CHUFT – IHT
Long-Term Partnership

Strategic Outline Case (SOC)

January 2017

Colchester Hospital University NHS
NHS Foundation Trust

The Ipswich Hospital NHS
NHS Trust

CHANGE LOG

Date	Change	Date	Change
31/10/16	Regulatory approach added		
2/11/16	New template applied		
29/11/16	Template page size changed to A4		
29/11/16	Update to wording in context and strategic case		
29/11/16	Scenarios identification process added		
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19/12/16	Shortlist added		
19/12/16	Section for ambition and objectives added		
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10/01/17	Executive summary and conclusion added		
12/01/17	Reviewed and updated following B2B		
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18/01/17	Scenario benefit and drawbacks added to conclusion		
19/01/17	Updated to final version following PAB approval		

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Executive Summary

Introduction and context

In May 2016 the Boards of Ipswich Hospital NHS Trust (IHT) and Colchester Hospital University NHS Foundation Trust (CHUFT) committed to entering into a Long-Term Partnership (LTP). This will be built on a foundation of collaborative working that has been established between the two Trusts over recent years. At the same time CHUFT appointed IHT's Chief Executive and Chair, who now lead both organisations with the support of NHS Improvement (NHSI).

IHT and CHUFT are both District General Hospitals (DGHs) that serve a similar sized population of between 380-390,000. In addition, IHT also provides some community services. Both offer a range of secondary clinical services, including 24/7 undifferentiated take Emergency Departments, obstetric-led maternity units and inpatient paediatrics.

The purpose of the Strategic Outline Case (SOC) is to develop and shortlist scenarios, and recommend a preferred scenario (or scenarios) for the LTP for further development into an Outline Business Case (OBC) and Full Business Case (FBC).

Clinical and strategic case

The LTP is core to delivering the local Sustainability and Transformation Plan[1] (STP), which sets the strategic direction for health and care services in the area. The STP contains an ambition not only for closer working between the Trusts, but also for reconfiguration of acute services. Both Trusts have identified that strategic partnership is essential to their sustainability, and that IHT and CHUFT are appropriate partners for this.

Analysis undertaken during the development of the STP 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

There is a recognition that a step change in the level of transformation is required to ensure sustainability. While both Trusts have individual development initiatives underway (such as Every Patient, Every Day at CHUFT and the Accountable Care Organisation plan in Ipswich & East Suffolk), none of these alone will wholly address the challenges faced.

Long-Term Partnership ambitions and objectives

An ambition, scope and objectives have been developed to articulate the LTP in more detail.

The ambition for the Partnership is that by working together CHUFT and IHT will secure sustainable and high quality healthcare for Ipswich, East Suffolk and North East Essex

Four objectives have been defined which align with the strategic challenges:

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

Scenarios: formulation, evaluation & shortlisting

In order to assess how the LTP could achieve its ambition and objectives, a range of scenarios was identified and evaluated. The scenarios describe organisational forms or approaches which the partnership could take in order to realise the benefits of working together.

In total 18 scenarios have been identified, informed by a number of sources including the Dalton Review[2], models emerging from the Acute Care Collaboration vanguards[3], and examples from NHS Improvement[3].

Sources: 1) Suffolk and North East Essex Sustainability and Transformation Plan (2016); 2) Examining new options and opportunities for providers of NHS care, The Dalton Review, (2014); 3) Acute care collaborations: Guidance on options for structuring foundation groups, NHS Improvement (2016)

Executive Summary (cont'd)

Scenarios: formulation, evaluation & shortlisting (cont'd)

The longlist was evaluated against hurdle criteria to arrive at a shortlist. The hurdle criteria tested the scenarios against the objectives of the LTP and key constraints (such as 24/7 A&E on both sites). The outcome of this was a shortlist of 8 scenarios. This was then subjected to a more detailed evaluation to identify a preferred set of scenarios. Detailed evaluation was carried out by expert stakeholders against four, non-financial criteria:

- Quality: outcomes, safety and patient experience
- Access
- Deliverability
- Workforce sustainability

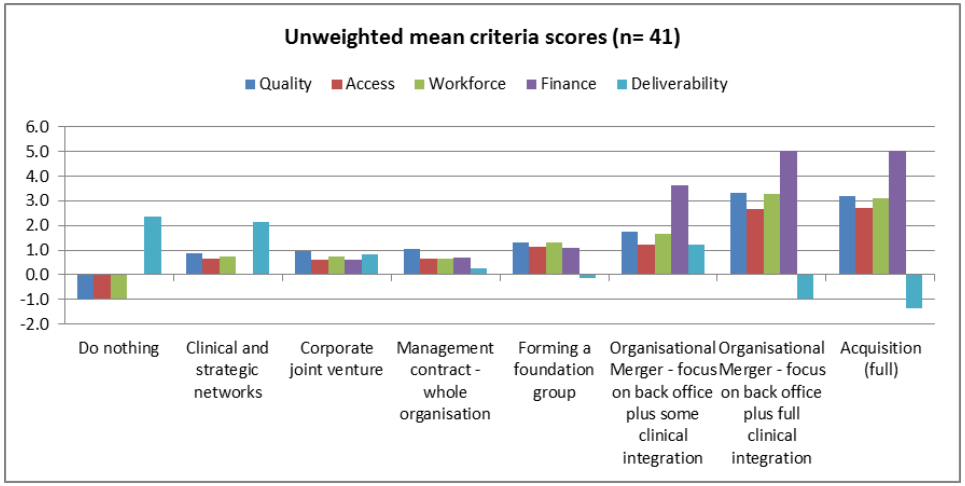
The identification of the recommended scenarios and the approach to evaluating them was carried out by working closely with three key groups of stakeholders: a clinical reference group, the commissioners and the executive teams of both Trusts. At each stage they were asked for their views on the approach, and inputs to deliver outputs from the process; the approach was regularly reviewed and amended in the light of this feedback. This also ensured that there was good strategic fit with the local health and care system.

Financial case

In parallel a financial evaluation of the shortlisted options was undertaken, based on a five step process:

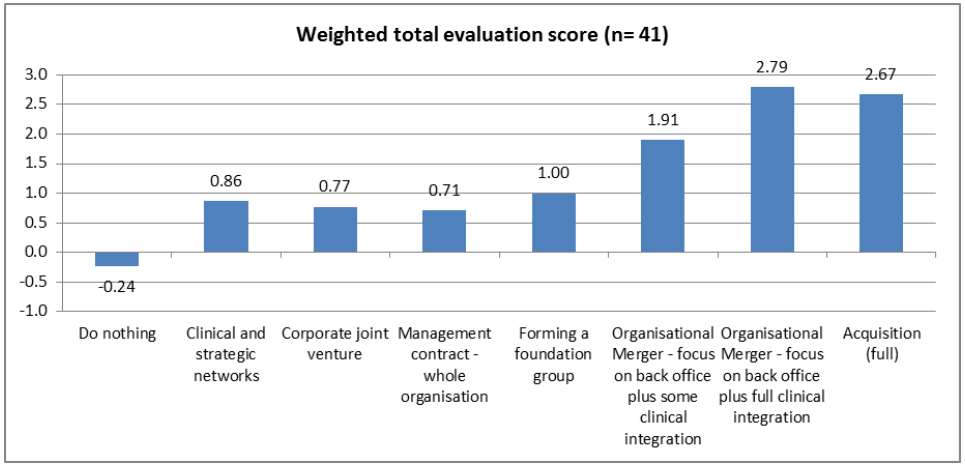
- Develop separate financial submissions for NHSI for CHUFT and IHT
- Combine NHSI submissions to create the baseline scenario
- Develop and agree assumptions for each shortlisted scenario
- Apply assumptions to each scenario's P&L forecast
- Convert P&L forecasts to financial criterion score

At the end of this stage each of the scenarios was awarded a score for financial sustainability, compared with the baseline financial case. The scenario with the greatest impact on sustainability was awarded the highest score.



Preferred scenarios

Combining the non-financial and financial analysis resulted in total 'scores' for each shortlisted scenario. There were three scenarios that scored markedly higher than the others: **merger plus full clinical integration, acquisition (full)** and **merger plus some clinical integration**.



Executive Summary (cont'd)

Management case

A governance approach was developed to ensure timely progress and sufficient oversight of the production of the SOC. This governance will be fully refreshed for OBC phase, ensuring that the governance structures supports closer working between Trusts within the remit of the LTP.

A high level programme timeline has been developed. This also supports an increased level of stakeholder (including staff and commissioner) and, crucially, public engagement. The ambition is to implement in April 2018.

Workforce case

The purpose of the Workforce case is to describe, for the preferred scenario(s), the implications for the workforce at CHUFT and IHT in relation to:

- The benefits for the IHT and CHUFT workforce, as well as the workforce across the broader STP footprint
- The extent of cultural alignment / integration required across the CHUFT and IHT workforce
- The strategic workforce initiatives to deliver the benefits and the cultural alignment / integration
- The workforce plan for the preferred scenario(s)

At the SOC stage, it is not possible to describe these in further detail as no preferred scenario(s) have been agreed. However as the programme progresses through the OBC and FBC stages, further consideration will be given to the four areas described above. The workforce case will describe the expected benefits that the preferred scenario(s) will deliver or enable.

Commercial case

The purpose of the Commercial case is to describe how any final preferred scenario(s) is (are) being procured and the contractual terms through which the scenario(s) will deliver the objectives of the LTP.

At the SOC stage, it is not possible to describe these as the final preferred scenario(s) is (are) yet to be confirmed. However as the programme progresses through the OBC and FBC stages, further consideration will be given to two main elements, related to the shortlisted scenarios:

- The contractual terms related to any potential scenario for delivering strategic clinical networks, a corporate joint venture, a management contract (whole organisation), or forming a foundation group
- The contractual vehicle for any potential scenario involving an organisational merger or acquisition

Conclusion

The results of the evaluation suggest that a higher degree of corporate control offers more opportunity to realise the benefits of partnership. Three scenarios are clearly distinguished above the others: merger with full clinical integration, acquisition and merger with some clinical integration.

Next steps for the programme include:

- Defining the objectives of the OBC phase, based on the scale of ambition
- Defining the pace of ambition for the OBC phase
- Establish the governance structure and resources, based on the scale and timeline of the OBC

The latter will also include the development of a resource plan for the delivery of the OBC phase. This will have to be agreed by the CHUFT and IHT Boards, and it is anticipated that this will be presented at the February Boards

Recommendation

The Partnership Advisory Board recommend that the two trusts proceed to evaluate these three scenarios (merger with full clinical integration, acquisition and **merger with some clinical integration) plus the "do nothing" baseline scenario, in detail through an Outline Business Case (OBC).**

Section 1

INTRODUCTION AND CONTEXT

Introduction

Overview of the programme

In May 2016 the Boards of Ipswich Hospital NHS Trust (IHT) and Colchester Hospital University NHS Foundation Trust (CHUFT) committed to entering into a Long-Term Partnership (LTP). This will be built on a foundation of collaborative working that has been established between the two Trusts over recent years. At the same time CHUFT appointed IHT's Chief Executive and Chair, who now lead both organisations with the support of NHS Improvement (NHSI).

The LTP is core to delivering the local Sustainability and Transformation Plan[1] (STP), which sets the strategic direction for health and care services in the area. The STP contains an ambition not only for closer working between the Trusts, but also for reconfiguration of acute services. Both Trusts have identified that strategic partnership is essential to their sustainability, and that IHT and CHUFT are appropriate partners for this. An ambition, scope and objectives have been developed to articulate the LTP in more detail.

Drivers for change

The challenges facing the NHS are well recognised, with patients' needs increasing and a demanding financial context. Partly as a result of this, both Trusts are forecasting a significant deficit for 2016/17. IHT has a 'good' rating from the Care Quality Commission (CQC), and is seeking to improve, or at the very least, maintain the quality of clinical services. In contrast, CHUFT has been rated as 'inadequate' and is subject to enforcement action by the regulator.

In addition to these challenges, the STP also describes 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. Taken together, these challenges mean that neither Trust is likely to be clinically and financially sustainable, and deliver their respective visions, in the medium- to long-term. NHSI and the CQC jointly recommended a long-term partnership between CHUFT and IHT to secure the services for patients in the long term.

Local context

IHT and CHUFT are both District General Hospitals (DGHs) that serve a similar sized population of between 380-390,000. In addition, IHT also provides some community services. Both offer a range of secondary clinical services, including 24/7 undifferentiated take Emergency Departments, obstetric-led maternity units and inpatient paediatrics.

Both Trusts offer some specialist services, for example spinal surgery at IHT and vascular surgery at CHUFT. In line with national policy, though, some specialist services have been centralised and are commissioned from other providers.

CHUFT is facing significant challenges recruiting and retaining staff, including senior decision-makers. IHT also faces similar challenges, albeit to a lesser extent. While both Trusts have individual development initiatives underway (such as *Every Patient, Every Day*), these will not wholly address the challenges faced.

Identifying scenarios for a viable future

The Boards of IHT and CHUFT, respectively, approved a Strategic Outline Programme (SOP) in October 2016. This described the work that would be undertaken in the SOC to identify a range of scenarios that could provide a viable future through a LTP. Both Trusts recognise that a strategic partnership is essential to sustainability and that CHUFT and IHT are ideal partners.

In total 18 scenarios have been identified, informed by a number of sources including the Dalton Review[2], models emerging from the Acute Care Collaboration vanguards[3], and examples from NHS Improvement[3].

The aim of this document is to describe the process through which these different scenarios were tested and assessed. The analysis was conducted to determine: (i) a strategic fit with the ambitions of both the STP and the LTP; and (ii) the extent to which they enable a set of desired benefits. This resulted in a ranked list of scenarios and a recommendation to the Boards for further, more detailed, investigation of the leading scenarios.

Sources: 1) Suffolk and North East Essex Sustainability and Transformation Plan (2016); 2) Examining new options and opportunities for providers of NHS care, The Dalton Review, (2014); 3) Acute care collaborations: Guidance on options for structuring foundation groups, NHS Improvement (2016)

Purpose of the Strategic Outline Case

The purpose of the Strategic Outline Case (SOC) is to develop and shortlist scenarios, and recommend a preferred scenario (or scenarios) for the LTP for further development into an Outline Business Case (OBC) and Full Business Case (FBC). The different stages of the business case process are determined by Treasury[1] and NHS Improvement guidance[2], and are shown in the table below:

Business case stage	Purpose	Expected date
Strategic Outline Programme (SOP)	• Determine strategic fit • Secure agreement & commit resources to develop the SOC	October 2016
Strategic Outline Case (SOC)	• Develop and shortlist the scenarios • Recommend preferred scenario(s) • Secure agreement & commit resources for Outline and Full Business Case development	January 2017
Outline Business Case (OBC)	• Determine VFM, affordability, funding requirements • Planning for delivery • [External scrutiny / assurance as required]	July 2017 *(Potential timeline)*
Full Business Case (FBC)	• Contractual arrangements • Assurance of delivery planning • Investment decision	January 2018 *(Potential timeline)*

The SOC was developed at a sufficient level of detail that allows the Boards to agree a decision on the future of the LTP. This is balanced with the need to consider a wide range of scenarios before narrowing this down to a shortlist for more detailed consideration in later business cases. The process for identifying the range and shortlist of scenarios is the focus of this document.

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

National and local context

Increasing expectations of quality and performance

The NHS 5 Year Forward View[1] identifies three gaps which must be closed:

- Care & quality;
- Health & wellbeing
- Funding & efficiency

New models of service delivery and organisational integration are expected to be developed to meet these.

Ongoing financial challenge

The NHS planning guidance[2] for 2017-2019 makes "sustainability funding" available to acute trusts who meet strict financial control totals. This requested providers to make a step change improvement in their financial plans for 2016/17 in order to obtain a portion of the sustainability fund. Funding will be increasingly targeted at "the STPs making most progress"[2]. Meanwhile, providers must continue to deliver 2% cost efficiency annually[2].

Expectations of collaboration and transformation

The Sustainability and Transformation Plans[3] introduced in 2016/17 offer a wider footprint for collaboration and increase the potential for partnerships between acute hospitals. The Dalton review[4] considered the options for provider sustainability and identified seven possible organisational forms for acute trusts. The Carter review[5] identified efficiencies available from collaboration between NHS organisations (and other public services) with an expectation that trusts will significantly reduce their overheads.

The Suffolk and North East Essex Sustainability and Transformation Plan

In Suffolk and North East Essex, the NHS, general practice and local government have come together to develop a five year Sustainability and Transformation Plan. This is a unified plan to improve the health and care of the local people and bring the system back into a financially sustainable position. The system has created a plan which 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 STP has in place a strong, visible, collective leadership and a well-structured programme of work to address:

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

As aforementioned, both trusts have performance development initiatives underway with the STP and LTP set to address the challenges that they face as a whole.

Sources: 1) NHS Five Year Forward View, NHS England (2014); 2) NHS operational planning guidance 2017/18-2019/20, NHS England (2014); 3) Planning, assuring and delivering Service Change for Patients, NHS England (2015); 4) Examining new options and opportunities for providers of NHS care, Dalton Review (2014); 5) Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. Carter Review (2015)

The Suffolk and North East Essex STP

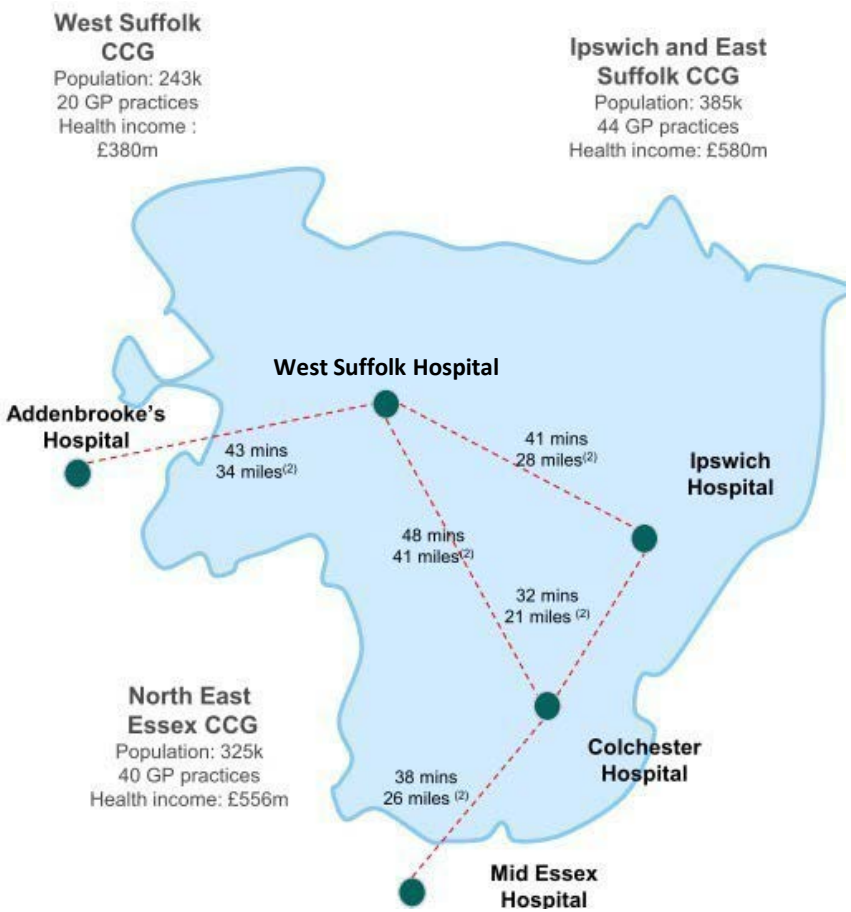
The STP intends to explore the following opportunities:

- A system control total that allows us to work as three sub-systems, respecting the sensitivities around local authority boundaries
- Extended joint commissioning arrangements with the local authorities
- To co-commission primary care to enable the transformation of general practice
- To change the approach to engage with the regulators to align with the local system ambitions

STP plans for service transformation

Within the STP there are three projects addressing acute hospital transformation:

1. IHT-CHUFT partnership (focus of this document)
2. West Suffolk Accountable Care Organisation
3. Redesign of major services / service bundles



Supporting the Health and Wellbeing Strategies for Essex and Suffolk

In common with other parts of the country, Health and Wellbeing Strategies have been developed for both Suffolk and North East Essex by their respective Health and Wellbeing Boards (HWBs). These are informed by local Joint Strategic Needs Assessments (JSNAs), which develop a profile of the local population and its requirements for health and care services. These assessments also underpin the local STP, as well as the local CCG commissioning intentions. Therefore, they set the wider context for health and care locally.

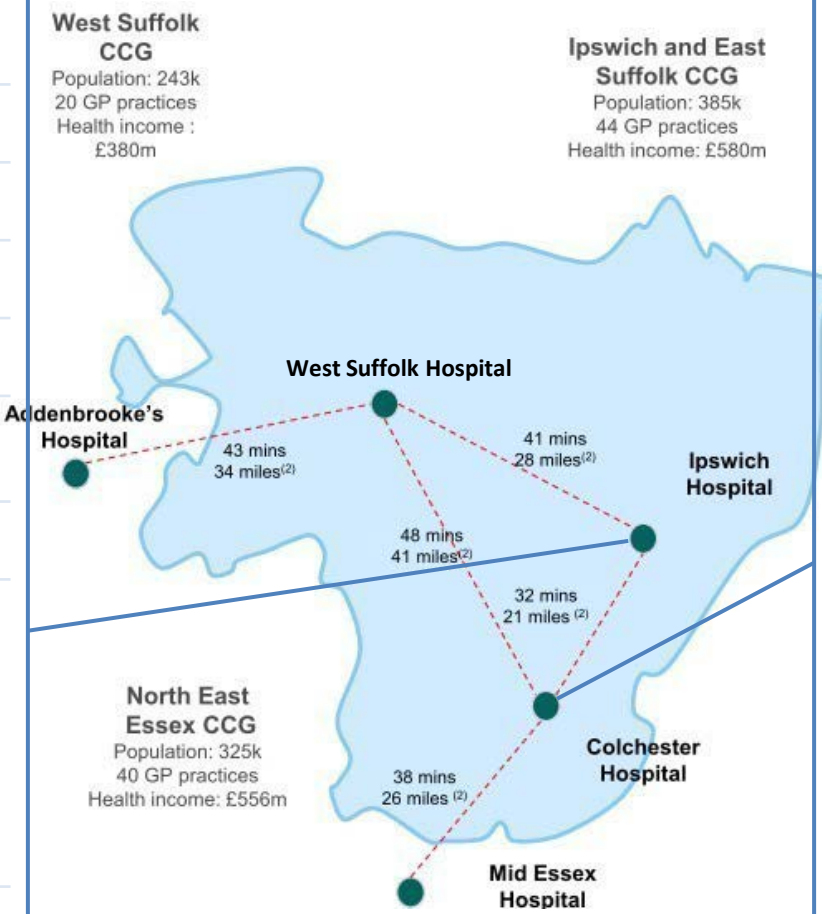
Both HWB strategies prioritise the need for greater integration of health and social care and other specific priorities including:

- **Ageing well**, including effective healthcare, ensuring a positive experience of services and helping people live as independently as they can for as long as possible
- **Giving every child the best possible start in life and helping them develop well**
- **Living and working well:** ensuring that residents make better lifestyle choices and residents have the opportunities needed to enjoy a healthy life
- **Enhancing the quality of life for people with long-term conditions** including supporting people to manage their condition, helping patients recover from episodes of ill health or following injury, improving outcomes from planned procedures and working towards better recovery from fragility fractures
- **Improving independent life** for people with physical and learning disabilities
- Ensuring people have the opportunity to **improve their mental health and wellbeing**

The developing LTP has a strong role to play in helping meet all these priorities. Equally, if there are no changes to the way in which services are provided, then the strategies are unlikely to be delivered, with a subsequent impact on the care that the local population receives.

