proposed changes to NHS services or organisations can be worrying for patients, staff, the wider public and stakeholders.
- Recognition that the trusts serve rural communities and hard to reach groups, all of whom must have access to information and opportunities for engagement.
- Establishing that the communication materials and messaging must be clear, understandable and consistent, and focus on practical information and planned benefits.
- Communication should work through existing networks and relationships to broaden reach and impact, especially with harder to reach communities. They should use the most appropriate channels and language for the audience based on feedback from surveys.
- Promoting the opportunities, including public reassurance on the impact of the new organisation, especially on travel.
- Be a national exemplar for organisational change; clear, consistent corporate branding in place; using intelligence-led activity to increase impact with all audiences.

8.3 Equality impact assessment

The equality impact assessment (EIA) to assess whether a change has an adverse impact on any of the protected groups is important in meeting the public sector general equality duty as outlined in Section 149 of the 2010 Equality Act.

An assessment of the potential impact of the merger on equality and diversity has been undertaken (Appendix 7). The FBC for the merger does not propose any significant changes to patient service configuration.

There is a firm commitment by the leadership that any such changes proposed in future would be subject to the completion of an Equality Impact Assessment in line with the requirements of the Act.

8.4 Travel impact assessment

An important part of any future service or other change will be an assessment of the impact on travel for local residents and staff. To this end an assessment of the impact of the merger on travel has been developed (Appendix 8) to consider any actual or potential impact on travel related to the FBC. This travel impact assessment (TIA) should be read as a companion to the EIA.

Concern regarding potential increases in travel times and distance has been a key public message throughout the merger engagement events.

Preliminary discussions with transport providers to explore potential bus route options to improve public transport between the main CGH and IH sites have commenced.

The FBC does not include any detailed proposals for service changes, but there are implications for travel and transport within the document. There is a firm and public commitment by the leadership that any service changes proposed by ESNEFT would be subject to a TIA in line with best practice.

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

- There are no detailed changes proposed which would negatively impact on existing travel and transport requirements for patients, families and carers.
- There is an emphasis within the FBC on greater use of community services and new technology to reduce travel time in some cases.
- There are opportunities to save, strengthen and grow services, especially more specialised services, which may reduce the need to travel to regional centres.
- There are no changes impacting on majority of staff, but the ESNEFT leadership and senior management will need to have an increased presence across both sites to support the single team model.
- There is 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.

To ensure that the concerns regarding travel continue to be given attention, the following recommendations from the TIA are supported:

- Detailed TIAs will be undertaken for all relevant service changes in the future
- A travel working group including representatives from staff, patients, residents and other interested parties will be established to discuss current and future travel and transport plans
- ESNEFT will engage with patients and carers in developing the use of technology and community services which may reduce existing travel time
- ESNEFT will ensure all staff are aware of relevant policies relating to travel and transport.

8.5 Engagement activity

8.5.1 Staff engagement

Staff engagement is a priority through any organisational change. The engagement activity with staff has been coordinated closely with the human resources team and has built on existing channels and relationships to maximise effectiveness. The staff engagement throughout this period has included:

- Meetings with staff reference groups to provide feedback on messages and channels.
- Regular updates to consultant and senior medical staff committees.
- Multiple staff events held at all eight physical hospital sites.
- Regular core briefing from executives to disseminate messages for cascade through the two trusts to local leaders via face-to-face meetings, with email follow-up. Each core brief has focussed on one particular aspect of the merger, for example, the detail and timeline for staff consultation and TUPE, organisational structures and the draft clinical model.
- Online surveys; using these staff have been asked their views on messaging, options for the name of the new trust and the most effective way for them to be engaged.
- All relevant information, including frequently asked questions, is available on the trusts' intranet sites and some of this material is displayed as screen savers.
- Leaflets, display stands and posters outlining key messages at all sites.

A full list of activity and events can be found in Appendix 5.