Organisational profiles

IHT Profile	
Profile	District general hospital (DGH) and community services provider
Beds	541 G&A
Turnover (2015/16)	£283m
Catchment population	390,000
Employees	3,800
Specialist areas	Spinal surgery Radiotherapy Gynae-oncology
Latest CQC rating	Good (April 2015)
NHSI Single Oversight Framework: shadow segmentation[1]	2 - Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up.
Vision	To be an outstanding provider of health services for the population



CHUFT Profile	
Profile	DGH
Beds	560 G&A
Turnover (2015/16)	£278m
Catchment population	380,000
Employees	4,200
Specialist areas	Vascular surgery Radiotherapy Urology oncology[2]
Latest CQC rating	Inadequate (July 2016)
NHSI Single Oversight Framework: shadow segmentation[1]	4 - Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures.
Vision	Delivering great healthcare to every patient, every day

Sources: 1) NHS Improvement has segmented trusts (in shadow form) based on the level of support they believe is required. Segmentation is based on performance data and other information gathered before the SOF came into place on 1 October 2016. Score from 1 (lowest) to five (highest); 2) Service ceasing in Apr 2017

Section 2

CLINICAL AND STRATEGIC CASE

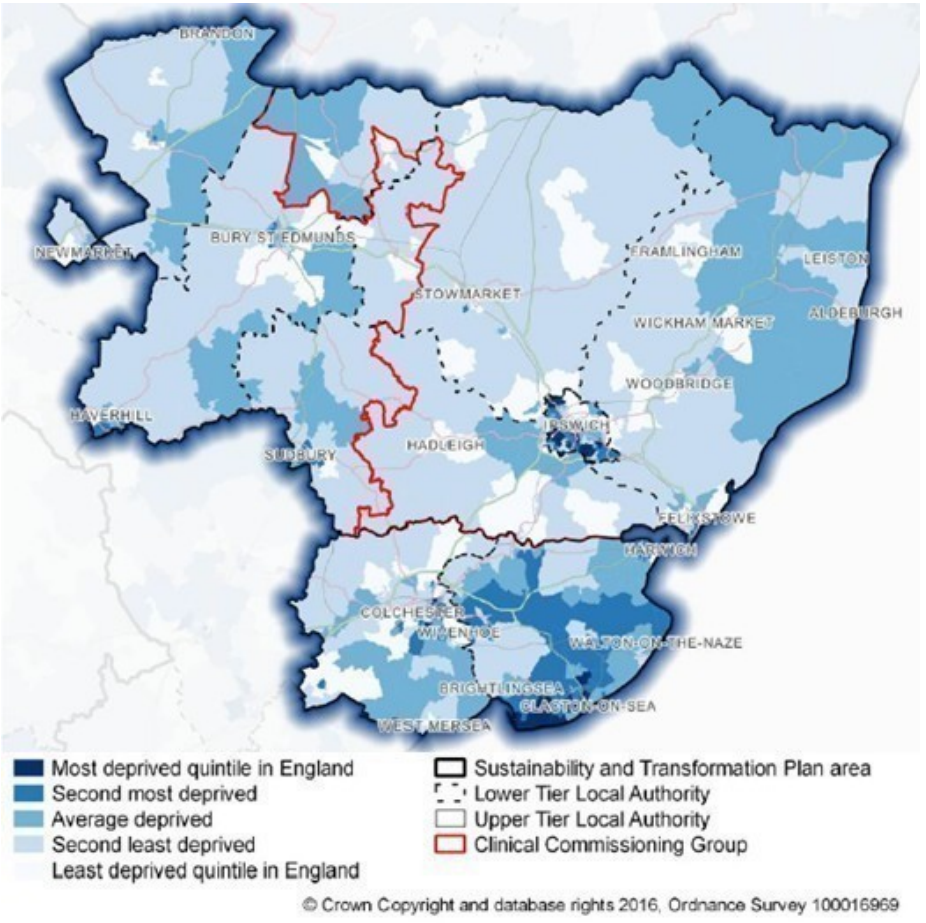
The local population is changing and there is a widening health and wellbeing gap

Through the development of the Suffolk and North East Essex STP the characteristics of the local population were investigated in detail. The catchment population of IHT and CHUFT are a subset of this wider population, though shares a similar profile. The challenges identified within the STP need to be addressed by local providers.

Demography

In Suffolk and North East Essex there is a population of 953,000 people, with the following characteristics[1]:

- By 2034 a 50% increase in the number of people over 65 is expected.
- Up to 2021 a 3.2% increase in the population[2], and 17.9% increase in those aged 75+ is expected
- 1 in 5 children aged 4-5 years in Suffolk and North East Essex are overweight or obese. For children aged 10-11 years this rises to 1 in 3, and 2 in 3 for adults
- Almost half of all people in the footprint eat the recommended 5 or more portions of fruit and veg per day
- Almost 1 in 4 adults do less than 30 minutes of physical activity per week
- Almost 1 in 5 people smoke; in the poorest communities this increases to 1 in 3
- In Suffolk 1 in 10 rural households have no access to personal transport
- Suffolk has higher levels of fuel poverty compared to its geographical neighbours



Sources: 1) Suffolk and North East Essex Sustainability and Transformation Plan (2016)
Notes: 2) There are significant plans for housing growth in Suffolk and North East Essex. Advice from public health colleagues is that ONS estimates are reasonable at this stage.

The local population is changing and there is a widening health and wellbeing gap (cont'd)

Deprivation and life expectancy[1]

Healthy life expectancy (the number of years lived in good health) remains lower than overall life expectancy and is falling in some population groups. Males born between 2012 and 2015 in the areas of lowest deprivation can expect to live 8 years longer on average than their counterparts born in the areas of highest deprivation. 11.5% of the population live in the 20% most deprived areas of England[2]. This amounts to:

- 1 in 3 residents of Tendring and Ipswich
- 1 in 10 residents of Colchester, and 1 in 9 residents of Suffolk
- Hidden rural deprivation is a particular issue in Suffolk

Health outcomes[1]

Health outcomes are inequitable across the footprint. Mortality rates from causes considered preventable are variable across the geography.

People within Suffolk and North East Essex are living with a significant number of years in ill health or with a disability potentially increasing demand on health and care services.

Locally this will mean that by 2018, 45,000 people in the area will have three long-term conditions. By contrast, a quarter of people in Great Britain have one long-term condition.

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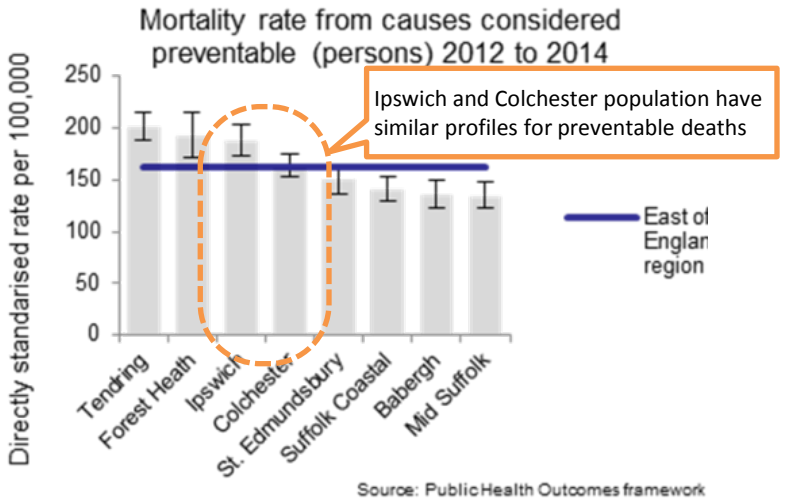
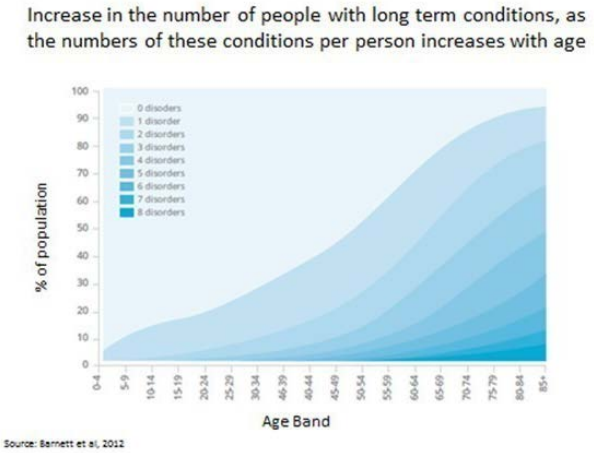




Sources: 1) Suffolk and North East Essex Sustainability and Transformation Plan (2016); 2) Index of Multiple Deprivation, Office for National Statistics (2016)

There are significant care and quality issues and increasing demand for services

In common with other areas nationally, the Suffolk and North East Essex STP has identified significant areas of variation in care and quality in the provision of services within the area. These include challenges that relate to both IHT, but significantly CHUFT.

Unwarranted Variation across the System

- Patient outcome opportunities in a range of specialties as identified in RightCare
- Referral, prescribing and clinical pathway variation in outcomes from General Practice
- Significant variation in health and wellbeing across Suffolk & North East Essex, and against England

Specific Provider Concerns

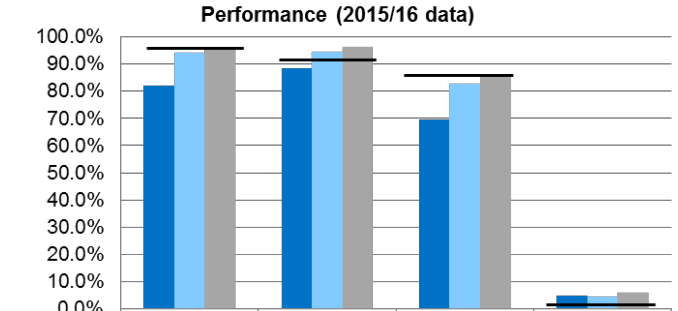
- **Acute - Colchester Hospital (CHUFT) - CQC rating overall inadequate, in special measures and increasing mortality rates**
- Mental Health - North Essex Partnership University NHS Foundation Trust (NEPT), Norfolk and Suffolk NHS Foundation Trust (NSFT) – CQC rating overall requires improvement
- Ambulance – East of England Ambulance Service NHS Trust (EEAST) CQC rating overall requires improvement
- Primary Care – 5 (NEE) practices with CQC rating overall inadequate and in special measures, others requiring improvement; there are also recruitment and retention pressures, particularly for coastal practices
- Nursing homes – above average number of CQC inadequate ratings
- Workforce challenges across all sectors

Serious Incidents

A systematic review of serious incidents has highlighted common themes and learning. These have helped pinpoint the areas of focus in each sector on to reduce the likelihood of incidents occurring, and reduce associated impacts and the level of harm.

Waiting Times for Treatment & Transfer

Currently, challenges exist across the STP footprint to meet national targets for waiting times. This is demonstrated in the graph below, with North East Essex and West Suffolk in particular struggling to meet targets in several areas:



	A&E 4hour	RTT Incomplete	62 Day Cancer	DToC
NEE	82.1%	88.5%	69.7%	5%
West	94.2%	94.5%	82.83%	4.58%
I&E	95.3%	96.17%	85.15%	6.05%
National Target	95%	92%	85%	3.5%

It is becoming increasingly difficult to recruit and retain staff

The planning guidance for 2017-18 has reconfirmed the commitment towards seven-day working in the NHS. To provide this in the current configuration of acute services would require a 14% increase in the workforce.

Several clinical and clinical support specialties are already experiencing long-term recruitment challenges. This affects medical, nursing and allied health-professional staff in specialties including acute medicine, emergency medicine, gastroenterology, endoscopy, respiratory medicine, care-of-the-elderly, neurology, radiology, pathology, physiotherapy and occupational therapy. The current levels of vacant posts are shown in the table to the right.

These pressures are not unique to the acute sector, there are recruitment and retention challenges being felt in the community and primary sectors. Taken together, this presents a system-level vacancy rate, which is also shown in the table to the right.

Estimates from Health Education England (HEE) and local workforce partnerships indicate that many of these staffing shortages are likely to worsen over the next five years and that other specialties will also experience shortages of supply.

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

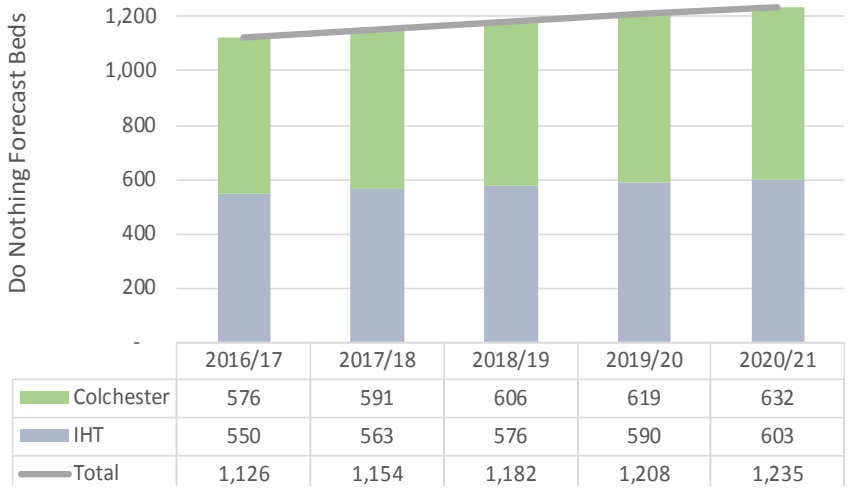
Area	IHT	CHUFT
Vacant Consultant Posts	8 WTE	24 WTE
Long-term Locum Consultants*	NHS 8 Agency 4	NHS 11
Junior doctor vacancy rate**	6.54% (10WTE employed by IHT; 7 WTE employed by St Helier)	15.91%
Nurse agency usage rates (Registered):	8.1%	15.7%
Nurse agency usage rates (Non-registered):	3.4%	13.6%
AHP vacancy rate:	7.35% (20 WTE)	6.31%
Overall vacancy rate (acute)***	6.29% (226 WTE)	13.79%
Community provider vacancy rate:	For those services under IHT counted in IHT numbers	-
Mental health provider vacancy rate:	-	-
Primary care vacancy rate:	-	-
Overall turnover rate (system)	8.125%	15.38%

Notes: * For IHT long term locums are those in post for six months or over
** This includes GP Vocational Training Scheme posts, which are employed by Epsom & St Helier NHS Trust
*** For IHT this excludes Division 4 (corporate services) and the Medical division
****CHUFT snapshot as at November 2016. Data source ESR/NHSP reports.

Sources: 1) NHS operational planning guidance 2017/18-2019/20, NHS England (2014)

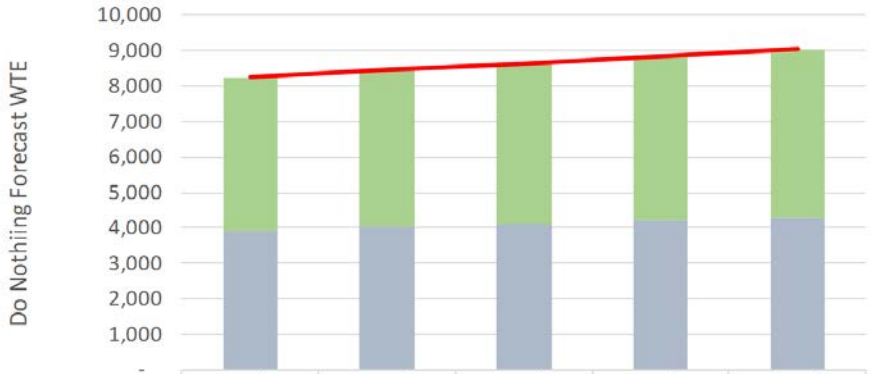
CHUFT and IHT are financially unsustainable in their current form – reflecting the finance and efficiency gap

The combined 16/17 forecast deficit is £69m: £42m at CHUFT and £27m at IHT. The Sustainability & Transformation plan (STP) submitted to NHS England at the end of October 2016 included forecasts to 2020/21.



	2016/17	2017/18	2018/19	2019/20	2020/21
Colchester	576	591	606	619	632
IHT	550	563	576	590	603
Total	1,126	1,154	1,182	1,208	1,235

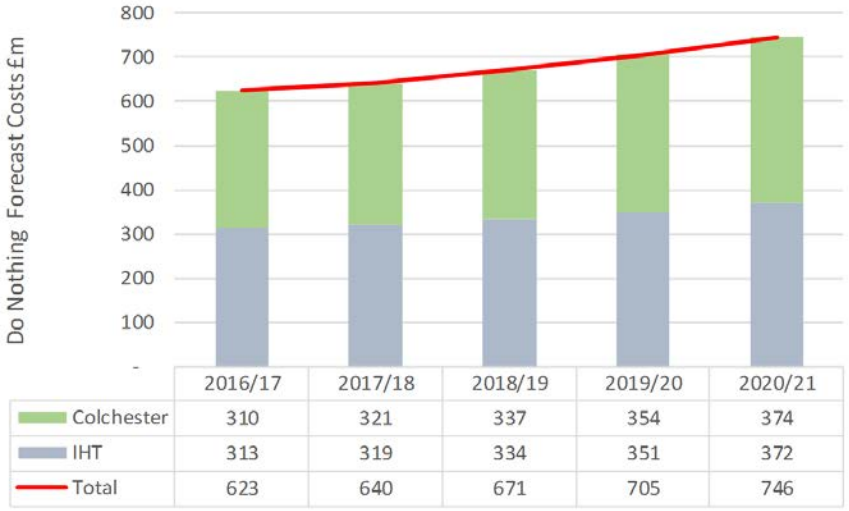
- The chart to the left shows the forecast increase in beds required at both IHT and CHUFT if there is no action taken between now and 2020/21
- The overall requirement for beds increases from 1,126 to 1,235 – this will require sufficient estates to house these beds as well as an increased workforce to ensure that these are safely staffed



	2016/17	2017/18	2018/19	2019/20	2020/21
Colchester	4,309	4,421	4,534	4,635	4,737
IHT	3,928	4,022	4,114	4,211	4,307
Total	8,237	8,443	8,648	8,846	9,044

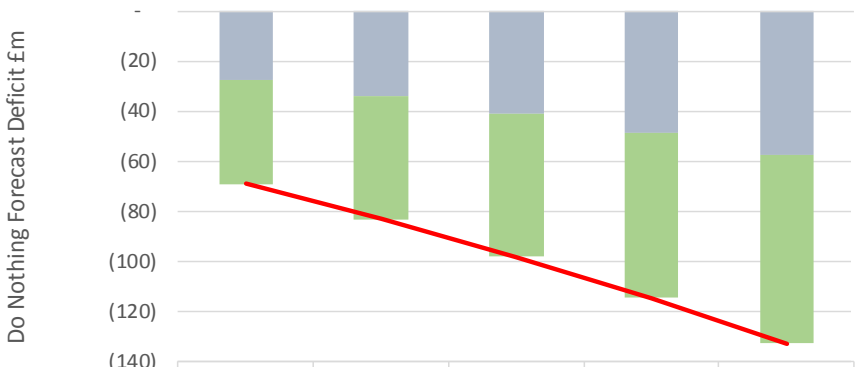
- The chart to the left shows the forecast increase in workforce Whole Time Equivalents (WTE) if the way that care is provided is not changed between now and 2020/21
- In line with the increase with required beds shown above, the WTE requirement increases from 8,237 to 9,044 over the period
- This is in the context of current challenges to recruit and retain sufficient staffing levels

CHUFT and IHT are financially unsustainable in their current form – reflecting the finance and efficiency gap (cont'd)



	2016/17	2017/18	2018/19	2019/20	2020/21
Colchester	310	321	337	354	374
IHT	313	319	334	351	372
Total	623	640	671	705	746

- As a result of the increased beds and staffing requirements, the costs of providing services also increases over the period
- Costs to IHT increase from £313m to £372m (an increase of 19%) and for CHUFT increase from £310m to £374m (an increase of 21%).



	2016/17	2017/18	2018/19	2019/20	2020/21
Colchester	(42)	(49)	(57)	(66)	(76)
IHT	(27)	(34)	(41)	(48)	(57)
Total	(69)	(83)	(98)	(114)	(133)

- The STP concluded that income levels for increased activity will not keep up with the costs and demand, meaning that the deficit in the local area will increase significantly over the period.
- The STP forecast deficits at IHT increasing from £27m to £57m, and at CHUFT from £42m to £76m. For the partnership this represents a deficit of £133m by the end of the period.

- NHS Improvement issued revised control totals to all trusts in November 2016 and the trusts submitted their 2 year operational and financial plans to NHS Improvement at the end of December 2016; this includes revised CIP targets. The Financial Case for change assesses scenarios against this updated plan.

SWOT and PESTLE analysis

IHT SWOT analysis

Strengths Good service quality Joint provider of community services Good commissioner relationships Specialist service provider (spinal, gynae, radiotherapy) Maternity centre (3.5k births)	**Weaknesses** In deficit in 2016-17 (7% of turnover) Workforce gaps in key specialties Some estates in need of re-provision soon
Opportunities Better integration with community services Partnership with other acute trusts Clinical pathway transformation with other STP partners	**Threats** Increasing scale required to provide specialised services acute trust reconfigurations in neighbouring STPs (Essex Success Regime, Norfolk & Waveney)

CHUFT SWOT analysis

Strengths Laparoscopic training centre Specialist service provider (vascular, radiotherapy) Maternity centre (3.5k births) Generally good quality estate	**Weaknesses** Inadequate service quality In deficit in 2016-17 (15% of turnover) Workforce gaps in key specialties Some estates in need of re-provision soon
Opportunities Partnership with other acute trusts Clinical pathway transformation with other STP partners	**Threats** Remains at risk of TSA Increasing scale required to provide specialised services acute trust reconfigurations in neighbouring STPs (Essex Success Regime, Norfolk & Waveney)

PESTLE analysis

Category	Factors
Political	• Secretary of State requirement for the assurance on the future quality of services at CHUFT • Pledges for the NHS to move towards a 'seven day service' • Political uncertainty related to Brexit negotiations diverting attention, plus uncertainty over status of EU staff in NHS adds to recruitment and retention challenges
Economic	• Lack of availability of capital and transformational funding available to and within the NHS • NHS as a whole unlikely to receive significant funding increase as part of the spending review process; social care funding substantially reduced • Changes to the tariff may increase income of acute trusts in line with increased demand and complexity
Social	• Growing and ageing population in the local area creates an increased demand on health and social care services, especially within the most frail and complex groups • Increased use of health services due to reduction in social and mental health service provision
Technological	• NHS due to produce standards on system interoperability allowing for the creation of shared records • Increased movement to digital records must be balanced against the threat of cyber crime and cyber attack • Innovations in telehealth and virtual appointments may reduce need for patients to be cared for within hospital estate; though poorly leveraged by the NHS
Legal	• Information governance remains the responsibility of individual trusts • Challenges related to competition for trusts seeking to work in partnership or collaboration • Increasing cost of CNST / Indemnity for medical negligence claims
Environmental	• All NHS estate must reduce environmental impact of their services and ensure the sustainability of services • There are some parts of the estate on both sites that are in need of refurbishment or renewal to ensure that they are fit for purpose

Market analysis

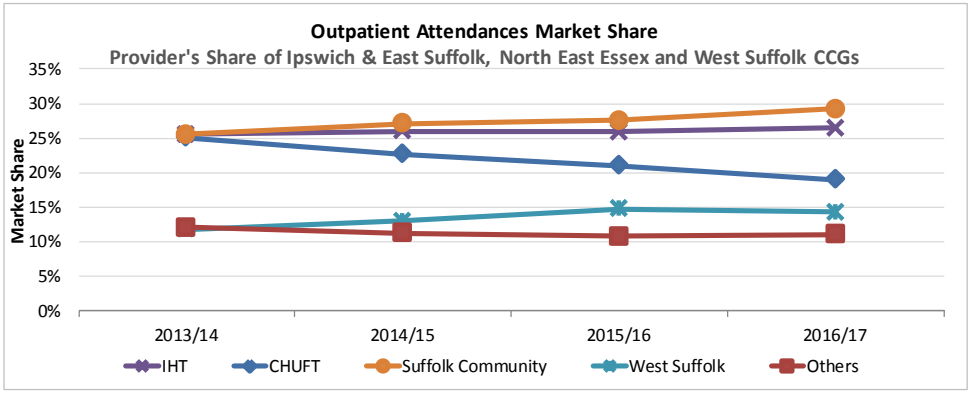
The charts opposite show each Trust's market share of outpatient attendances for the 3½ years to September 2016 for the two trusts relative to other providers within their 3 principal commissioning CCGs' market.

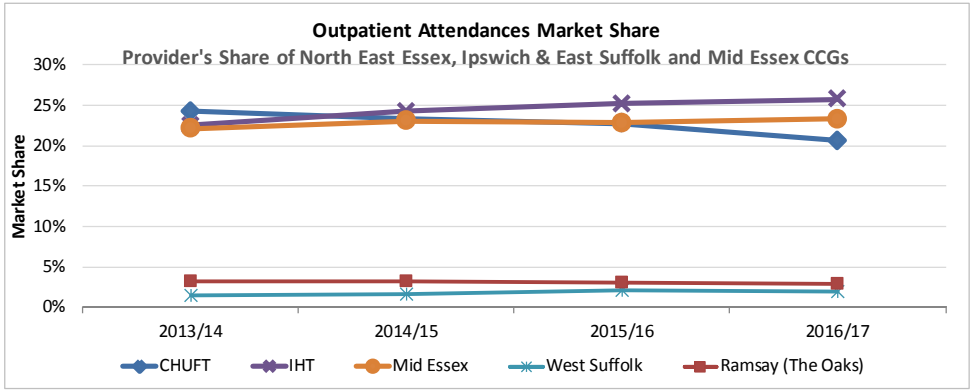
IHT

- IHT's host commissioner is NHS Ipswich and East Suffolk CCG (I&ES) with further patient flows from neighbouring North East Essex and West Suffolk CCGs. It's main competitors are West Suffolk NHS and Colchester Hospital University NHS Foundation Trusts.
- Ipswich has seen an increase in its market share of outpatient appointments from both I&ES and NEE CCGs.
- Table 1 below shows the Trust has been increasing its market share of in patient activity commissioned by Ipswich & East Suffolk CCG.

CHUFT

- CHUFT's host commissioner is NHS North East Essex CCG (NEE) with further patient flows from neighbouring Mid Essex and Ipswich and East Suffolk CCGs. Its closest competitors are Mid Essex and Ipswich Hospital NHS Trusts. It also has private sector competition for certain specialties from the Oaks Hospital (Ramsay Healthcare).
- The charts highlight the decrease in CHUFT's market share of outpatient appointments from both I&ES and NEE CCGs.
- Table 2 below shows that the Trust's market share of inpatient activity commissioned by NEE CCG stabilised after a sharp fall in 2014/15.





Market share of in-patient activity for host commissioning CCG (#spells/£m)

1

Ipswich & East Suffolk CCG	Market Share #Spells				Market Value £m			
	2013/14	2014/15	2015/16	2016/17	2013/14	2014/15	2015/16	2016/17
Total Market	97,171	109,176	111,062	55,998	£122.4	£122.2	£116.1	£56.4
IHT Market Share	77.9%	80.0%	80.5%	81.7%	£89.1	£102.4	£101.4	£42.1
Competition from:								
Colchester Hospital	1.3%	1.0%	1.0%	1.1%	£2.4	£2.2	£2.2	£1.4
West Suffolk Hospital	6.8%	6.3%	6.4%	6.1%	£8.6	£9.0	£9.1	£4.2
James Paget	0.2%	0.1%	0.1%	0.1%	£0.2	£0.2	£0.2	£0.1
Other providers	13.8%	12.6%	11.9%	11.0%	£22.1	£8.5	£3.1	£8.6

2

North East Essex CCG	Market Share #Spells				Market Value £m			
	2013/14	2014/15	2015/16	2016/17	2013/14	2014/15	2015/16	2016/17
Total Market	91,936	93,435	91,056	46,280	£131.8	£129.6	£129.9	£61.2
CHUFT Market Share	83.3%	81.2%	81.4%	81.4%	£101.6	£99.1	£99.1	£46.1
Competition from:								
Mid Essex Hospital	2.6%	2.9%	2.8%	3.1%	£3.5	£3.7	£3.6	£1.9
Ipswich Hospital	0.8%	1.2%	1.8%	1.8%	£1.2	£1.9	£3.1	£1.5
Ramsay (The Oaks)	4.1%	5.3%	4.8%	4.6%	£6.7	£7.5	£6.4	£3.0
Other providers	9.2%	9.3%	9.1%	9.1%	£18.9	£17.3	£17.7	£8.7

Data Source: Team analysis of Healthcare Evaluation Data (HED) FY2013/14 – Sept.2016/17:

There is a recognition that a step change in the level of transformation is required to ensure sustainability

The STP has put in place an ambitious programme of work that requires community resilience, demand management and acute reconfiguration. In relation to acute reconfiguration the aim is to create viable acute hospitals that have fully integrated patient pathways across the STP footprint, achieved through the redesign of clinically led patient pathways around outcomes; underpinned by innovation[1]. Both Trusts are undertaking ambitious programmes to meet the identified challenges, but these alone will not ensure sustainability in the future.

IHT

Where costs and expenditure are concerned, IHT benchmarks well financially; however like many other trusts, it has struggled to achieve financial sustainability for a number of years and faces increasing deficits due to rising demand and increasing staffing costs.

IHT has developed a draft strategy that concurs with the STP that radical change is needed. It shifts the organisation from one competing with others to one working in partnership. High-level goals show that the Trust wants to improve patient safety, productivity and staff experience to amongst the best in the country.

Strategic plans are being developed but clearly involve getting maximum benefits from the LTP with CHUFT, whilst also pursuing redesigned pathways in a community alliance within the Ipswich and East footprint.

The Trust is also exploring the opportunities from Carter and from redesigning the interactions with the rest of the health system (e.g. single point of access etc.)

CHUFT

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

	Every Patient, Every Day
Scope of programme	The Every Patient, Every Day programme aims to improve the quality of patient care and experience at CHUFT by addressing the clinical, performance, operational and financial issues that are faced, while holding themselves to account for this delivery to the Trust.
Scale	The programme is centred on three key modules of work: Quality & Governance (three workstreams), Operational Improvement & CIP delivery (two workstreams) and Cross-cutting improvements (six workstreams).
Timescale	Began in August 2016 and set to run for two years
Example KPIs affected	• Incomplete RTT pathways within 18 weeks has increased from 84.9% in September to 87.4% in October • The "Red to Green" programme has seen a dramatic improvement in the timed pathways of patients on urgent pathways for suspect cancer • % of patients waiting over 6 weeks for a diagnostics test has dropped from 1.45% in August to 0.9% in October

These programmes will not, by themselves, deliver the clinical, operational, and financial sustainability the two Trusts need. That is why CHUFT and IHT have therefore embarked on a LTP that can secure the futures of both Trusts.

Notes: 1) Suffolk and North East Essex Sustainability and Transformation Plan (2016)

Section 3

LONG-TERM PARTNERSHIP AMBITION AND OBJECTIVES

The LTP has a clear ambition and objectives

Scope

The LTP between IHT and CHUFT has been established to improve the quality of patient care at CHUFT and enable both organisations to be sustainable in the longer term. The LTP sits within the wider strategic context set out in the Suffolk and North East Essex STP; the two Trusts will be building and developing area-wide relationships and integrated pathways within local communities.

Within that context, the scope of the partnership is the delivery of services at both hospitals and how, by working together, they can become sustainable for the future. This includes front line clinical services, clinical support services and corporate services.

Improvements that can be achieved by working in partnership with other organisations sits outside the scope of the LTP, but they will influence its development.

Ambition

The ambition for the Partnership is that by working together CHUFT and IHT will secure sustainable and high quality healthcare for Ipswich, East Suffolk and North East Essex

Objectives

Four objectives have been defined which align with the strategic challenges:

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

The outcomes that each of the objectives is intended to achieve is set out in more detail on the following page.

These objectives are aimed at a number of outcomes

There are a number of intended outcomes for each of the objectives to achieve, and these are shown in the table below. Taken together these describe the ideal endpoint for the LTP:

Objective	Outcome
Improved quality and patient outcomes	• Maintain or, where necessary, improve the quality of services at IHT, and must fundamentally improve quality at CHUFT. Improve the quality of care by standardising practice across the services and sharing best practice where it exists locally and nationally. • Plan and use the workforce, estate and equipment in a way that maximises productivity. This will enable a reduction in waiting times and improve access to services, and provide a more consistent level of service to the residents. With teams working closely together it is possible to share out of hours rotas and make delivery of seven day working for the emergency services more sustainable
Better value for money	• The LTP will not completely solve the financial challenges faced. However it is expected that the LTP will contribute to improving the financial situation at both Trusts • Working together across a range of the non-clinical spend areas, will enable better value for money. Planning together will, for some contracts, increase the buyer power which will enable the negotiation of better rates for external services and products, saving money that can be better directed to clinical care for patients • Planning together for the technology systems so that best value can be achieved, and integration where needed. This will enable clinical teams at both hospitals to be fully informed of a patient's medical history and treat them at the right time, in the right place. • Have the capability to plan for delivering services to a population of c.700,000. This will enable the Trusts to look across the premises and facilities and get better use and value from the space and equipment • Through the LTP corporate services will be re-designed with the aim of reducing operating costs and improving the service provided to internal and external customers. It will also be possible to streamline and standardise to deliver best practice clinical administrative processes, to improve patient experience and reduce administrative burden
Sustained and improved access to services that meet the needs of the population	• Based on the needs of the local population the LTP will ensure that access is sustained, and where possible improved. • Specialist services increasingly require large population bases in order to achieve quality standards. At present, there are a number of services where patients have to travel long distances to receive the specialist treatment they need because the separate population sizes are not large enough to support delivering them within the geographical areas. The LTP offers an opportunity to ensure more local access, where appropriate
A sustainable, skilled workforce	• The LTP will not completely solve all the workforce challenges faced. However, by working together it will be possible to improve staff recruitment and retention and offer more staff development opportunities. For the clinical teams this will be made possible through the increase in providing more specialist services and subspecialisation • For the non-clinical teams the LTP will build on best practice in staff development and where necessary introduce skillsets, structures and, tools that enable them to continue improving and gain more career development opportunities

Design principles

There are a number of design principles that are essential to the success of the LTP. The principles are informed by the ambition and objectives for the LTP. The design principles are informed by the ambition and objectives for the LTP. They also take into account some key constraints within the local health and care systems. This includes the need for two A&E departments because the populations in which both Trusts are based exceed 300,000 people; this means that approximately 6,000 patients per year will present to each site with immediately life-threatening conditions[1]. Obstetric-led maternity services were also judged to be required in both population centres due to the numbers of deliveries on each site. Finally, undifferentiated acute medical take will also be required due to the large number of patients requiring care in both areas.

- Continue to operate as district general hospitals
- Focus on delivering acute services, and delivering them well
- Develop specialist services where there will be a demonstrable improvement in care for patients from improved access and/or outcomes
- Continue to provide A&E services on both acute hospital sites
- Continue to have obstetric-led maternity services on both sites
- Have a 24/7 undifferentiated acute medical take at both sites
- Have at least one paediatric assessment unit/paediatric intensive care unit
- Maximise clinical synergies and adjacencies
- Enhance teaching and training to develop the future clinical workforce
- Move at pace to minimise the disruption caused through uncertainty and maximise the speed by which improvements are made

The design principles have been used to inform the development of the 'hurdle' criteria, which are used to move from a longlist of potential scenarios to the shortlist (shown in section 4). The principles have been reviewed by various stakeholder groups, and were updated based on their feedback, ahead of making recommendations to the Boards in January 2017.

Sources: 1) "Delivering High-quality Surgical Services for the Future" (2006), The Royal College of Surgeons of England

Section 4

SCENARIOS: FORMULATION, SHORTLISTING & EVALUATION

The scenario formulation and evaluation approach

In order to assess how the LTP could achieve its ambition and objectives, a range of scenarios were identified and evaluated. The scenarios describe organisational forms or approaches which the partnership could take in order to realise the benefits of working together. These were assessed against criteria based on the objectives and design principles of the LTP.

A longlist of possible scenarios was developed and then evaluated against hurdle criteria to arrive at a shortlist. This was then subjected to a more detailed evaluation to identify a preferred set of scenarios. This approach was developed with key stakeholders at each stage, to ensure that there was good strategic fit with the local health and care system.

In the next phase of the business case the preferred scenarios will undergo a more detailed analysis to gain further insight into their suitability.

Stakeholder involvement in scenario evaluation

The identification of the recommended scenarios and the approach to evaluate them was carried out by working closely with three key groups of stakeholders: a clinical reference group, the commissioners and the executive teams of both Trusts. At each stage they were asked for their views on the approach, and inputs to deliver outputs from the process; the approach was regularly reviewed and amended in the light of this feedback. Details of the reference groups and the outputs can be found in Appendices D and E. In addition health and care system partners and regulators have been engaged to gain further verification and ensure strategic alignment.

Consulted	Informed
Clinical reference group: IHT, CHUFT, CCGs, Community Services, EEAST, County DPHs, Healthwatch	Trust staff
Commissioners	HOSCs
Trust executives	Health & Wellbeing Board chairmen
NHS improvement	CHUFT governors
	CEOs & chairmen of local public service partners
	NHS England

The scenario formulation and evaluation approach (cont'd)

The scenario evaluation process centred on the shortlisting of the initial longlist, followed by the more detailed evaluation of the shortlist (see diagram below).

The definition of the scope, ambition and objectives for the partnership served as the first stage of this process (see section 3). The resulting design principles were used to inform the 'hurdle' criteria which were then applied to the longlist of scenarios to derive a shortlist of possible scenarios. A second evaluation was undertaken whereby a set of evaluation criteria was developed to evaluate the shortlist; the evaluation criteria are weighted to reflect the relative importance of each criterion.

The longlist and shortlisting

The longlist aimed to provide the broadest starting point for the Trust's thinking. It was derived from existing models in use in the NHS, emerging models under the NHS "New Care Models" programme and other approaches used in industry but not currently in use in the NHS. It also includes the required "do nothing" scenario.

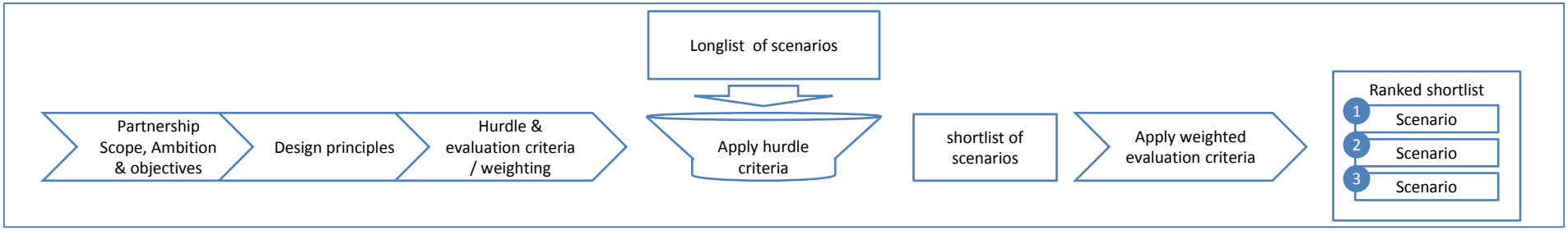
The shortlisting part of the process was intended to identify which of the scenarios offer the best opportunities for the clinicians and managers to realise benefits.

Evaluation of the shortlist

Once the shortlist was identified, each scenario was assessed based on criteria derived from the objectives of the LTP.

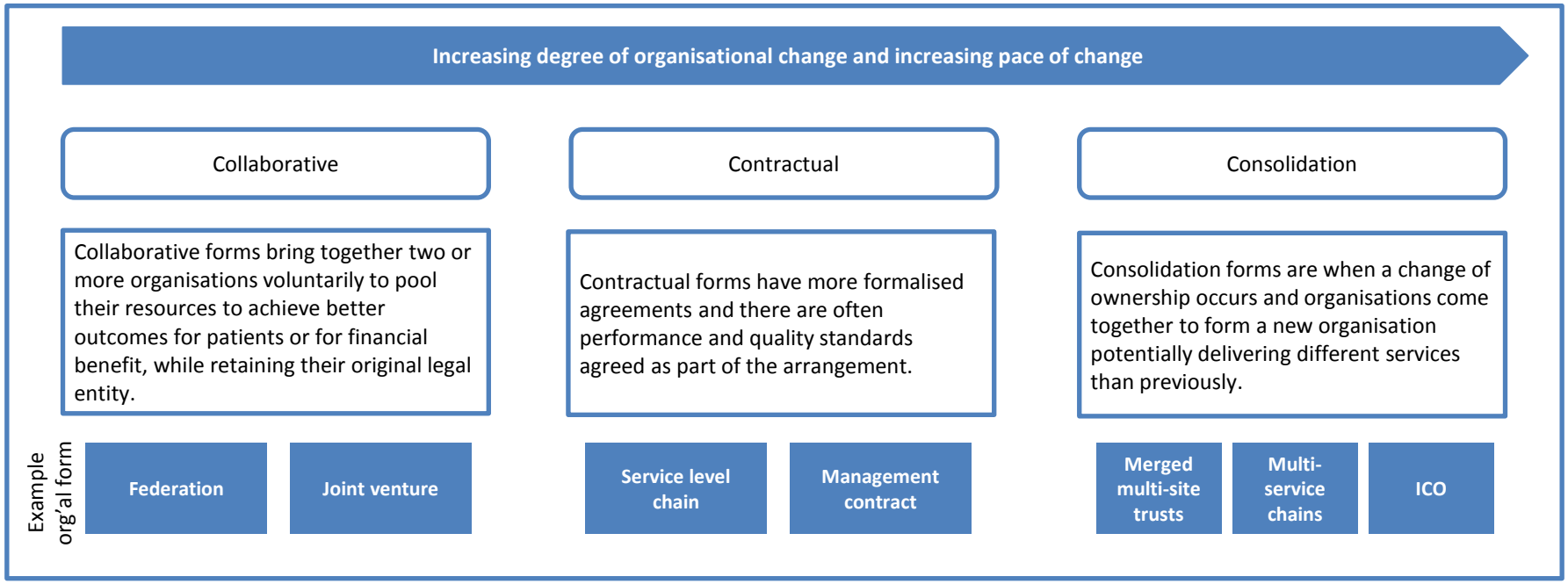
Thirty types of benefit which could arise from the LTP were identified; these were aligned to the evaluation criteria. Stakeholders were asked to rate each of the shortlisted scenarios against these benefits, scoring them on how much the scenario would facilitate the delivery of that benefit. Two elements of deliverability (timescale and risk to delivery) were also evaluated. Finance benefits were evaluated separately by the finance teams from the two trusts (see section 5).

The aim of the criteria was to deliver a balanced view that considered the potential benefits, against the risks of implementation and the time taken to deliver.



Longlist scenarios - collaboration, contractual and consolidation

At the highest level, possible scenarios for the future of the LTP can, broadly, be grouped into three types – collaboration, contractual and consolidation. These are based on the groupings used in the Dalton Review[1], and are defined in the diagram below:



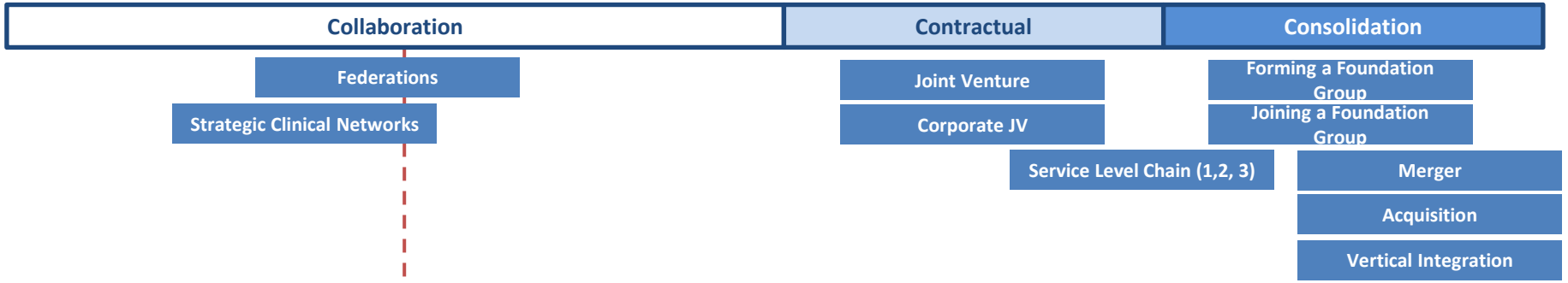
The Dalton Review[1]

In 2014 Sir David Dalton, Chief Executive of Salford Royal NHS Foundation Trust, was commissioned by the government to undertake a review of potential forms that NHS providers could take in the future, and how existing providers could support those in difficulty. The review conducted significant research into national and international examples, and the report publication coincided with that of the Five Year Forward View[2]. The full report can be found here: https://www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care

Sources: 1) Examining new options and opportunities for providers of NHS care, The Dalton Review, (2014); 2) NHS Five Year Forward View, NHS England (2014)

The scenarios fall on a spectrum of possibilities

Based on the higher level categories, scenarios could be defined based on the degree of integration and the type of organisational form:



Informal clinical networks

Often based on good-will and existing clinical networks, informal clinical networks are a method of sharing good practice, but without an enforcement route. Not considered by NHSI / NHSE as a 'new model of care'.