8.5.2 Stakeholder engagement

Given the large geography that ESNEFT will serve, the merger has offered an opportunity to consolidate and improve the existing methods of engagement across the two trusts. Recognising that the best engagement remains face-to-face, the merger leadership has dedicated as much time to this as possible.

A new e-bulletin has been introduced and bespoke targeting of representatives of seldom-heard groups has taken place, offering meetings or further information. Examples of stakeholder engagement activity include:

- Introduction of new e-bulletin, *Connect*, which offers brief items of information relating to the merger, with links to more information, to give feedback, take part in surveys or ask for a meeting or conversation. *Connect* is currently received by around 650 stakeholders, and as it is forwarded on, data confirmed that the January 2018 edition was read by over 2,500 recipients.
- Drafts of the communication and engagement plan were shared with both Suffolk and Essex county councils and with both local clinical commissioning groups.
- Updates on progress with the FBC and wider merger issues have been discussed at both the Essex and Suffolk Health Overview and Scrutiny Committees (HOSC); this positive dialogue resulted in a joint HOSC in March 2018 to scrutinise the FBC prior to final submission.
- To ensure stakeholders had as many opportunities as possible to engage throughout this process, bespoke letters were sent to stakeholders and to a number of representatives of seldom-heard groups asking if and how they might like further engagement.

A full list of activity and events can be found in Appendix 5.

8.5.3 Public engagement

Some of the tactics used to reach the public through the FBC process have included:

- Meetings with public and patient/carer representative groups, such as Ipswich Hospital User Group (IHUG) and GP practice-based patient participation groups (PPGs)
- Public 'drop-in' sessions at libraries and town halls across the region
- Board meetings held in public
- Dissemination of material, such as leaflets
- Online information and surveys
- Media items
- Social media and crowdsourcing.

A full list of activity and events can be found in Appendix 5.

8.6 Feedback summary

For the public and stakeholders the main area of feedback focused on travel and transport, with patients, families and carers concerned they may have to travel further to access care. Concerns included the distance and time involved; cost of parking or private taxi hire; access to, and

integration of, public transport; difficulties of travel due to ill health; and impact on family and carers.

To address this, key messages have been updated in public material to reassure the public that the majority of services will not change; but if they have to, it will be to concentrate them for a small number of patients to improve outcomes. In this event a full travel impact assessment and mitigation would be considered in each case.

For staff the main concerns were two-fold. Firstly, around possible job losses and secondly, around the need to travel between Colchester and Ipswich more frequently and the impact on their work and private life.

Staff have been kept up-to-date through the trusts' briefing processes on the proposed organisational structure, how posts will be identified and how the change process will be managed. Staff have also been briefed on any possible impact on travel patterns, including greater use of technology as a mitigation for those affected. This engagement and dialogue will continue.

9 Conclusion and recommendations

As separate organisations, CHUFT and IHT are unsustainable due to a combination of population growth and rising needs due to ageing and deprivation, continued workforce pressures and the complexity and cost of meeting ever-rising health care standards.

Without the merger, quality and access to services, as well as the trusts' financial deficit will continue to deteriorate.

Coming together as a single organisation offers important opportunities to sustain and develop the range and quality of services available to the local population. In particular, the scale of clinical services and the increased range of services available to patients through ESNEFT will create further opportunities for improvement. The time matters philosophy will reduce stress for patients and families.

The new corporate services model will release time for patients and staff. This will increase capacity within ESNEFT and give corporate staff more time to support transformation in clinical services.

There will be significant reductions in the cost of administrative and agency staff, releasing funding to support clinical services.

Recommendation:

That the Board approve the Full Business Case (and supporting documentation) and that this can now be submitted to NHSI

10 Index of appendices

1	Partnership Option Evaluation SOC and OBC stages
2	Demographic Review of the catchment area of ESNEFT
3	ESNEFT Draft FT Constitution
4	Organisational structure design principles
5	Engagement activity programme
6	Communication and engagement strategy
7	Equality Impact Assessment
8	Travel Impact Assessment
9	Workforce demographics CHUFT and IHT
10	Financial sensitivity assessment