Examples:

- Buddying arrangements between trusts
- Specialty-level networks (e.g. paediatrics, maternity)

Accountable clinical networks

A formalised version of the clinical networks, which features a consolidated decision-making body that is accountable for the performance of the entire service.

Examples:

- Accountable Clinical Network for Cancer, ACC Vanguard – formed of the Royal Marsden, The Christie and UCLH
- NHSE Operational Delivery Networks, which are designed to improve specialist services such as burns and neonatal services

Service franchise (Management contract)

Specialist providers offer a single service on another provider site, subject to being contracted by the host provider. Alternatively organisational sovereignty is pooled through a management contract.

Examples:

- Moorfields Hospital (ACC vanguard)
- Foundation Healthcare Group (ACC vanguard)

Merger / Foundation Groups

Formal consolidation of providers across all services across clinical and back office. Often allows for the reconfiguration of services following implementation of a new organisational model.

Examples:

- Four Foundation Groups now accredited by NHS Improvement
- Recent successful transactions include Frimley Park's acquisition of Healtherwood and Wexham Park, and Royal Free's acquisition of Barnet and Chase Farm

The longlist of scenarios must pass some core 'hurdle' criteria

The longlist considers all possible scenarios for the LTP. The full longlist is included as an appendix to this document (see Appendix A). Not all of these scenarios would result in a sustainable and viable future. A set of hurdle criteria was developed to ensure that the unviable scenarios were not considered further. The process for developing the hurdle criteria is also detailed in the appendix (see Appendix B). These hurdle criteria move from the widest strategic considerations (the STP) through to more specific 'filters'. The criteria shown below were agreed by both Boards on 21st December 2016:

Area	Criterion	Commentary
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	• STP has been made available to members of the Clinical Reference Group • Scenarios should be able to deliver acute reconfiguration
	Improve links to (and integration with) community services and improve transition	
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	• An ambition has been developed for the LTP, so at a minimum any scenario must support this
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	• NHS Improvement requires that any major service change (that would be reviewed under the 'transactions process') results in delivery of financial sustainability within a 3-5 year time period • This has been accelerated to align with: deteriorating position at both Trusts, overall system context and the aims of the STP
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	• A learning from major change programme for acute hospitals is that this sometimes results in an overall decline in performance, and this can put the programme at risk (i.e. Nottingham and Sherwood Forest potential merger)
Timeline	Owing to the scale of challenges at CHUFT scenarios must enable and support stabilisation in the short term	• Scenarios should support ongoing transformation programmes at both Trusts
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	• Clinical Reference Group to test scenarios as to whether they are likely to achieve these criteria from a clinical perspective

Applying the hurdle criteria to obtain the shortlisted scenarios

The Partnership Working Group applied the hurdle criteria to the longlist of scenarios. The output of this was reviewed by the Trusts' Executives, Clinical Reference Group, Commissioner Reference Group and Partnership Advisory Board (PAB) to give the following shortlist:

Scenario	This means…
Do nothing*	• No change to the existing organisations
Clinical and strategic networks**	• Networks that facilitate the sharing of best practice between clinicians, without a formal agreement to work together
Corporate joint venture	• Creating a separate legal entity that will provide services; this entity would not typically take the form of a trust, for example forming a controlled LLP or limited company for the JV vehicle
Management contract – whole organisation	• An alternative organisation is sought to take over management of the host trust resulting in pooled organisational executive control; host trust Board holds management to account for performance. The host trust retains activity, workforce and accountability to regulators • Potential for back office consolidation, and the implementation of standard operating procedures in all areas at the host trust
Forming a foundation group	• One of the trusts using the LTP as the basis to enter into the NHS Improvement accreditation process to become a Foundation Group
Organisational merger, focus on back office plus some clinical integration	• Merger between the two trusts, with back office consolidation and joint procurements, plus consolidation of some front line clinical services; services to be consolidated likely to be either specialist services or those with challenging requirements to meet clinical standards
Organisational merger, focus on back office plus full clinical integration	• Merger between two trusts with full consolidation of both front line clinical and back office functions; services become joined across both sites with a level of reconfiguration likely to form part of the plans
Acquisition (full)	• Identification of a target trust by the acquirer (which may be driven by regulators); this scenario shares many characteristics of 'full' organisational merger but is driven by the acquirer's strategy and vision, and there is a single 'controlling mind' throughout the process

Notes:

* The 'do nothing' scenario does not pass the hurdle criteria but its inclusion in the shortlist is a mandatory scenario for comparison purposes.

** The PAB recognised that those scenarios which met the hurdle criteria and were shortlisted were all at one end of the partnership spectrum. As such, they are all complex and high risk approaches.

PAB recommended that a scenario from the other (collaborative) end of the spectrum was also subjected to evaluation. The intention is to give the Boards a greater diversity of scenarios to inform their final decision about which one(s) to take forward.

For this purpose the clinical and strategic networks scenario has been included in the shortlist. This scenario was selected, after review of all the scenarios which did not pass the hurdle criteria, because this approach has been widely used in the NHS previously and its risks are better understood.

Rationale for selection to the shortlist

The rationale for each of the scenarios that went forward for consideration as part of the shortlist is shown in the table below. In addition, the broad rationale for those scenarios that didn't go forward for consideration is shown below. More detailed rationales for all scenarios are included as an appendix (see Appendix C).

Scenario	Rationale
Do nothing	• Although this option fails the hurdle criteria it continues forwards as a compulsory 'counterfactual'
Clinical and strategic networks	• Failed hurdle criteria, though included by PAB as shown on previous page
Corporate joint venture	• Has the potential to include a large enough range of services that could allow reconfiguration, good alignment with ambitions and objectives, promotes service redesign and improvement in quality
Management contract – whole organisation	• Facilitates rapid change and consolidation, sufficient scale for transformational change, supports fundamental change at CHUFT through holistic approach, stabilisation in the short term supported through single governance approach, implementation should allow for the realisation of benefits within the specified timeframe
Forming a foundation group	• Holistic approach that may deliver transformation in line with STP ambitions, significant opportunities to deliver efficiencies through the formation of a group, timelines mean that a Foundation Group would need to be formed before admitting CHUFT
Organisational merger, focus on back office plus some clinical integration	• Allows for transformation change that delivers benefits within specified timeframes, shared governance and integration design provides an opportunity to increase quality, level of scale and phasing ensures that benefits can be realised within timeframe
Organisational merger, focus on back office plus full clinical integration	• Allows for transformational change at the scale of the ambition and objectives of the LTP, compressed timelines achievable dependent on phased implementation, merger and integration process can drive fundamental change in standards
Acquisition (full)	• Allows for transformational change at a significant scale with one organisation leading, compressed timelines achievable dependent on phased implementation though aided by having a 'lead', shared governance and integration design provides an opportunity to increase quality

Typically, scenarios that did not pass had three common points of failure:

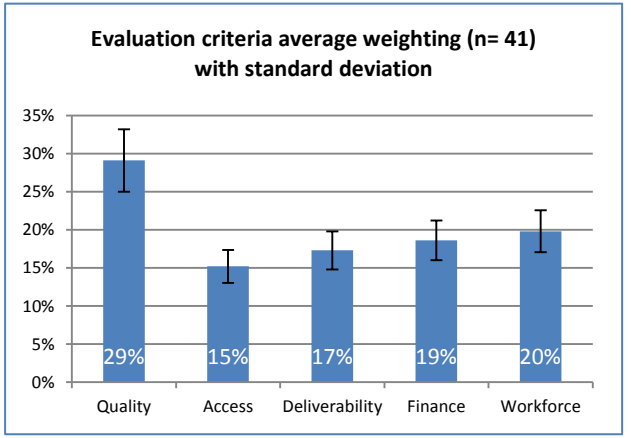
1. Does not deliver the scale and scope of the STP ambition
2. Does not deliver the holistic sustainability required for the LTP
3. Does not provide adequate support for CHUFT in the short term

Appraisal criteria have been defined to evaluate the shortlisted scenarios

As part of the more detailed evaluation of the shortlist, a set of appraisal criteria was developed. The criteria are based on the objectives and design principles of the LTP, and they are shown with their weightings as determined by the Trusts' Executives, the Clinical Reference Group, and the Commissioner Reference Group:

Criterion	Definition
1. Quality: outcomes, safety and patient experience	The extent to which a scenario enables the improvement of quality and safety in a consistent way and improves or maintains patient experience across the area covered by the LTP, and the wider system. Key considerations are: • The potential of a scenario to improve quality and safety and the extent to which it supports the spread of best practice and standardisation, where appropriate • Whether the scenario is likely to enable services to meet appropriate clinical standards, such as the Royal College (or equivalent) standards and NICE guidelines – especially through achieving recommended levels of senior decision-makers in services • The impact on interdependent and co-dependent services should be assessed, especially in light of the fixed points • A positive patient experience may correlate with better healthcare facilities, including a better quality of equipment, estates and environment – is the scenario able to deliver this? • For people requiring both health and social care provision, there should be co-ordination between these two services to provide a seamless pathway and better information-sharing; equally the scenario should consider the entrance to and exit from the acute pathway
2. Access	The extent to which the scenario enables equitable access to high quality services within the catchment area for all population groups. Key considerations are: • Whether services are provided when and where people need them, and the extent to which this would be enabled by the scenario and considerations on how travel will be impacted • Different types of services may be offered from different sites, but all people should be able to access the service that is most likely to give them the best clinical outcome, particularly for those groups with the greatest health needs • The extent to which the scenario can maintain and improve access to acute (and specialist, such as vascular) services within the catchment area, at a time and place that is convenient for the local population
3. Deliver-ability	The extent to which the scenario enables sustainable change to be delivered by the dates that have been set out, including assessing the risks associated with the implementation, and the potential level of difficulty that this involves. Key considerations are: • The extent to which key stakeholders are likely to be supportive of the scenario and the political acceptability of the proposal • Understanding what can be accommodated on any given site and the high level capital investment associated with this as a measure of the likelihood of being able to achieve it • Whether the relevant workforce capacity and expertise exists to implement the scenario, within the local system or more widely, and any cost implications of this
4. Financial sustainability	The scenario's ability to contribute to the short-term and longer-term financial sustainability for the LTP as well as the wider system. Key considerations are: • The estimated cost to implement the scenario • The estimated financial benefits of the scenario • Assessment of whether the scenario makes best use of scarce resources, such as staff and equipment, and offers the potential to take advantage of efficiencies
5. Workforce sustainability	Assess whether the scenario will allow the LTP to attract, develop and retain the staff needed to provide high quality healthcare in the local area. Key considerations are: • The extent to which the workforce, comprising both clinical and non clinical staff, will be better developed as a result of the proposed scenario • The impact of the scenario on the ability for the LTP to attract and retain the highest quality workforce • Assessment of the extent to which the scenario will enable staff to access appropriate training and development, opportunities to advance, particularly for those with specialist skills

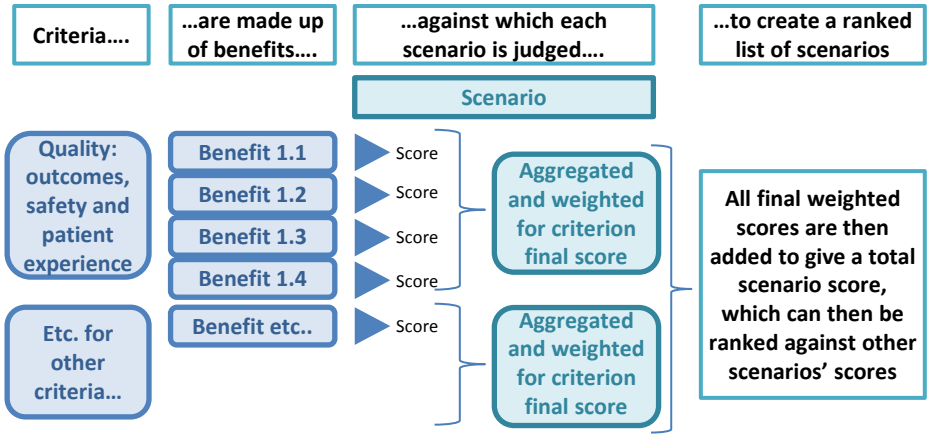
The weightings of each criterion were determined together with their corresponding standard deviations, as follows:



Evaluating the shortlist

Benefits model

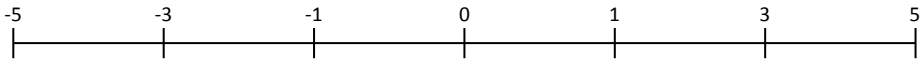
To evaluate the shortlisted scenarios, a benefits model was developed. This enabled each scenario to be scored against each criterion based on its ability to realise the benefits identified in the LTP ambition and objectives. This creates a clear link between the principles of the LTP and the scenarios scoring, as shown below.



Each criterion was therefore mapped to a range of benefits which describe ways in which that criterion could be achieved. The benefits were reviewed with stakeholders for completeness and consistency. Details of the benefits model can be found in Appendix B. The key groups of stakeholders brought a wide range of expertise in evaluating these benefits. At this stage the evaluation is qualitative, in terms of the relative merits of each scenario, while a detailed quantitative evaluation will be undertaken in the next stages of the business case.

Scoring

The scoring of the scenarios was carried out via a survey completed by the key group of stakeholders. The scorers were asked to bring their expert views into the scoring against each benefit for the different scenarios where they felt competent to do so. Each benefit was scored against a seven point scale, which was developed to deliver clear definition between results, and is shown below; 5 represents the greatest benefit, 0 is no change and -5 is the greatest loss of benefit:



It was possible to negatively score on certain benefits where it was deemed that implementing a scenario would result in a situation worse than baseline (i.e. where access was significantly worsened). A subgroup analysis of all respondents can be found in Appendices D and E. The financial sustainability criterion was evaluated separately as part of a financial case, as detailed in Section 5.

Aggregating the scores

Criterion scores were determined as the mean of the benefit scores relating to that criterion. The weighting was then applied to the criterion score and all the criteria were subsequently aggregated to give an overall score for the scenario.

Criteria benefits for evaluating the shortlist

Criteria Benefits

The benefits for the five criteria, Quality, Access, Workforce Sustainability, Deliverability and Financial Sustainability are as follows:

Objective	Criteria	Benefits
Improved quality and patient outcomes	**Quality: outcomes, safety and patient experience**	Better accountability through stronger governance
		Co-ordinated IT investment increases system resilience
		Co-ordinated IT investment reduces avoidable variation in quality
		Improved ability to deliver 7 day working
		Increased compliance with standards
		Less intensive or better filled OOH rotas
		Segregating elective flow increases productivity
		Services at scale to meet national standards or evidence base
		Standardisation of practice reduces avoidable variation in quality
		Standardisation of practice reduces errors
A wider range of services	**Access**	Increase prevention
		Increased breadth of offer through more subspecialisation
		Pathway integration with community services & social care
		Repatriation or retention of specialist services
		Standardisation of IT increases clinical teams' effectiveness
-	**Deliverability**	Time to deliver
		Risk to delivery
Better value for money	**Financial sustainability**	Better utilisation of estates
		Consolidate corporate & support services
		Co-ordinate research effort
		Cost of purchasing
		Modernise clinical administrative processes
		More efficient capital expenditure
		Procurement efficiency
		Standardisation to reduce avoidable variation in costs
		Streamlined governance
		Use technology to streamline care & promote self-care
		Investment required
A sustainable, skilled workforce	**Workforce sustainability**	Create a culture that helps staff give their best
		Improved development opportunities for staff
		Improved recruitment & retention
		More scope for leadership & talent development
		Larger clinical teams are more resilient

Note: Although deliverability does not map directly to an objective, it is implicit within all

It is against these benefits that the scenarios were directly scored by key stakeholders as part of a survey. However, as noted above, the financial sustainability criterion was scored separately with a high-level financial case assessment carried out by the two Trusts' financial teams. The benefits from this criterion formed the basis for the assumptions used in the financial case.

Section 5

FINANCIAL CASE

High level financial case development

In order to determine a score for the Financial Sustainability criteria for the shortlisted scenarios, high-level three year forecasts for each of the scenarios were produced using the following 5-step approach:

Each trust has developed separately a 2 year financial plan for submission to NHS Improvement (NHSI). A draft was submitted on the 24 November and the final plan submission required by NHS Improvement was submitted on 23 December 2016

These separate 2 year financial plans have been combined to produce a baseline financial forecast. The impact of the Sustainability and Transformation Plan (STP) on CHUFT and IHT has been included in the planning as applicable

The main assumptions for each of the shortlisted scenario have been agreed with the Trusts' Directors of Finance and at the PAB, including the expected financial benefits and costs of each scenario

The assumptions are used to generate the forecast P&L for each shortlisted scenario

Finally the P&L forecast for each scenario is converted to a score for the financial criterion to inform the overall evaluation of the shortlisted scenarios

This assessment was conducted to provide an initial view of the potential financial impacts of the scenarios by both CHUFT and IHT finance teams working in collaboration,. During the development of the OBC, this will be built on by performing a more detailed financial analysis of the preferred scenarios recommended from the SOC.

Developing and agreeing assumptions for each shortlisted scenario

The main assumptions for the financial analysis of the scenarios were established based on the Financial Sustainability criteria benefits, as follows:

Category	Description	Rationale
Existing	Trust Board	Savings from a rationalisation of the two Trust Boards as a result of closer working
Existing	Corporate / Back office	Closer working will enable the trusts to realise synergies and efficiencies in back-office divisional infrastructures and so make progress with achieving Lord Carter's recommendations for back-office functions.
Existing	Employee Costs (substantive)	Closer working will enable services to operate at more efficient scale providing the opportunity for a rationalisation of the workforce. Benchmarking also suggests there is scope to pursue as part of the wider workforce transformation. Roles and pay grades can be aligned. Increased ability to recruit and retain clinical and non-clinical staff
Existing	Employee Costs (agency/locum)	The workforce resilience strategy will enable a trust to reduce reliance on agency and locum staffing with a focus on reducing staff turnover/absences and recruiting to substantive posts.
Existing	Procurement (clinical/general supplies, establishment)	A combined Procurement Transformation Plan and strategy will further reduce duplication and waste in the procurement of day-to-day consumables. Procurement functions move to a centralised approach.
Existing	Drugs	Combining the trusts' Hospital Pharmacy Transformation Plans will improve further efficiencies in the procurement of drugs.
Existing	NHSLA (impact unknown)	It is assumed that closer working will have a positive impact on both organisations' clinical outcomes and so result in a reduction in litigation activities. This would result in reduced liabilities in clinical negligence claims and reduce the trusts' required contributions to the insurance scheme.
Existing	Premises	Rationalisation of estates and trust's environmental footprint. This will be reliant on the clinical models being developed. Rationalising estates is also a key recommendation from the Lord Carter review of variability in the NHS.
New	Governance/Legislative	A shared resource will enable more efficient clinical and corporate governance arrangements
New	Management Contract structure	Additional infrastructure and costs arising from managing large, inter-connected contracts between the two trusts.
Transformation	NR Enacting costs	Non recurrent funding to support enabling costs of transition to the new operating model (restructuring/exit costs/legal/due diligence/transaction costs)
Transformation	Change Program Delivery	Non recurrent funding to support transformation and change management programmes within the new operating model
Income	Income Generation/Repatriation	The new operating model is expected to enable a rationalisation of capacity and enable increased throughput of activity thereby enabling repatriation of outsourced activity and/or improved patient choice.
Capex	Unknown - dependent on clinical model	Capex requirements arising from new operating and clinical model

A high-level summary of the estimated impact for each scenario is given on the next page

Developing and agreeing assumptions for each shortlisted scenario (cont'd)

The financial impact of each of the scenarios was assessed by estimating the potential outcomes for the assumptions that could be achieved in a three-year period. The outcomes are shown in the table below as a range of possible percentage impacts for each of the cost types (see Appendix F for further detail of the analysis). The percentages were obtained based on the informed judgment of IHT and CHUFT finance teams on the maximum potential benefit that could be realised for the scenarios. A more detailed quantitative analysis of the preferred scenarios will be carried out as part of the OBC in the next phase.

This assessment assumes that maximum integration (merger/acquisition) would provide the greatest opportunity for savings:

Category	Cost Type	Description	2017/18 Combined Plan £m	Financial benefit opportunity as a % of 2017/18 Plan							
				Do nothing	Clinical/ strategic networks	Corporate Joint Venture	Manage-ment Contract	Found-ation Group	Merger (back office some clinical)	Merger (back office full clinical)	Acquisition (full)
Existing	Pay	Trust Board	3	0%	0%	0%	15-25%	15-25%	40-50%	40-50%	40-50%
Existing	Pay	Corporate / Back office	34	0%	1%	1%	3-5%	3-5%	8-10%	8-15%	8-15%
Existing	Pay	Employee Costs (substantive)	304	0%	0%	<1%	<1%	1%	1-2%	2-3%	2-3%
Existing	Pay	Employee Costs (agency/locum)	30	0%	0%	1-3%	1-3%	3-5%	5-8%	8-10%	8-10%
Existing	Non pay	Procurement (clinical/general supplies, establishment)	96	0%	0%	1-3%	1-3%	1-3%	5-8%	8-10%	8-10%
Existing	Non pay	Drugs	17	0%	1-2%	1-2%	1-2%	2-3%	6-8%	7-10%	7-10%
Existing	Non pay	NHSLA (impact unknown)	27	0%	Unknown so not forecast						
Existing	Non pay	Premises	17	0%	0%	1%	2-5%	3-5%	5-10%	8-10%	8-10%
New	Pay	Governance/Legislative (estimate)	(2)	0%	20-30%	25-50%	25-50%	50-70%	80-100%	80-100%	80-100%
New	Pay	Management Contract structure (estimate)	(2)	0%	0%	0%	50-75%	0%	0%	0%	0%
Transformation	Pay/non pay	NR Enacting costs (estimate)	(12)	0%	0%	15-25%	15-25%	15-25%	50-75%	70-90%	90-100%
Transformation	Pay/non pay	Change Programme Delivery (estimate)	(10)	0%	0%	8-10%	8-10%	10-20%	30-50%	30-50%	30-50%
Income	Income	Income Generation/Repatriation	10	0%	0-2%	5-10%	8-10%	8-10%	20-25%	30-50%	30-50%
Capex	Capital	Unknown - depends on clinical model	TBA	0%	Unknown so not forecast						

By way of example, in the table above, merger/acquisition would require only one Trust Board but a management contract would require a reduced level of Board savings to be re-invested back into some form infrastructure to manage the contract. Conversely merger/acquisition would require a higher level of investment in transformation. The change programme delivery would not be delivered in full in the 3 year timeframe.

Whilst the percentages applied here have been derived using informed judgement, these judgements have been checked against the available evidence base and are in line with research in this field (see also note over the page).

Applying assumptions to each shortlisted scenario

The range of percentages for each of the scenarios on the previous page were applied against the baseline cost forecast giving a range of possible overall financial outcomes for each scenario. These are summarised below. These potential outcomes are based on what could be achieved at the end of a three-year time frame.

In order to determine a score for each scenario the lower estimate was used based on the recurrent outcomes. The baseline case (do nothing) was set at 0 against which the other scenarios are compared. The highest value is assigned a 5 with all other values scored proportionally. Any scenario with an outcome worse than the baseline would be assigned a negative score.

All in £'m. Costs are shown as ()

Impact	Do nothing	Clinical/ strategic networks	Corporate Joint Venture	Management Contract	Foundation Group	Merger (back office some clinical)	Merger (back office full clinical)	Acquisition (full)
Recurrent impact (on an annual basis (not cumulative) after three years)	0	Minor cost to minor benefit	3 - 6	3 - 7	5 - 10	17 - 26	23 - 33	23 - 33
Non recurrent impact (after three years)	0	0	(3) - (4)	(3) - (4)	(3) - (5)	(9) - (14)	(11) - (16)	(14) - (17)
Total	**0**	**(0)**	**0 - 2**	**1 - 3**	**3 - 5**	**8 - 12**	**12 - 17**	**10 - 16**
FINANCIAL CRITERION SCORE	**0**	**(0)**	**0.6**	**0.7**	**1.1**	**3.6**	**5**	**5**

These are high-level estimates for each scenario and the underpinning assumptions will need testing further as part of the development of the OBC

Note: For comparison, McKinsey & Company[1] estimates that service consolidation can contribute in some cases to operating cost savings of between 12% and 14% (compared to between 1% and 2.5% without service consolidation) through standardising and integrating work processes, support functions, suppliers and investments. As a comparison 12% of the combined operating costs of the two organisations is c. £63m.

NHS Improvement's document *Making mergers work: improvements NHS providers have achieved through mergers*[2] (May 2016) also note that savings of 0.5% to 1% of turnover through consolidating board and senior management have been seen. The merger assumptions on the previous page would see savings of this order.

Sources: 1) *Marry in haste, repent at leisure: when do hospital mergers make strategic sense?* McKinsey & Company, 2012; 2) https://improvement.nhs.uk/uploads/documents/Mergers_improvements.pdf

Section 6

PREFERRED SCENARIOS

Based on the criteria, the scenarios have been rated as follows

The non-financial and financial analysis scores were combined for each shortlisted scenario. There were three scenarios that scored markedly higher than the others: **merger plus full clinical integration, acquisition (full)** and **merger plus some clinical integration**.

The final score for each criterion was obtained as the arithmetic mean of all benefits scores related to that criterion. This mean score was then weighted to give the final criterion score. Finally, these were totalled and ranked, as shown below:

Scenario	1. Quality*	2. Access	3. Deliverability (Time)	3. Deliverability (Risk)	4. Financial sustainability	5. Workforce sustainability	Total	Weighted Total	Rank
Do nothing	-1.03	-0.96	3.42	1.25	0.00	-0.95	-0.61	-0.24	**8**
Clinical and strategic networks	0.87	0.65	2.52	1.73	0.00	0.72	4.39	0.86	**5**
Corporate joint venture	0.96	0.59	1.88	-0.19	0.60	0.73	3.73	0.77	**6**
Management contract – whole organisation	1.04	1.14	1.04	-0.56	0.70	0.67	3.33	0.71	**7**
Forming a foundation group	1.31	0.67	-0.12	-0.19	1.10	1.31	4.71	1.00	**4**
Organisational merger, focus on back office plus some clinical integration	1.73	1.21	1.33	1.07	3.60	1.67	9.41	1.91	**3**
Organisational merger, focus on back office plus full clinical integration	3.31	2.66	-0.33	-1.61	5.00	3.25	13.25	2.79	**1**
Acquisition (full)	3.18	2.71	0.30	-3.04	5.00	3.11	12.63	2.67	**2**

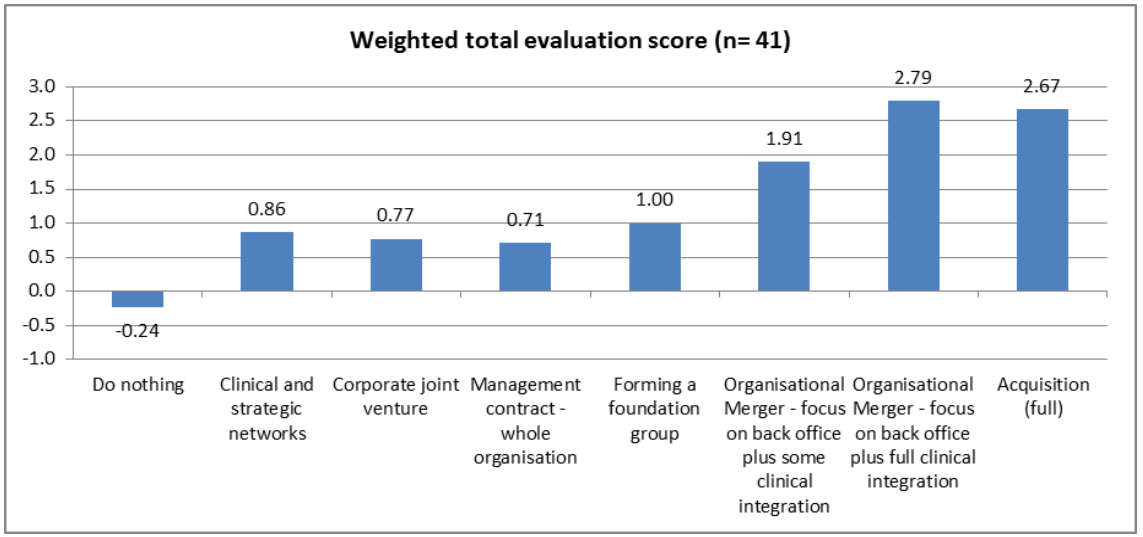
* Quality includes outcomes, safety and patient experience; Note that totals may not sum due to rounding errors

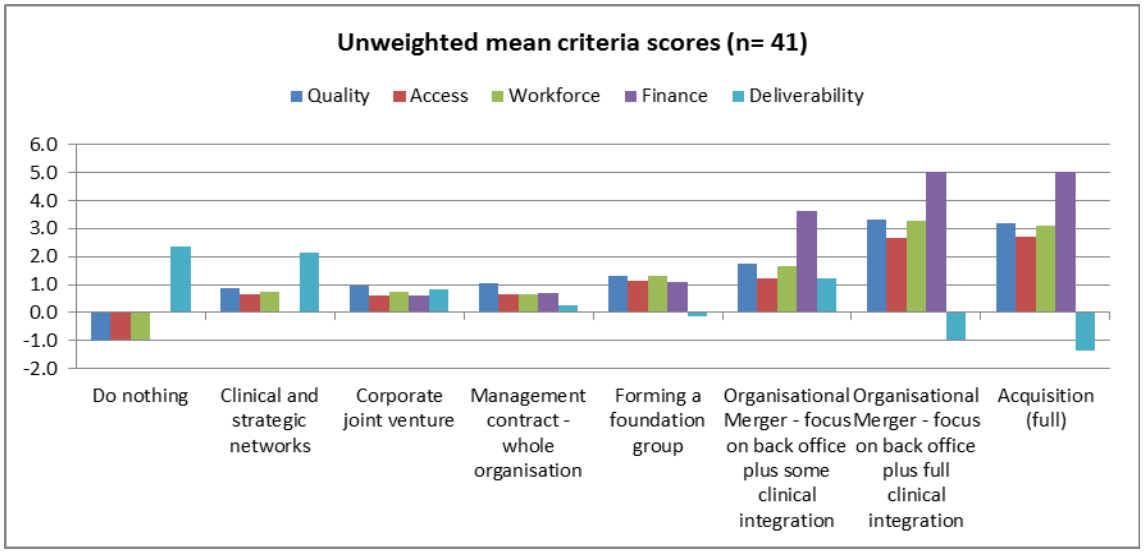
Based on the criteria, the scenarios have been rated as follows (Cont'd)

It is apparent from these results that a partnership involving consolidation of the two Trusts, with a high level of organisational change, were believed to be more likely to deliver the benefits and outcomes described by the objectives of the LTP.

The three scenarios that scored markedly higher than the others (**merger plus full clinical integration, acquisition (full)** and **merger plus some clinical integration**) scored higher in all evaluation criteria except deliverability; this was also true when the weightings were removed from the criteria.

Therefore it is recommended that these three scenarios are taken forward as the preferred scenarios for Outline Business Case.



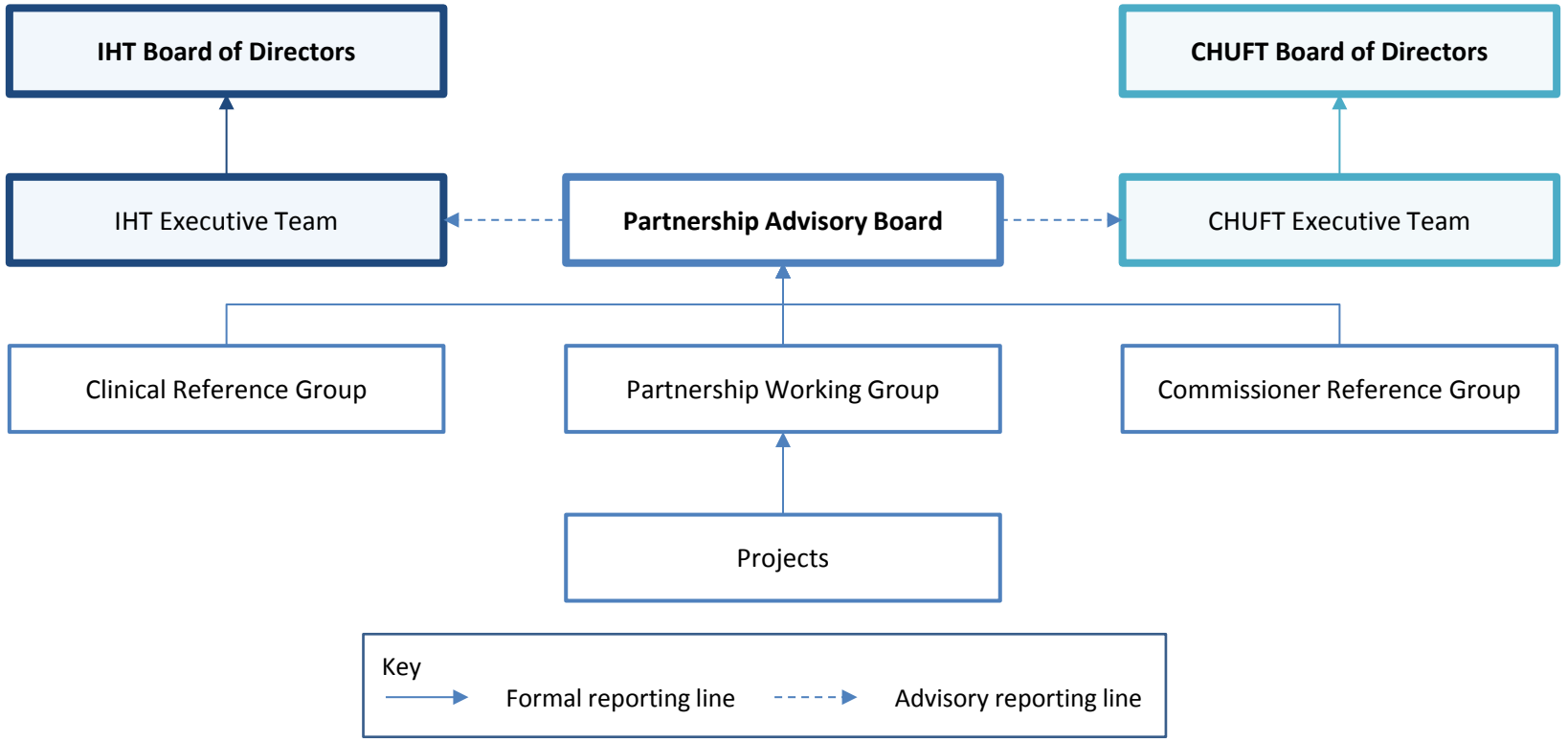


Section 7

MANAGEMENT CASE

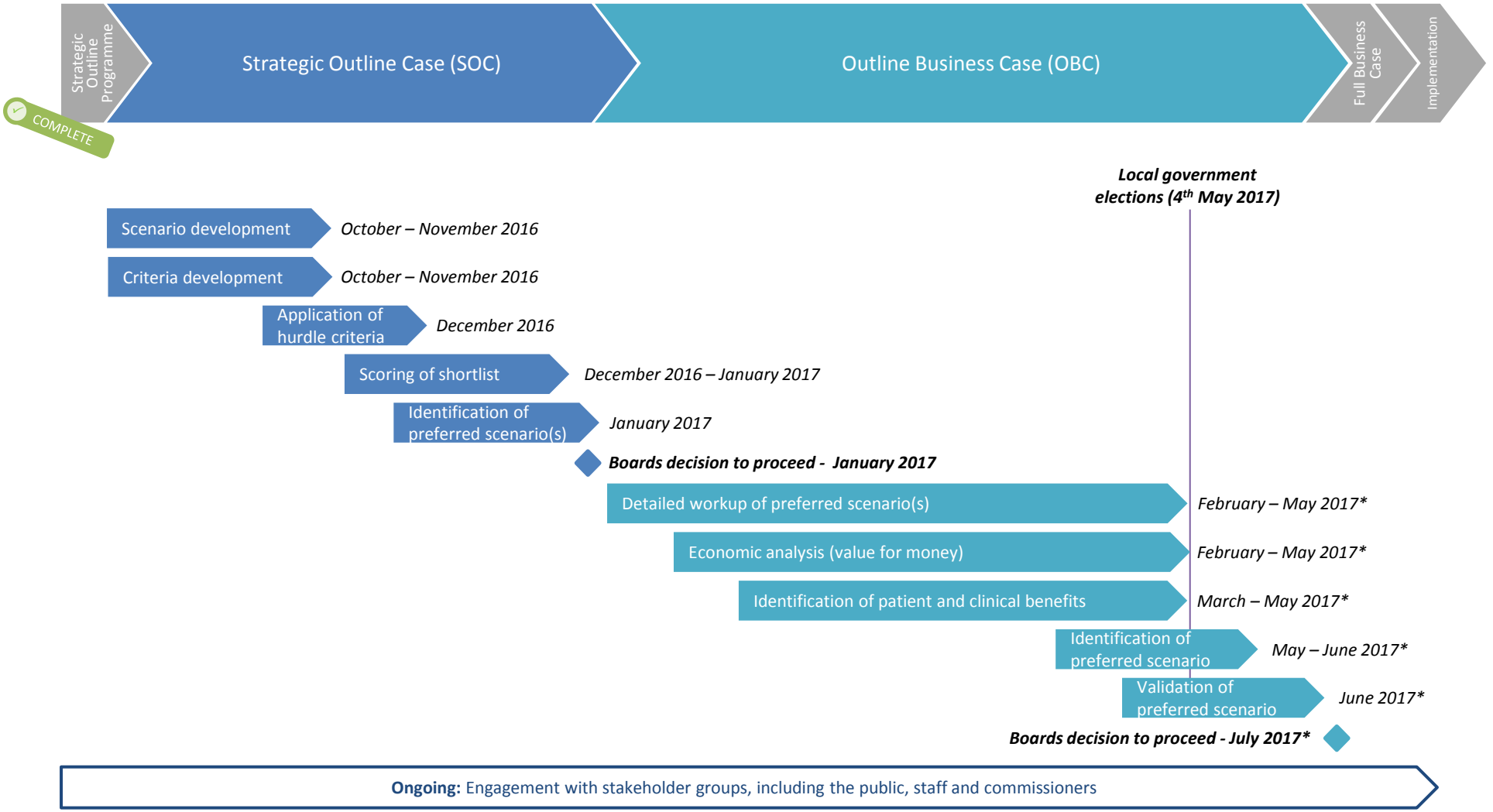
SOC programme governance

A governance structure was put in place to support the development of this SOC document. This provided oversight of the development of the process that this document describes, as well as the document itself. This ensured satisfactory progress and that both Executive and Non-Executive Directors had sufficient insight to come to a decision on the recommendations included within this document.



Subject to the approval of the SOC, the programme governance will be reviewed for the next stage of the programme (OBC). The objective is to ensure that programme oversight is maintained, but also that governance structures support closer working between the Trusts within the remit of the LTP.

Programme timeline



** Note that OBC timeline is indicative, and reliant on Boards approval for the development of scenarios in January 2017 at the end of the SOC phase*

Regulatory stakeholder analysis

The programme has, and will continue to, engage with a number of regulatory bodies. The table below shows a subset of the major bodies, and their status with respect to the programme. This is a subset of all the stakeholders that the programme has been (and will be) engaging with during its development; the fuller list is included as part of the communications plan (see next page).

Note that based on the 'RACI' classification of stakeholders, the two Trust Boards are accountable (A) for the programme, and the partnership structures (the Partnership Advisory Board and Partnership Working Group) are responsible (R) for progress.

Organisation	Consulted (C)	Informed (I)	Engagement
NHS Improvement (NHSI)	✓ Responsible for the licencing of health service providers		• Ongoing engagement with regards to progress • Provides regulatory approval for change in registration or licence conditions
NHS England (NHSE)	✓ Responsible for the commissioning of health services		• Ongoing engagement with regards to progress • Provides assurance for major service changes
Competition and Markets Authority (CMA)	✓ Consulted where there is the potential for significant lessening of competition		• Initial discussions, through NHSI • Reviews changes in services that result in significant lessening of competition
Care Quality Commission (CQC)		✓ Registers and inspects quality of all providers of health services	• Updates as a result of enforcement action being taken against CHUFT • Informed in the case of a change of registration
Essex County Council Health Oversight and Scrutiny Committee / Suffolk County Council Health Scrutiny Committee		✓ Informed of changes to health services likely to impact on local population	• Engaged to inform on programme progress and potential implications for local population
Health and Wellbeing Boards (Essex and Sussex)	✓ Support required in order to meet the 'four tests' for service change		• Engaged to ensure that the programme aligns with local health and wellbeing priorities

Communications and engagement plan

A Communications and Engagement Plan has been developed that aims to ensure that potential scenarios for change are informed, influenced and responsive to the views of people who use, or may use their services, carers, clinicians and employees, commissioners and partners in the local health and social care systems. It additionally aims to keep stakeholders well informed about what is happening and why, and give them opportunities to make their views known, ask questions and have them answered.

As and when any specific options for change are proposed, this plan and its messaging will need to be refined further so both organisations meet in full the requirement for meaningful public consultation.

The plan has been developed following discussion with partners in a number of local organisations, including those in the voluntary sector.

Objectives

The objectives of the plan are:

1. To provide meaningful opportunities for key stakeholders to help shape and influence potential scenarios for partnership and service change and development
2. To minimise uncertainty or confusion for patients, staff, partners and residents
3. To build and sustain confidence in the ability of both organisations to deliver high quality and safe healthcare during the transitional phases and beyond
4. To promote a positive reputation for CHUFT/IHT in the effective management of change and as deliverers of safe, caring and high quality care for residents
5. To ensure the Trusts meet their full statutory responsibilities to consult and engage on significant service change in a proper and meaningful way, meeting and exceeding statutory requirements

Proposed programme engagement structures

It is anticipated that the programme engagement structures will be revised at the start of the next phase and may include some of the following:

- **Patient and User Reference Groups (one for each hospital):** will enable the LTP to identify and take into account the potential impacts of scenarios on patients and service users. The groups will be asked to help define and articulate the values that underpin the planning of specific service changes. These groups will have knowledge of organisations involved with patients and service users, and access to local voluntary and community networks. A proposed membership list has been developed in liaison with key partners and includes representatives from hospital patient and service user involvement groups, patient and carer and principal voluntary umbrella organisations and Healthwatch. The groups will meet and work together and be supported to visit and learn more about each other's hospital, services and issues
- **Stakeholder Reference Group:** will ensure the LTP is responsive to the views and needs of the partners in the North East Essex and Suffolk health and social care system, and that it aligns with local commissioning, health, social care and well-being strategies. It will draw its membership from key partners in health, local government and social care
- **Clinical Reference Group:** will ensure any proposed service changes are clinically led and based on robust clinical evidence and best practice. Members are drawn from clinical and allied professions and come from both hospitals, CCGs, Public Health, the East of England Ambulance Trust, the Local Medical Committees and GP Federations
- **Staff Partnership Reference Groups (one for each hospital):** will help inform and influence the partnership development by contributing their ideas, advice and feedback effect and impact of the partnership on staff. Their considerations will also help test, guide, facilitate and develop effective internal communication and engagement

Next steps for the programme

To proceed to the next stage of development (OBC), there are a number of immediate next steps (based on the assumption that the preferred scenarios identified in the SOC are accepted):

- **Define the objectives of the OBC phase, based on the *scale* of ambition for**:
  - The anticipated outputs, for example: the clinical, workforce, and financial benefits for each shortlisted scenario; a financial model for each shortlisted scenario; and an OBC setting out these benefits, the evaluation process, and the preferred scenario(s)
  - The extent of stakeholder engagement required to articulate the clinical, workforce, and financial benefits for each shortlisted scenario
  - The extent of stakeholder engagement required to consult and inform on the objectives, progress, and outcomes of the OBC phase
  - The depth of financial modelling required for each shortlisted scenario
- **Define the *pace* of ambition for the OBC phase, based on the expected timeline to achieve the objectives above**:
  - Draft an implementation plan for the OBC's objectives setting out the timescale, key milestones, and key risks and mitigations
- **Establish the governance structure and resources, based on the scale and timeline of the OBC**:
  - Draft an updated governance structure for the OBC phase of the programme, based on the lessons learnt from the SOC phase and learnings from other organisations that have undertaken similar programmes
  - Draft a resource plan to deliver the OBC phase, based on the implementation plan and the scale and pace of ambition

The above will have to be agreed by the CHUFT and IHT Boards, and it is anticipated that this will be achieved at the February Boards.

Critical success factors

There are two types of critical success factors (CSFs) related to this programme of work:

- Those to do with ensuring that the programme itself is run according to best practice
- Those related to the *outcomes* that the programme is seeking to deliver.

For the CSFs to do with ensuring that the programme itself is run according to best practice, NHS Improvement has produced guidance[1] setting these out.

Critical Success Factor	Key issues
A clear and compelling narrative about the benefits for patients	• Strong narrative easily overlooked • Communicating benefits helps attract support from staff, commissioners and the public • The Independent Review Panel for the NHS cites "the clinical case not convincingly described or promoted" as a common reason for unfavourable review outcomes
Thorough preparation and planning	• Delays due to insufficient planning are common • Analyse how the capabilities of each organisation fit together • Broad objectives, not just smaller back-office changes, need to be planned to make a scenario a compelling proposition • Set realistic timeframes
Engage stakeholders	• Clinical leadership support is central to successful implementation • A clear case for change, understood by all stakeholders • Engage staff at all levels • Start engagement early
Sustain momentum of day-to-day services	• Sustain momentum in the change but safeguard day-to-day delivery • Lack of dedicated capacity creates delay and risk
Embed common culture	• Bringing cultures together is key to success • Staff engagement is important, communicating a clear and consistent vision
Recognise the challenges of increased scale	• Increased number of sites requires change in the management structure and approach

Sources: 1) *Making mergers work: factors affecting the success of NHS mergers,* NHS Improvement, May 2016

Critical success factors (Cont'd)

The CSFs related to the outcomes that the programme is seeking to deliver are based directly on achieving the LTP's objectives. These CSFs are shown below, mapped to the LTP objectives:

LTP objective	Clinical	Non-clinical
Improved quality and patient outcomes	• Maintain a high-level of engagement with clinicians, focused on the Clinical Reference Group • Ensure that benefits realisation is central to the programme – define how the scenarios to be taken forward will contribute to improved quality and patient outcomes	• Start engagement on requirements for back office services as a result of the expected benefits
Better value for money	• Work with clinicians to further develop the clinical savings expected from the scenarios to be taken forward	• Develop detailed plans for delivering identified cost savings across back office services
Sustained and improved access to services that meet the needs of the population	• For the scenarios to be taken forward, map out patient pathways to understand how services could be delivered in acute and non-acute settings	• Ensure a system-wide approach to patient pathway redesign, through ongoing engagement with STP partners
A sustainable, skilled workforce	• Work with key clinical subject matter resources to define future workforce skills requirements • Work towards implementing a common culture that aligns with the depth of the preferred LTP approach	• Work with key operational and managerial subject matter resources to define future workforce skills requirements • Work towards implementing a common culture that aligns with the depth of the preferred LTP approach

Based on the work done to date, the CSFs shown above will be used to inform the design and implementation of the next phase of the programme (which is subject to approval from both Boards), in particular for the following areas:

- A realistic timescale for delivery
- Setting out the potential clinical model(s) and benefits early
- Widening the stakeholder engagement, and ensuring ongoing clinical engagement

Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) process

Quality Impact Assessment process

A Quality Impact Assessment (QIA) has been identified as a key requirement for the next phase of work. As more detailed work is undertaken in the OBC, QIAs will be developed as part of the overall assessment of any preferred scenario(s). QIAs will be developed by both of the Trusts using their current processes and governance, as there will be no formal or contractual link between the two Trusts.

Equality Impact Assessment process

In parallel a high-level Equality Impact Assessment (EIA) will also be carried out by each Trust for each scenario under consideration. As with the QIA, this will be completed following each individual Trust's process and governance. They will seek to assess questions such as:

1. Who will benefit from the initiative? Is there likely to be a positive impact on specific equality groups (whether or not they are the intended beneficiaries) and if so how? Or is it clear at this stage that it will be equality 'neutral'?
2. Is there likely to be an adverse (detrimental) impact on one or more equality group as a result of this initiative? If so, who may be affected and why? Or is it clear at this stage that it will be equality 'neutral'?
3. Is the impact of the initiative, whether positive or negative, significant enough to warrant a more detailed assessment? If not, is there a need to monitor and review to assess the impact over a period of time?

Section 8

WORKFORCE CASE

Workforce case

The purpose of the Workforce case is to describe, for the preferred scenario(s), the implications for the workforce at CHUFT and IHT in relation to:

- The benefits for the IHT and CHUFT workforce, as well as the workforce across the broader STP footprint
- The extent of cultural alignment / integration required across the CHUFT and IHT workforce
- The strategic workforce initiatives to deliver the benefits and the cultural alignment / integration
- The workforce plan for the preferred scenario(s)

At the SOC stage, it is not possible to describe these in further detail as no preferred scenario(s) exist. However as the programme progresses through the OBC and FBC stages, further consideration will be given to the four areas described above. The workforce benefits will describe the expected benefits that the preferred scenario(s) will deliver or enable.

Although the extent of cultural alignment / integration required across the CHUFT and IHT workforce will clearly depend on the scale and depth of joint working required by the preferred scenario(s), it is likely that the OBC / FBC will need to consider the development of shared values across the two Trusts, and how to embed these. If the preferred scenario(s) require a high degree of integration, then the OBC / FBC will set out how a single organisational culture will be developed, expressed through a vision for the workforce and an organisational development strategy.

The strategic workforce initiatives will describe the programmes through which the workforce benefits and cultural alignment / integration will be delivered. Potential examples include initiatives related to new ways of providing patient care (including the use of roles and technology), and a review of the current cultures at CHUFT and IHT to create a baseline for cultural alignment / integration.

The workforce plan will set out, at a high-level, the forecast workforce profile for the preferred scenario(s), taking into account any expected changes clinical services and skills mix required to deliver the scenario(s).

Section 9

COMMERCIAL CASE

Commercial case

The purpose of the Commercial case is to describe how any final preferred scenario(s) is (are) being procured and the contractual terms through which the scenario(s) will deliver the objectives of the LTP.

At the SOC stage, it is not possible to describe these as the final preferred scenario(s) is (are) yet to be confirmed. However as the programme progresses through the OBC and FBC stages, further consideration will be given to two main elements, related to the shortlisted scenarios:

- The *contractual terms* related to any potential scenario for delivering strategic clinical networks, a corporate joint venture, a management contract (whole organisation), or forming a foundation group
- The *contractual vehicle* for any potential scenario involving an organisational merger or acquisition

For the OBC / FBC stages, the Commercial case in relation to *contractual terms* will follow the process set out in NHS Improvement's Integrated Support and Assurance Process (ISAP) guidance[1]. Although the ISAP applies to commissioners, in relation to providers the expectation is that "NHS Foundation Trusts and NHS Trusts will be subject to NHS Improvement's transaction review process, which for complex contracts will now be incorporated into the ISAP"[2]. The ISAP will consider Key Lines of Enquiry (KLOEs), which is the collective term for the areas of focus for NHS England and NHS Improvement's assurance regimes. KLOEs are structured as questions, which will establish the risk profile and other relevant parameters of the complex contract. Example KLOEs include:

- Do the providers have the ability to execute the contract successfully?
- Is quality maintained as a result of the contract?
- Does the contract result in an entity that is financially viable?

For the Commercial case in relation to the *contractual vehicle* (for organisational merger or acquisition), at the OBC / FBC stages consideration will be given to the possible options and which best suits the preferred scenario(s). In parallel with this, the Commercial case will use the guidance on transactions for NHS Foundation Trusts set out in March 2015 by Monitor[3]. Key areas of consideration will be:

- The competition implications of any preferred scenario(s), and the role of the Competition and Markets Authority (CMA)
- Whether any preferred scenario(s) constitute a significant transaction

Classifying a transaction as significant depends on its risk profile (e.g. in relation to the financial or quality profile of the trust). For significant transactions, the OBC / FBC stages will also consider whether a Long-Term Financial Model (LTFM), an Outline Post-Transaction Integration plan (PTIP), and due diligence are required.

Sources: 1) Integrated Support and Assurance Process: an introduction to assuring novel and complex contracts, NHS Improvement and NHS England, November 2016; 2) Ibid., p. 9; 3) Supporting NHS providers: guidance on transactions for NHS Foundation Trusts, Updated March 2015, Monitor.

Section 10

CONCLUSION AND RECOMMENDATION

Conclusion and recommendation

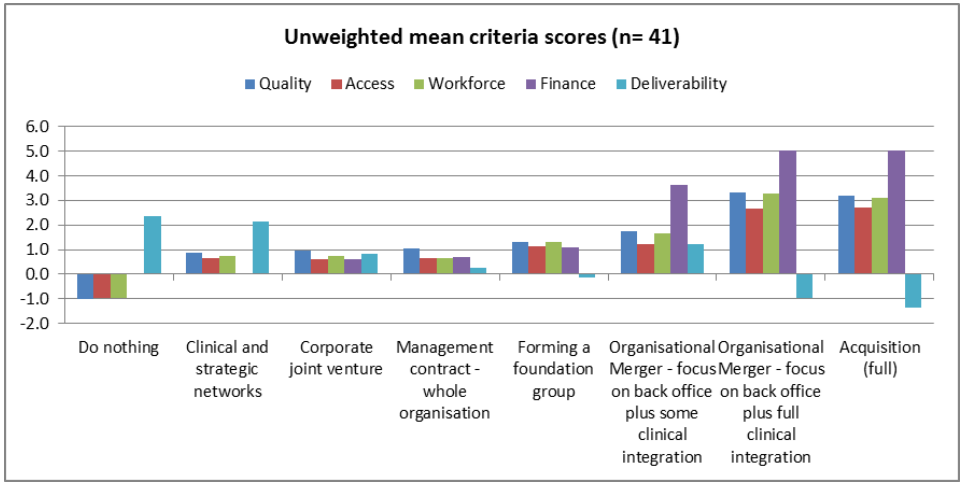
Conclusion

The Strategic Outline Case has set out a scope, ambition and objectives for the LTP which are supported by key stakeholders in the trusts and the local health and care systems. These stakeholders include clinical representatives and commissioners. Wider engagement has also included Essex and Suffolk County Councils, their Health and Wellbeing Board chairmen and their Overview and Scrutiny committees.

A long-list of scenarios was developed and an evaluation methodology was employed. Key stakeholders were involved at each step. A shortlist was produced by applying hurdle criteria to the long-list. Each shortlisted scenario was scored against the evaluation criteria (quality, access, workforce sustainability, financial sustainability and deliverability) to give an indication of which scenarios are preferred.

The evaluation process has identified three scenarios (**merger with full clinical integration, acquisition** and **merger with some clinical integration**) which score markedly higher than the others; it is recommend that these be explored further. These scored higher in all evaluation criteria except deliverability; this was also true when the weightings were removed from the criteria (see chart to the right). The identified benefits and drawbacks of these scenarios, and do nothing, are shown on the following page.

Much more detailed evaluation is required to enable the Board to make a final decision on the way forward for the LTP. The next phase of work will be undertaken, subject to the Board's approval, in an Outline Business Case. This will involve much broader stakeholder and regulatory engagement as well as detailed financial modelling and implementation planning.



Recommendation

That the Board accepts the Strategic Outline Case and agrees to proceed to develop an Outline Business Case evaluating the scenarios of:

- **Merger with full clinical integration**
- **Acquisition**
- **Merger with some clinical integration**
- **'Do nothing'**

Benefits and drawbacks of the preferred scenarios

Scenario	Benefits	Drawbacks	Costs
Merger with full clinical integration	Ranked *most favourable* for: **Quality**: Stronger governance & accountability; System resilience through co-ordinated IT investment; Reduce variation in quality through co-ordinated IT investment; Enable 7 day working (1st equal); Better compliance with standards; Separating elective & emergency flows; Services at scale to meet national standards; Reduce errors through standardisation. **Access**: Reduce need for access through better prevention (1st equal); Repatriation of services; Increase clinical effectiveness by standardisation of IT. **Workforce**: Create a culture that helps staff give their best; Improve recruitment & retention; More resilient clinical teams; More scope for leadership & talent development **Financial benefit**: £23-33m recurrent saving at Year 3	Ranked *least favourable* for: **Deliverability**: time to deliver	£11-16m non-recurrent cost
Acquisition (full)	Ranked *most favourable* for: **Quality**: Enable 7 day working (1st equal); Less intensive or better filled rotas; Reduce variation in quality through standardisation. **Access**: Reduce need for access through better prevention (1st equal); Increase access to subspecialist care; Better integration with community-based services **Workforce**: Improve development opportunities for staff **Financial benefit**: £23-33m recurrent saving at Year 3	Ranked *least favourable* for: **Deliverability**: risk to delivery	£14-17m non-recurrent cost
Merger with some clinical integration	Ranked *most favourable* for: none Ranked *third-most favourable* for: **Quality**: all quality benefits **Access**: Repatriation of services; Increase clinical effectiveness by standardisation of IT. **Workforce**: all workforce benefits **Financial benefit**: £17-26m recurrent saving at Year 3	Ranked *least favourable* for: none Ranked *fourth most favourable* for: **Deliverability**: time to deliver	£9-14m non-recurrent cost
Do nothing	Ranked *most favourable* for: **Deliverability**: Time to deliver **Financial benefit**: none (baseline)	Ranked *least favourable* for: **Quality**: all quality benefits **Access**: all access benefits **Workforce**: all workforce benefits	None (baseline)

Section 11

APPENDIX A: LONGLIST OF SCENARIOS

Long list of scenarios

	Area	Longlist Scenario	Origin
N/A	Do minimal / nothing	**Do minimal / nothing**	• Compulsory scenario
Collaboration	Collaboration - Federation	**Federation**	• Dalton Review
	Collaboration - Other	**Clinical and strategic networks**	• Dalton Review
		Buddying	• Existing arrangement
Contractual	Contractual – Joint venture	**Joint venture (contractual)**	• Dalton Review • Some emergent joint ventures (i.e. SWLEOC) • Acute care collaboration (ACC) vanguard – One NHS in Dorset
		Corporate joint venture	• NHSI Policy Guidance (related to foundation groups)
	Contractual - Service-level chain	**Service-level chain type 1 – outsourced**	• ACC vanguard – Moorfields • Dalton Review
		Service-level chain type 2 - provision	• ACC vanguard – Moorfields • Dalton Review
		Service-level chain type 3 – policies and protocols	• Dalton Review
	Contractual - Management contract	**Management contract – single service**	• Dalton Review • Acute care collaboration (ACC) vanguard – Foundation Healthcare Group
		Management contract – whole organisation	• Dalton Review
		Joining an existing foundation group	• NHSI Policy Guidance (related to foundation groups)
Consolidation	Consolidation – New care models	**Forming a foundation group**	• NHSI Policy Guidance (related to foundation groups)
	Consolidation – Organisational merger	**Organisational merger, focus on back office**	• Options working paper
		Organisational merger, focus on back office plus some clinical integration	• Options working paper
		Organisational merger, focus on back office plus full clinical integration	• Options working paper
		Acquisition (full)	• Experience of other processes (reverse acquisition)
	Consolidation – Vertical integration	**Vertical integration**	• Experience of other processes • International examples (ACOs)

Sources: 1) *Examining new options and opportunities for providers of NHS care,* The Dalton Review, (2014); 2) *Acute care collaborations: Guidance on options for structuring foundation groups,* NHS Improvement (2016)

Scenarios descriptions - Collaborative

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Do minimal / nothing	• Compulsory scenario	• No change to current state	• No change to current state	• Draft SOC suggests combined deficit approaching £200m by 2020/21	• N/A
Federation[1]	• Dependent on whether clinical services were included within the federation agreement; could extend to joint delivery of services subject to MoU	• Back office services often jointly delivered or commissioned	• Each organisation retains individual sovereignty • Typically one trust would take lead on governance, quality and finance as set out in MoU	• Relatively minimal • Required for infrastructure to allow joint working, i.e. technology • Associated procurement costs	• UCL Partners in London has a central team that allows best practice to be shared across 40 organisations, with support for implementation; has used model to support changes to stroke care in London • ***Critical success factor:*** *Independent coordinating and support function*
Buddying	• Input and advice from buddy trust workforce to improve performance, though of a more informal nature than a management contract • Will result in changes to operating procedures and ways of working	• Input and advice from buddy trust workforce to improve performance, though of a more informal nature than a management contract • Will result in changes to operating procedures and ways of working	• Clinical and corporate governance would initially remain unchanged, though there would be the opportunity to update governance based on buddy trust experience • Accountability for performance and quality remains with the host trust	• Minimal investment, though buddy trust will require additional resource to provide assistance • Some financial assistance from regulators may be available	• Current situation between IHT and CHUFT • Introduced into the NHS as a result of the Keogh Review and the subsequent Special Measures regime[1]; intended to enable a two-way learning relationship between trusts • ***Critical success factor:*** *Openness to learn from each trust*
Clinical and strategic networks[1]	• Sharing of best practice between clinicians, changing procedures and sharing evidence-base[1]	• Minimal impact	• No change to governance as likely to be based on informal sharing agreements, individual services remain accountable for performance and quality	• Minimal impact	• Regional Strategic Clinical Networks in areas such as maternity, paediatrics, mental health, dementia and neurological conditions • ***Critical success factor:*** *Support from local Clinical Senate and clinical input*

Sources: 1) *Examining new options and opportunities for providers of NHS care,* The Dalton Review, (2014)

Scenarios descriptions - Contractual

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Joint venture (JV) – Contractual[1]	• Only services that are included within the JV would be affected; not all services have to be included • Potentially minimal change to services, especially where services are offered by a subcontractor to a prime provider • Prime contractor may define new or different service standards and ways of working, holding subcontractors to account	• JV can also be used to provide back office and corporate functions into 'owner' trusts (and others)	• Contractual JVs are based on existing contractual structures and do not result in the creation of a new separate entity • Contractual forms include: prime contractor, lead contractor, subcontracting, alliance contacting[2] • Clinical governance: accountability ultimately lies with contract holder (exception is alliance contracting)	• Required for the development of the legal entity or the	• Acute care collaboration (ACC) vanguard – One NHS in Dorset • South West London Elective Orthopaedic Centre (SWLEOC) is a contractual joint venture between St George's, Epsom and St Helier, Croydon and Kingston. Located on Epsom site, carries out elective orthopaedic surgery only with high levels of efficiency, surplus shared between 'owner' trusts. • ***Critical success factor:*** *Development of appropriate contractual vehicle*
Corporate joint venture[2]	• Only services that are included within the JV would be affected; not all services have to be included • Included services would be provided by the JV, this could result in workforce transfers; pooled staffing can enable clinical standards to be met • JV may set standardised operating procedure across sites where services are provided	• As with a contractual joint venture, back office services can be provided into 'owner' and other trusts	• Core difference is that a corporate joint venture always results in the creation of a separate entity – either a company limited by shares or a limited liability partnership (LLP) • FTs taking part in a corporate joint venture remain accountable for the decisions they take under their provider licence[2]	• Requires legal and professional advice to select and implement the appropriate organisational form • Additional costs incurred, for example corporate JVs would be treated differently for tax purposes compared with NHS vehicles[2]	• ACC vanguards – some of the Foundation Groups are exploring this as an enabling organisational form • There are few examples of implementation within the NHS, though NHSI is developing further guidance • Balances freedoms not available to NHS Trusts / FTs against losing some benefits (i.e. tax treatment) • ***Critical success factor:*** *Selection of the most appropriate legal entity type*

Sources: 1) *Examining new options and opportunities for providers of NHS care,* The Dalton Review, (2014); 2) *Acute care collaborations: Guidance on options for structuring foundation groups*, NHS Improvement (2016)

Scenarios descriptions – Contractual (cont'd)

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Service-level chain type 1 – outsourced[1]	• Service or speciality is offered by an entirely new provider, and is directly accountable for performance • 'Host' trust provides the physical space for the service and sometime clinical support services • At the time of change of provider workforce may transfer into new provider (TUPE), or provider may bring in their own workforce • Operating procedures and policies are those of the new provider	• Full outsource of back office functions into a separate legal entity (or offered by an existing entity) • Corporate services related to the clinical service are the responsibility of that provider • Requires a 'landlord' contract between host trust and provider	• Full governance and accountability for the service sits with the provider, and is transferred from the host trust • Host trust assumes role of landlord, renting physical space (not necessarily income generating) to provider • Agreements required to ensure governance, data gathering, performance reporting and quality inspections are undertaken correctly[1]	• For host trust: relatively low investment, though will require additional expertise to develop and manage landlord contracts[3], and a procurement may need to be run • For provider: Investment required to respond to a procurement, and costs associated with implementing service onto a new site, including for technology and training	• ACC vanguard – Moorfields Eye Hospital • Moorfields @ model, where Moorfields run the entire ophthalmology unit at St Geroge's, London as a satellite to the main site. Service is outsourced to Moorfields in its entirety, who 'take' the activity, employ workforce and own equipment • ***Critical success factors:*** *Suitable specialism selection, appropriate contractual expertise of both parties*
Service-level chain type 2 – provision[1]	• Service or speciality is offered by an alternative provider, and is accountable to the host trust for the quality and performance of the service • 'Host' trust provides the physical space for the service and sometime clinical support services • At the time of change of provider workforce may transfer into new provider (TUPE), or provider may bring in their own workforce • Operating procedures and policies are those of the new provider	• Most common organisational form for outsourced back office functions, where the host trust remains ultimately accountable for the performance of these and, in turn, holds them to account • Can take the form of shared service centres	• Key difference to 'type 1' is that accountability for the service is to the host trust, not directly to the regulator; in this respect this is similar to a subcontracting agreement • For a Foundation Trust, the host trust remains ultimately accountable for the service as per the terms of the licence conditions • Agreements required to ensure governance, data gathering, performance reporting and quality inspections are undertaken correctly[1]	• As above	• ACC vanguard – Moorfields Eye Hospital (additionally provide visiting services) • ACC vanguard – The Neuro Network: The Walton Centre, Liverpool, provides Consultant Neurologists into a large number of surrounding hospitals, spreading best practice and providing outpatient reviews. • Also applicable for back office services; Northumbria Healthcare NHS FT provides payroll services across the NHS • ***Critical success factors:*** *Capacity to 'sell' services and develop an appropriate price*

Sources: 1) *Examining new options and opportunities for providers of NHS care,* The Dalton Review, (2014); 3) *Interviews with Director of Strategy at Moorfields Eye Hospital NHS Foundation Trust,* (2016)

Scenarios descriptions – Contractual (cont'd)

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Service-level chain type 3 – policies and protocols[1]	• Trust 'buys in' and implements the procedures and policies from another provider • Existing workforce is required to operate in a new and different way, though workforce may not change	• Introduction of alternative providers standard operating procedures and policies • Provision of the service is still by the original team, though job roles and skill mix may be altered	• No transfer or accountability to the provider of policies and protocols, though they may provide inspection and oversight	• Policies and procedures may need to be purchased from the provider under a franchise agreement, the cost of this can vary considerably • There will be additional cost associated with training	• ACC vanguard – National Orthopaedic Alliance is developing a 'kite mark' for services, based on the opportunity identified in Getting it Right First Time[4] • ***Critical success factors:*** *Suitable specialism selection, appropriate target market*
Management contract – Single service[1]	• Service in question moves to be managed in its entirety to a new provider under contract, for a time-limited period • Workforce is likely to be retained in original form, though would report into management contract owner	• Standardised practices could be brought across wholesale from the organisation that is managing the contract. Allows sharing of back office functions to a greater degree including procurement practices and operational and clinical policies and procedures[1]	• Accountability of the service in its entirety moves to the contract manager • Often used in the case of significant service failure • Host trust holds contract provider to account; regulator holds host trust to account for service	• Minimal from the perspective of the host trust, though dependent on the management contract financial agreement income from the operated service may be forfeited	• Extended form of buddying arrangement, where an alternative provider manages an entire service on behalf of a host trust (not outsourced) • ***Critical success factors:*** *Clearly articulated replicable operating model, clarity on service changes required (back office and clinical), leadership capacity*
Management contract – Whole organisation[1]	• Clinical services come under the management of the contacted organisation; potential to have significant change • Could result in changes to policies and procedures for frontline workforce	• Standardised practices could be brought across wholesale from the organisation that is managing the contract. Allows sharing of back office functions to a greater degree including procurement practices and operational and clinical policies and procedures[1]	• Accountability for the performance of the organisation under contract moves to the contract holder • Often used in the case of serious organisational failure • Regulator holds the contract owner to account	• Potentially significant for the managing organisation, in terms of implementing new operating procedures, which will require additional resource and external support • Deficit support may be required from national bodies at the outset of the contract	• ACC vanguard – Foundation Healthcare Group: Examining how a trust that is not viable can be supported through pooling organisational sovereignty on the route to development into a Foundation Group • Hinchingbrooke is an example of the risks associated • ***Critical success factors:*** *Clearly articulated replicable operating model, clarity on service changes required (back office and clinical), leadership capacity*

Sources: 1) *Examining new options and opportunities for providers of NHS care,* The Dalton Review, (2014); 4) *Getting it Right First Time,* Briggs, T. (2015)

Scenarios descriptions – Consolidation| New care models (foundation groups)

Scenario	Clinical (front line)	Corporate	Governance	Investment required	Example
Joining an existing foundation group (four currently accredited)	• Dependent on membership option chosen (range being developed); some of these include wholesale adoption of clinical operating procedures and standardisation of practices • At the 'least integrated' level of the spectrum similar to buddying, at the most integrated end similar to merger	• Dependent on membership option chosen (range being developed); some of these include wholesale adoption of clinical operating procedures and standardisation of practices • For many options there are likely to be significant back offices synergies sought, moving to shared back office functions	• Dependent on membership option chosen, but in most cases individual organisations retain accountability for quality and performance • NHS Improvement is developing a regulatory approach to foundation group members	• Dependent on membership option chosen, but under all there is investment required from the trust becoming the centre of the foundation group to codify operating model and procedures • Dedicated resource required to pass through the NHSI accreditation process	• Four foundation groups have now been accredited by NHS Improvement[5] - all of which have had to identify initial partners; they are now in a position to open discussions with other potential partners • ***Critical success factors:*** *Aligned strategic visions, identification of a suitable Foundation Group to join, capacity of Foundation Group*
Forming a foundation group	• Requires codification of clinical services and the development of a clinical standard operating procedures by the trust forming the foundation group • May involve the reassessment of current procedures and policies and any required updating	• Corporate services may undergo significant transformation, including the organisation of services into 'headquarters' and 'site-level' functions • Range of services provided and capabilities will have to increase to provide group level functions	• New group level governance arrangements will be required, for the spectrum of different group membership options • Accountability for performance and quality at 'owned' sites are the responsibility of the foundation group organisation	• Potentially significant investment to prepare the organisation to pass through the NHSI accreditation process • Legal and professional support required to develop new organisational forms	• Four foundation groups have now been accredited by NHS Improvement[5] - passing through the newly developed accreditation process (which includes desktop review of organisational performance and Board to Board meeting) • NHSI has recently encouraged South Warwick to form a foundation group to support Wye Valley[6] • ***Critical success factors:*** *Clearly articulated replicable operating model, clarity on service changes required (back office and clinical), leadership capacity*

Sources: 1) *Examining new options and opportunities for providers of NHS care,* The Dalton Review, (2014); 5) *High-performing Foundation Trusts to support others in improving patient services,* NHS Improvement (2016) https://improvement.nhs.uk/news-alerts/high-performing-foundation-trusts-support-others-improving-patient-services/ ; 6) *Wye Valley Trust removed from special measures*, NHS Improvement (2016) https://improvement.nhs.uk/news-alerts/wye-valley-trust-removed-special-measures/

Scenarios descriptions – Consolidation| Merger and acquisition

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

Sources: 1) *Examining new options and opportunities for providers of NHS care,* The Dalton Review, (2014)

Scenarios descriptions – Consolidation| Merger and acquisition

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

Sources: 1) *Examining new options and opportunities for providers of NHS care,* The Dalton Review, (2014)

Section 12

APPENDIX B: PROCESS DESCRIPTION

Define LTP scope, ambition and objectives

Prior to initiating the evaluation process, the scope, objectives and design principles of the LTP were defined:

The LTP between IHT and CHUFT has been established to improve the quality of patient care at CHUFT and enable both organisations to be sustainable in the longer term. The scope of the partnership is the delivery of services at both hospitals and how, by working together, they can become sustainable for the future. This includes front line clinical services, clinical support services and corporate services.

Out of scope of this partnership programme is any improvements that can be achieved through working in partnership with other organisations.

The ambition for the Partnership is that by working together CHUFT and IHT will secure sustainable and high quality healthcare of Ipswich, East Suffolk and North East Essex

IHT and CHUFT are not sustainable in the long-term unless changes are made to the way both currently operate

The long term partnership will allow the necessary changes to be made. The ambition is to secure sustainable and high quality healthcare for the residents of Ipswich, East Suffolk and North East Essex.

Four objectives have been defined that the partnership needs to achieve:

1. Improved quality and patient outcomes;
2. Better value for money;
3. A wider range of services; and
4. A sustainable, skilled workforce.

Improved quality and patient outcomes

By working together the LTP must maintain or, where necessary, improve the quality of services at IHT, and fundamentally improve quality at CHUFT. The LTP will improve the quality of care by standardising practice across the combined services and sharing best practice where it exists locally and nationally.

By working together the Trusts will plan and use the workforce, estate and equipment in a combined way that maximises productivity. This will enable waiting times to be reduced and improved access to services, and provide a more consistent level of service to residents. The larger teams will be able to establish shared out of hours rotas and make delivery of seven day working for emergency services more sustainable.

Define LTP scope, ambition and objectives (cont'd)

Better value for money

Working at scale across a range of non-clinical spend areas, will enable better value for money. It will increase buyer power which will enable the LTP to negotiate better rates for external services and products, saving money that can be better directed to clinical care for patients.

Technology systems will be brought together so they allow medical records and information to be shared. This will enable the clinical teams at both hospitals to be fully informed of a patient's medical history and treat them at the right time, in the right place.

Planning for delivery of services to a population of c.700,000 will provide a view across the combined premises and facilities and get better use and value from space and equipment.

Through the LTP corporate services will be redesigned with the aim of reducing operating costs and improving the service provided to internal and external customers. The LTP will also streamline and standardise to deliver best practice clinical administrative processes, to improve patient experience and reduce administrative burden.

A wider range of services

The Trusts will continue to operate as district general hospitals with some specialist services. At present, there are a number of services where patients have to travel long distances to receive the specialist treatment they need because the separate population sizes are not large enough to support delivering them within the geographical areas. By working at scale with the larger population the partnership provides, there is an opportunity to increase the number of specialist services provided locally and for subspecialisation.

A sustainable, skilled workforce

The LTP will not completely solve all the workforce challenges currently faced. However, by working together there is the opportunity to improve staff recruitment and retention and offer more staff development opportunities. For the clinical teams this will be made possible through the increase in providing more specialist services and subspecialisation.

For the non-clinical teams the LTP will build on best practice in staff development and where necessary introduce skillsets, structures and, tools that enable them to continue improving and gain more career development opportunities.

Define LTP design principles

A number of design principles were established based on the objectives of the LTP to serve as the foundation for the scenario evaluation. The principles also took into account some key constraints within the local health and care systems.

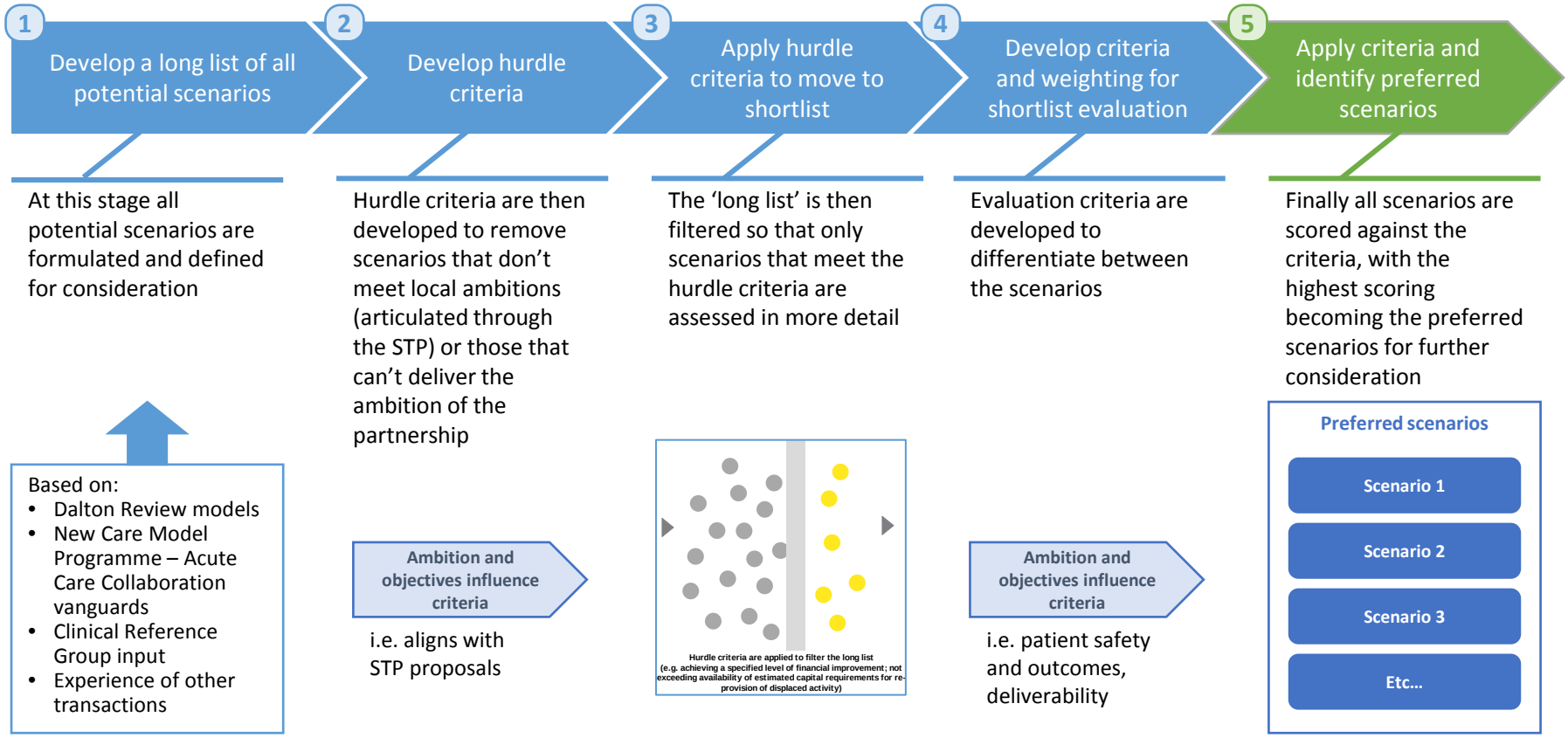
These principles are essential to the success of the LTP and needed to be met for a scenario to pass the evaluation stage. Developing these principles has taken into account the LTP's role in the health and care system, the case for change, and the respective sizes of the two populations.

- Continue to operate as district general hospitals
- Focus on delivering acute services, and delivering them well
- Develop specialist services where there will be a demonstrable improvement in care for patients from improved access and/or outcomes
- Continue to provide A&E services on both acute hospital sites
- Continue to have obstetric-led maternity services on both sites
- Have a 24/7 undifferentiated acute medical take at both sites
- Have at least one paediatric assessment unit/paediatric intensive care unit
- Maximise clinical synergies and adjacencies
- Enhance teaching and training to develop the future clinical workforce
- Move at pace to minimise the disruption caused through uncertainty and maximise the speed by which improvements are made

Overview of the evaluation and selection process

After establishing the LTP objectives and design principles, an evaluation and selection process was developed to facilitate the identification of the most suitable future scenarios for the LTP. This was based on an established methodology[1] and was developed with input from key stakeholders at each stage to ensure that there was a good strategic fit with the local health and care system. The process was followed by working closely with a clinical reference group, commissioners and the executive teams of both Trusts. At each stage they were asked for their views on the approach as well as inputs and outputs, which have been incorporated accordingly. The health and care system partners and regulators have also been engaged on progression through the process to ensure strategic alignment.

The model below outlines the end-to-end process from defining the longlist of potential scenarios to evaluating the shortlisted scenarios to obtain their final scores and identifying the preferred scenarios:



Notes: 1) For example, this methodology was used (in combination with decision-trees to develop scenarios) in South West London for the Better Service, Better Value programme.

1. Develop a long list of all potential scenarios

A wide range of potential scenarios were considered to identify those most suitable for the LTP. The list was developed from models included in the Dalton Review[1], early models emerging from the Acute Care Collaboration vanguards[2], examples from NHS Improvement guidance[2] and experience from similar programmes. Only high-level models were considered as scenarios as each scenario may have various sub-scenarios. The longlist consisted of the following scenarios:

	Scenario	This means…
N/A	**Do minimal / nothing**	• No change to the existing organisations, assumes that collaboration between trusts remains at the current level
Collaboration	**Federation**	• A formalised agreement for trusts to work together, which may include the joint commissioning of back office functions or clinical service delivery, but stopping short of contractual agreements
	Clinical and strategic networks	• Networks that facilitate the sharing of best practice between clinicians, without a formal agreement to work together
	Buddying	• Input and advice from buddy trust (often on an enforced basis by regulators) across the entire remit of service including clinical, corporate and governance
Contractual	**Joint venture (contractual)**	• Offering clinical services (individual services or full specialties) through a separate joint venture; utilises existing contracting structures to enable the joint venture so that individual organisational sovereignty is maintained
	Corporate joint venture	• Creating a separate legal entity that will provide services; this entity would not typically take the form of a trust, for example forming a controlled LLP or limited company for the JV vehicle
	Service-level chain type 1 – outsourced	• When another (specialist) trust offers a particular service on behalf of the host provider, on a fully outsourced basis. The provider of the outsourced services takes full accountability for the service and the associated activity; the Board of the host trust holds this provider to account
	Service-level chain type 2 - provision	• When another (specialist) trust has a contract to provide staff with the host trust on a per session basis; the host trust retains the activity and accountability for the service and pays the provider trust for staff time
	Service-level chain type 3 – policies and protocols	• When another (specialist) trust provides the host trust with standard operating procedures and policies, on licence; the provider trust should have developed a set of replicable standard operating procedures based on evidence and best practice guidance • No workforce, activity or accountability moves between trusts
	Management contract – single service	• An alternative organisation is sought to take over management of a particular service (or set of services) within a host organisation; the host trust retains the activity, workforce and accountability for the service, although the service is managed on behalf of the host trust
	Management contract – whole organisation	• An alternative organisation is sought to take over management of the host trust resulting in pooled organisational executive control; host trust Board holds management to account for performance. The host trust retains activity, workforce and accountability to regulators • Potential for back office consolidation, and the implementation of standard operating procedures in all areas at the host trust
	Joining an existing foundation group	• Working with one of the four accredited Foundation Groups to join as a member of the group; the most likely options would be one of the two London-based Foundation Groups (Royal Free London and Guys and St Thomas's)
Consolidation	**Forming a foundation group**	• One of the trusts using the LTP as the basis to enter into the NHS Improvement accreditation process to become a Foundation Group
	Organisational merger, focus on back office	• Merger between the two trusts, where back office functions are consolidated or jointly procured but front line clinical services remain in their current form
	Organisational merger, focus on back office plus some clinical integration	• Merger between the two trusts, with back office consolidation and joint procurements, plus consolidation of some front line clinical services; services to be consolidated likely to either specialist services or those with challenging requirements to meet clinical standards
	Organisational merger, focus on back office plus full clinical integration	• Merger between two trusts with full consolidation of both front line clinical and back office functions; services become joined across both sites with a level of reconfiguration likely to form part of the plans
	Acquisition (full)	• Identification of a target trust by the acquirer (which may be driven by regulators); this scenario shares many characteristics of 'full' organisational merger but is driven by the acquirer's strategy and vision, and there is a single 'controlling mind' throughout the process
	Vertical integration	• Integration between an acute hospital trust and one or more community services providers to increase the range of services on offer

Sources: 1) Examining new options and opportunities for providers of NHS care, The Dalton Review, (2014); 2) Acute care collaborations: Guidance on options for structuring foundation groups, NHS Improvement (2016)

2. Develop hurdle criteria

The longlist considers all possible scenarios for the LTP. However, not all of these scenarios would result in a sustainable and viable future. A set of hurdle criteria was developed to ensure that these unviable scenarios were not considered further. These hurdle criteria move from the widest strategic considerations (the STP) through to more specific 'filters' and were agreed by both boards on 21st December 2016.

Area	Criterion	Commentary
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	• STP has been made available to members of the Clinical Reference Group • Scenarios should be able to deliver acute reconfiguration
	Improve links to (and integration with) community services and improve transition	
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	• An ambition has been developed for the LTP, so at a minimum any scenario must support this
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	• NHS Improvement requires that any major service change (that would be reviewed under the 'transactions process') results in delivery of financial sustainability within a 3-5 year time period • This has been accelerated to align with: deteriorating position at both trusts, overall system context and the aims of the STP
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	• A learning from major change programme for acute hospitals is that this sometimes results in an overall decline in performance, and this can put the programme at risk (i.e. Nottingham and Sherwood Forest potential merger)
Timeline	Owing to the scale of challenges at CHUFT scenarios must enable and support stabilisation in the short term	• Scenarios should support ongoing transformation programmes at both Trusts
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	• Clinical Reference Group to test scenarios as to whether they are likely to achieve these criteria from a clinical perspective

3. Apply hurdle criteria to move to shortlist

All scenarios were passed through the hurdle criteria in order to determine the overall strategic fit, the suitability, the acceptability, and the ability to maintain the fixed points. Scenarios were tested against all of the criteria even after the 'failure' of a single criterion to ensure a thorough assessment.

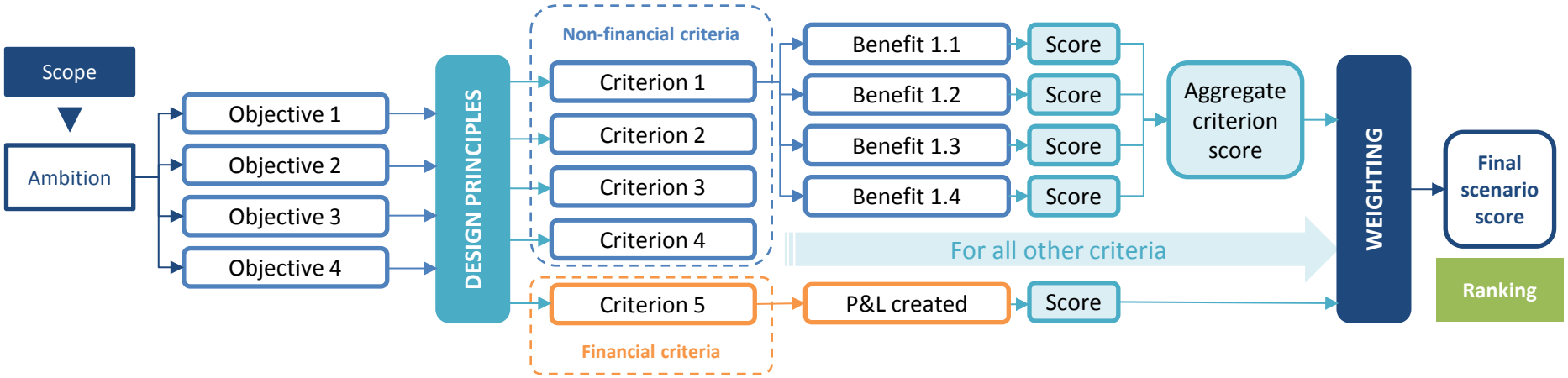
The Partnership Working Group (PWG) applied the hurdle criteria to the longlist of scenarios. The output of this was reviewed by the Trusts' Executives, Clinical Reference Group, Commissioner Reference Group and Partnership Advisory Board (PAB):

Scenario	This means…
Do nothing	• No change to the existing organisations, assumes that there is no change from the do nothing projections arising from LTP
Clinical and strategic networks	• Networks that facilitate the sharing of best practice between clinicians, without a formal agreement to work together
Corporate joint venture	• Creating a separate legal entity that will provide services; this entity would not typically take the form of a trust, for example forming a controlled LLP or limited company for the JV vehicle
Management contract – whole organisation	• An alternative organisation is sought to take over management of the host trust resulting in pooled organisational executive control; host trust Board holds management to account for performance. The host trust retains activity, workforce and accountability to regulators • Potential for back office consolidation, and the implementation of standard operating procedures in all areas at the host trust
Forming a foundation group	• One of the trusts using the LTP as the basis to enter into the NHS Improvement accreditation process to become a Foundation Group
Organisational merger, focus on back office plus some clinical integration	• Merger between the two trusts, with back office consolidation and joint procurements, plus consolidation of some front line clinical services; services to be consolidated likely to be either specialist services or those with challenging requirements to meet clinical standards
Organisational merger, focus on back office plus full clinical integration	• Merger between two trusts with full consolidation of both front line clinical and back office functions; services become joined across both sites with a level of reconfiguration likely to form part of the plans
Acquisition (full)	• Identification of a target trust by the acquirer (which may be driven by regulators); this scenario shares many characteristics of 'full' organisational merger but is driven by the acquirer's strategy and vision, and there is a single 'controlling mind' throughout the process

The PAB recognised that those scenarios which met the hurdle criteria and were shortlisted were all at one end of the partnership spectrum. These are considered to be the more complex and high risk approaches so the PAB recommended that a scenario from the other (collaborative) end of the spectrum was also subjected to evaluation. The intention was to give the Boards a greater diversity of scenarios to inform their final decision about which one(s) to take forward. For this purpose the clinical and strategic networks scenario has been included in the shortlist. This scenario was selected, after review of all the scenarios which did not pass the hurdle criteria, because this approach has been widely used in the NHS previously and its risks are better understood.

4. Develop criteria and weighting for the shortlist evaluation

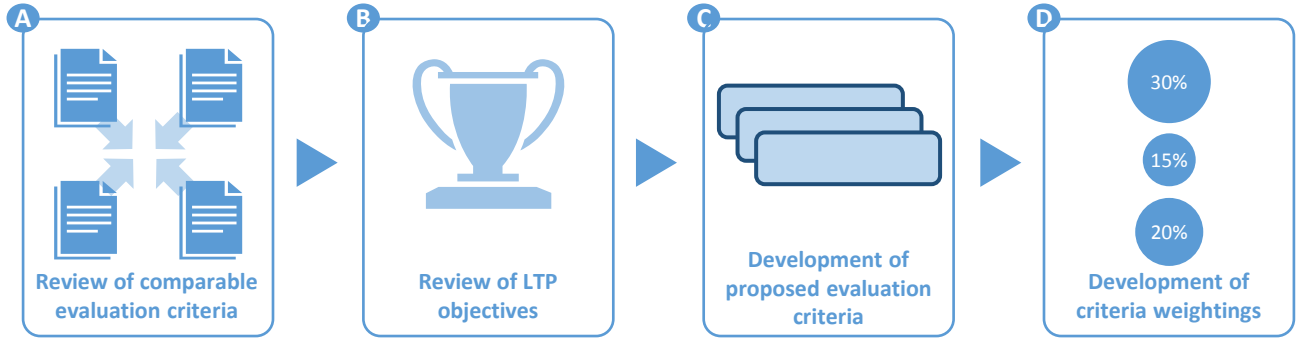
In order to facilitate the selection of preferred scenarios for the LTP from the established shortlist, a considered and rigorous evaluation approach was employed. As with the hurdle criteria, the evaluation criteria were developed based on the LTP scope, objectives and design principles:



- **Defining the evaluation criteria**: a set of criteria (financial and non-financial) based on the design principles was established, along with their weightings of relative importance
- **Developing a benefits model**: each criterion was broken down into a group of benefits for scoring by designated scorers
- **Assigning benefit scores**: for a given scenario, the scorers were asked to provide a score for the size of the benefit that could be realised based on a scoring scale
- **Allocating the final scenario scores**: average benefits scores for each scenario were obtained and combined, before applying the weighting factor to obtain the final scores and ranking

4. Develop evaluation criteria and weighting (cont'd)

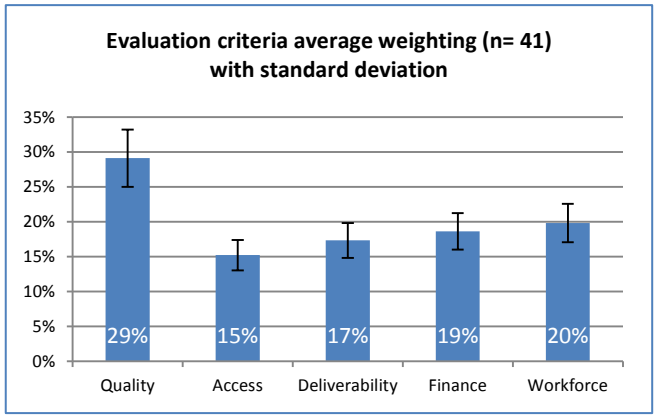
The next step following the identification of the shortlist of scenarios was to define the success criteria for the scenario evaluation. A four stage process (shown below) was employed to establish the evaluation criteria (steps A to C) and the corresponding weightings of each (step D):



A-C: After a review of the comparable evaluation criteria and LTP objectives, five evaluation criteria were proposed as: (i) *Quality: outcomes, safety and patient experience*; (ii) *Access*; (iii) *Deliverability*; (iv) *Financial Sustainability* and (v) *Workforce Sustainability*

The criteria were then reviewed and verified with clinicians, commissioners and Trust executives.

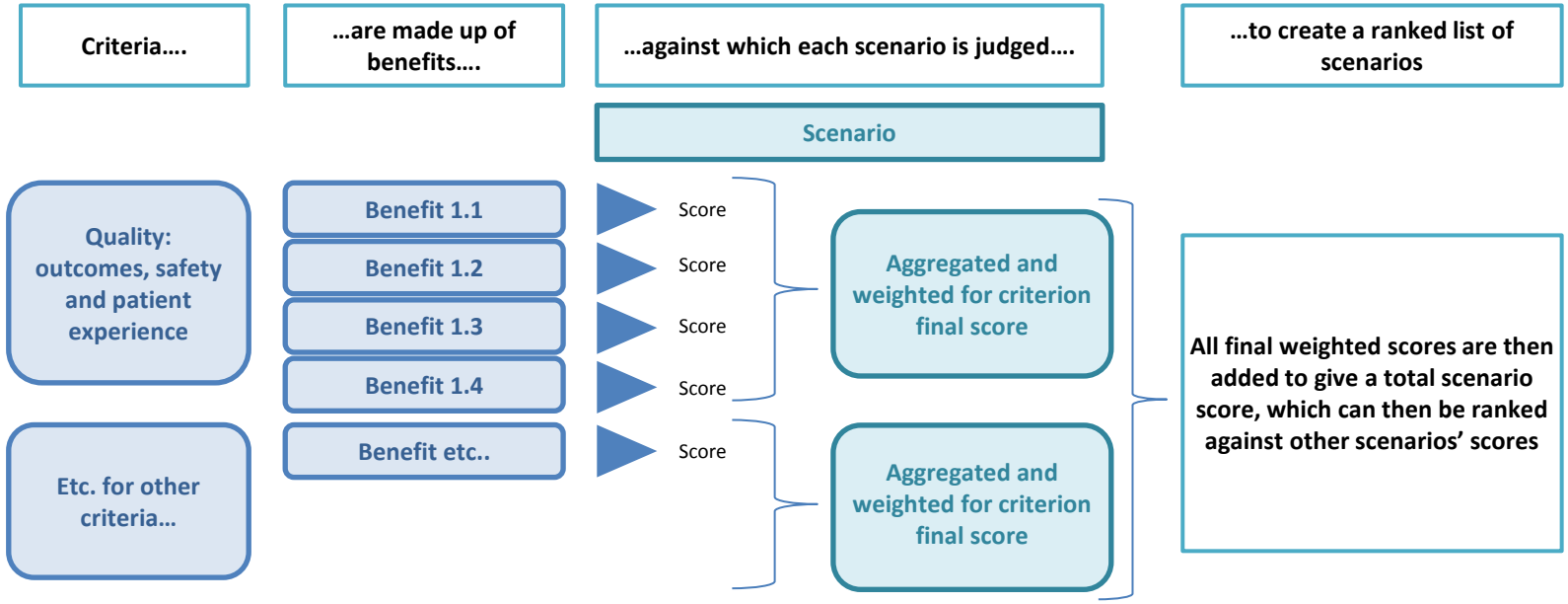
D: The criteria were assigned weightings based on an assessment of their importance. This was carried out as a survey whereby Trust executives, clinicians and Commissioners (41 respondents) ranked the criteria in terms of relative importance. This gave the criteria weightings as:



5. Apply criteria and identify preferred scenarios

Benefits model

Having defined the evaluation criteria and their weightings, a range of benefits were mapped to each of the criterion, against which each scenario would be directly scored based on the ability to deliver the individual benefits and hence satisfy the criteria. The application of this benefits model ensured that the evaluation of scenarios was directly linked to the LTP ambition and objectives. This approach and the benefits were developed in collaboration with the Clinical Reference Group, Commissioners and Trust executives.



A total of 30 benefits, plus two elements of a deliverability criterion (timescale and risk to delivery) were evaluated. The aim of the criteria was to deliver a balanced view that considered the potential benefits, against the risks of implementation and the time taken to deliver.

5. Apply criteria and identify preferred scenarios (cont'd)

The criteria benefits were initially defined by the SOC Task Group and Partnership Working Group, and then verified and approved through the programme governance process to ensure completeness and accuracy.

Objective	Criteria	Benefits
Improved quality and patient outcomes	**Quality: outcomes, safety and patient experience**	Better accountability through stronger governance
		Co-ordinated IT investment increases system resilience
		Co-ordinated IT investment reduces avoidable variation in quality
		Improved ability to deliver 7 day working
		Increased compliance with standards
		Less intensive or better filled OOH rotas
		Segregating elective flow increases productivity
		Services at scale to meet national standards or evidence base
		Standardisation of practice reduces avoidable variation in quality
		Standardisation of practice reduces errors
A wider range of services	**Access**	Increase prevention
		Increased breadth of offer through more subspecialisation
		Pathway integration with community services & social care
		Repatriation or retention of specialist services
		Standardisation of IT increases clinical teams' effectiveness
-	**Deliverability**	Time to deliver
		Risk to delivery

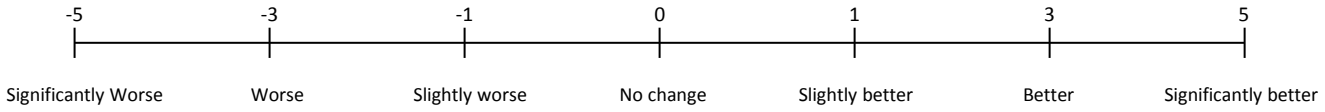
Note: Although deliverability does not map directly to an objective, it is implicit within all

Objective	Criteria	Benefits
Better value for money	**Financial sustainability**	Better utilisation of estates
		Consolidate corporate & support services
		Co-ordinate research effort
		Cost of purchasing
		Modernise clinical administrative processes
		More efficient capital expenditure
		Procurement efficiency
		Standardisation to reduce avoidable variation in costs
		Streamlined governance
		Use technology to streamline care & promote self-care
		Investment required
A sustainable, skilled workforce	**Workforce sustainability**	Create a culture that helps staff give their best
		Improved development opportunities for staff
		Improved recruitment & retention
		More scope for leadership & talent development
		Larger clinical teams are more resilient

It is against these benefits that the scenarios were directly scored by key stakeholders as part of a survey. However, the financial sustainability criterion was scored separately with a high-level financial case assessment carried out by the two Trusts' financial teams. The benefits from this criterion formed the basis for the assumptions used in the financial case as part of an initial quantitative assessment of P&Ls for the scenarios. Details of the financial scoring are given in the Financial Case appendix.

5. Apply criteria and identify preferred scenarios (cont'd)

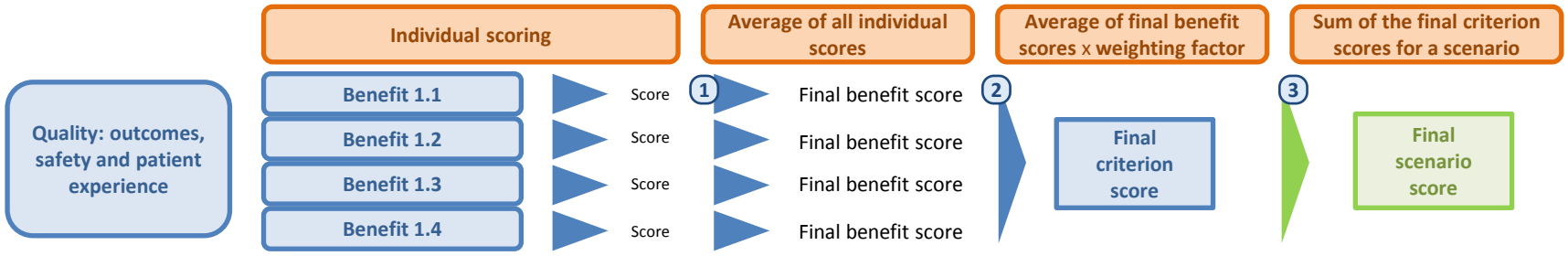
As part of a survey, stakeholders (from the Clinical Reference Group, Commissioners and Trust executives) were asked to rate each of the shortlisted scenarios against these benefits, scoring them on how much the scenario would facilitate the delivery of that benefit. The scenarios were scored against the criteria benefits using a seven point scale, -5 to +5; where 5 represents the greatest benefit, 0 is no change and -5 is the greatest loss of benefit. The subgroup analysis detailing the benefits scoring from the 41 respondents is provided in the Subgroup Analysis appendix (Appendix D and E).



It was possible to negatively score on certain benefits where it was deemed that implementing a scenario would result in a situation worse than baseline (i.e. where access was significantly worsened).

The final scores were calculated as follows:

1. **Final benefit score for a given scenario**: obtained by calculating the arithmetic mean of all scores from each scorer
2. **Final criterion score for a given scenario**: obtained by calculating the arithmetic mean of the final benefit scores (1) and applying the corresponding weighting factor
3. **Final scenario score**: obtained by summing the final criterion scores (2)



Section 13

APPENDIX C: SHORTLISTING RATIONALE

Scenario 1: Do nothing

Description

By this we mean…

- No change to existing organisations

Clinical (front line)	Corporate	Governance	Investment required	Example
• No change to current state	• No change to current state	• No change to current state	• Draft SOC suggests combined deficit approaching £200m by 2020/21	• N/A

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Fail	Does not align with the STP; fails to deliver financial sustainability and clinical acute reconfiguration
	Improve links to (and integration with) community services and improve transition	Fail	No change on current situation
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Fail	No improvements in access, quality or sustainability
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Forecasting shows this will not deliver financial sustainability
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	Does not deliver fundamental change at CHUFT
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Does not support stabilisation in the short term
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Fail	Limited benefits, unlikely to be achieved within specified timescale
OUTCOME:		Pass	**Although this option fails the hurdle criteria it continues forwards as a compulsory 'counterfactual'**

Scenario 2: Federation

Description

By this we mean…

- A formalised agreement for Trusts to work together, which may include the joint commissioning of back office functions or clinical service delivery, but stopping short of contractual agreements

Clinical (front line)	Corporate	Governance	Investment required	Example
• Dependent on whether clinical services were included within the federation agreement; could extend to joint delivery of services subject to MoU	• Back office services often jointly delivered or commissioned	• Each organisation retains individual sovereignty • Typically one trust would take lead on governance, quality and finance as set out in MoU	• Relatively minimal • Required for infrastructure to allow joint working, i.e. technology • Associated procurement costs	• UCL Partners in London has a central team that allows best practice to be shared across 40 organisations, with support for implementation

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Fail	Lack of a formal contractual agreement means priorities are unlikely be delivered, examples have delivered benefits in a piecemeal way
	Improve links to (and integration with) community services and improve transition	Fail	No change on current situation
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Fail	Improvement in access, quality, sustainability is piecemeal and lacks sufficient scale, UCLH example has taken a service-specific route
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Limited examples of where this model has contributed towards financial sustainability
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	Only sharing best practice will not drive fundamental change at CHUFT
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Does not contribute to CHUFT stabilisation due to the piecemeal nature and the longer timescales
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Fail	Examples of the delivery of patient benefits, but in a piecemeal way and not within timeframe
OUTCOME:		**Fail**	**Fails hurdle criteria as does not have the scale to deliver transformational change or sustainability**

Scenario 3: Clinical and strategic networks

Description

By this we mean…

- Networks that facilitate the sharing of best practice between clinicians, without a formal agreement to work together

Clinical (front line)	Corporate	Governance	Investment required	Example
• Sharing of best practice between clinicians, changing procedures and sharing evidence-base	• Minimal impact	• No change to governance as likely to be based on informal sharing agreements, individual services remain accountable for performance and quality	• Minimal impact	• Regional Strategic Clinical Networks in areas such as maternity, paediatrics, mental health, dementia and neurological conditions

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Fail	Merely sharing best practice will not deliver the priorities (including acute reconfiguration)
	Improve links to (and integration with) community services and improve transition	Fail	Lacks the scale and ambition to deliver transformation change within STP
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Fail	Improvement in access, quality, sustainability is piecemeal and lacks sufficient scale; may allow for some workforce sharing
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Does not deliver scale of change required due to the piecemeal nature of delivery
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	Merely sharing best practice will not drive fundamental change at CHUFT
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Cannot provide overall stabilisation at CHUFT due to piecemeal approach; creating differing networks between services could destabilise
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Fail	Unlikely to be realised within the timeframe; lacks sufficient incentives and based on informal agreement
OUTCOME:		**Fail**	**Fails all hurdle criteria and sharing best practice alone doesn't deliver hospital transformation**

Scenario 4: Buddying

Description

By this we mean…

- Input and advice from buddy trust (often on an enforced basis by regulators) across the entire remit of service including clinical, corporate and governance

Clinical (front line)	Corporate	Governance	Investment required	Example
• Input and advice from buddy trust workforce to improve performance, informal • Will result in changes to operating procedures and ways of working	• Input and advice from buddy trust workforce to improve performance, informal • Will result in changes to operating procedures and ways of working	• Initially unchanged, opportunity to update governance based on buddy trust experience • Accountability for performance and quality remains with the host trust	• Minimal investment, though buddy trust will require additional resource to provide assistance • Some financial assistance from regulators may be available	• Introduced into the NHS as a result of the Keogh Review and the subsequent Special Measures regime; intended to enable a two-way learning relationship between trusts

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Fail	Input and advice are insufficient to deliver the transformation and acute reconfiguration
	Improve links to (and integration with) community services and improve transition	Fail	May improve links but insufficient to drive transformation or transition
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Fail	Improvement in access, quality, sustainability is piecemeal and lacks sufficient scale
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Does not deliver financial sustainability as buddying in itself does not drive any costs out from the system
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	Input and advice are insufficient to deliver fundamental change at CHUFT, it may be a distraction to IHT
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Cannot provide overall stabilisation at CHUFT, existing arrangements have not delivered this on their own
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Fail	Unlikely to be realised within the specified timeframe due to informality of arrangements
OUTCOME:		**Fail**	**Fails all hurdle criteria; unable to deliver the scale and breadth of change required**

Scenario 5: Joint venture (contractual)

Description

By this we mean…

- Offering clinical services (individual services or full specialties) through a separate joint venture (JV); utilises existing contracting structures to enable the joint venture so that individual organisational sovereignty is maintained

Clinical (front line)	Corporate	Governance	Investment required	Example
• Only services that are included within the JV would be affected; • Potentially minimal change, especially where services are offered by a subcontractor to a prime provider • Prime contractor may define new or different service standards	• JV can also be used to provide back office and corporate functions into 'owner' trusts (and others)	• Based on existing contractual structures and does not result in the creation of a new separate entity • Contractual forms include: prime contractor, lead contractor, subcontracting, alliance contacting • Clinical governance: accountability ultimately lies with contract holder (exception is alliance contracting)	• Required for the development of the legal entity or the new contractual forms	• South West London Elective Orthopaedic Centre (SWLEOC) is a contractual joint venture between St George's, Epsom and St Helier, Croydon and Kingston. Located on Epsom site, it carries out elective orthopaedic surgery only with high levels of efficiency.

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Pass	Potential to deliver transformational change for a range of services
	Improve links to (and integration with) community services and improve transition	Pass	Focus on pathways could enable closer links in those areas
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Pass	Potential to improve access and quality for the in-scope services
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Unlikely to have enough scale to significantly contribute to financial sustainability
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	May fragment governance and only deliver fundamental change to a subset of services
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Governance challenges addressed only for in-scope services; does not address wider issues at CHUFT and for services out of scope
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Once contract is developed and implemented services could be provided within timescales
OUTCOME:		**Fail**	**Fails on three hurdle criteria; not a holistic solution and may result in fragmentation**

Scenario 6: Corporate joint venture

Description

By this we mean…

- Creating a separate legal entity that will provide services; this entity would not typically take the form of a Trust, for example forming a controlled limited liability partnership (LLP) or limited company for the JV

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

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Pass	Has the potential to include a large enough range of services that could allow reconfiguration
	Improve links to (and integration with) community services and improve transition	Pass	Focusing on single pathways allows for redesign, giving opportunity for better links
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Pass	Potential to improve access and quality across a range of services, supports sustainable workforce
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Pass	Potential to improve financial sustainability; some constraints on timescales
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Pass	Services moved into joint venture would be designed to an agreed standard
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Pass	Service could move under new management rapidly; potentially some fragmentation
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Once legal entity is created services could be provided within timescales
OUTCOME:		**Pass**	**Passes hurdle criteria so included for further consideration**

Scenario 7: Service-level chain type 1 - outsourced

Description

By this we mean…

- When another (specialist) trust offers a particular service on behalf of the host provider, on a fully outsourced basis. The provider of the outsourced services takes full accountability for the service and the associated activity; the Board of the host trust holds this provider to account

Clinical (front line)	Corporate	Governance	Investment required	Example
• Service or speciality is offered by an entirely new provider • 'Host' trust provides the physical space for the service • Original workforce may transfer into new provider or provider may bring in their own workforce • Operating procedures and policies are those of the new provider	• Full outsource of back office functions into a separate legal entity (or offered by an existing entity) • Corporate services related to the clinical service are the responsibility of that provider • Requires a 'landlord' contract between host trust and provider	• Full governance and accountability for the service sits with the provider • Host trust assumes role of landlord • Agreements required to ensure governance, data gathering, performance reporting and quality inspections are undertaken correctly	• For host trust: relatively low investment, though will require additional expertise to develop and manage landlord contracts • For provider: Investment required to respond to a procurement, and costs associated with implementing service onto a new site, including for technology and training	• Moorfields @ model, where Moorfields run the entire ophthalmology unit at St George's, London as a satellite to the main site. Service is outsourced to Moorfields in its entirety, who 'take' the activity, employ workforce and own equipment

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Fail	Fragmentation of services into different providers may not deliver STP priorities
	Improve links to (and integration with) community services and improve transition	Fail	Has the potential to fragment links, creates inconsistencies between services
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Fail	Improvement in access, quality, sustainability is piecemeal and lacks sufficient scale
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Does not deliver scale of change to ensure financial sustainability
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	Focus on discrete services will not deliver fundamental change at CHUFT, may distract
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Focus on discrete services unlikely to positively impact on stability of CHUFT; fragmenting
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Fail	Timescales for procurement and implementation make it unlikely benefits will be realised in time
OUTCOME:		**Fail**	**Fails as has insufficient scale due to a focus on discrete services**

Scenario 8: Service-level chain type 2 - provision

Description

By this we mean…

- When another (specialist) trust has a contract to provide staff with the host trust on a per session basis; the host trust retains the activity and accountability for the service and pays the provider trust for staff time

Clinical (front line)	Corporate	Governance	Investment required	Example
• Service or speciality is offered by an alternative provider • 'Host' trust provides the physical space for the service • At the time of change of provider workforce may transfer or provider may bring in their own workforce • Operating procedures and policies are those of the new provider	• Most common organisational form for outsourced back office functions, where the host trust remains ultimately accountable for the performance of these and, in turn, holds them to account • Can take the form of shared service centres	• Key difference to 'type 1' is that accountability for the service is to the host trust, not directly to the regulator • For FTs the host trust remains ultimately accountable for the service as per the terms of the licence conditions	• For host trust: relatively low investment, though will require additional expertise to develop and manage landlord contracts • For provider: Investment required to respond to a procurement, and costs associated with implementing service onto a new site, including for technology and training	• ACC vanguard – The Neuro Network: The Walton Centre, Liverpool, provides Consultant Neurologists into a large number of surrounding hospitals, spreading best practice and providing outpatient reviews

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Fail	Fragmentation of services into different providers may not deliver STP priorities
	Improve links to (and integration with) community services and improve transition	Fail	Has the potential to fragment links, creates inconsistencies between services
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Fail	Improvement in access, quality, sustainability is piecemeal and lacks sufficient scale
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Does not deliver scale of change to ensure financial sustainability
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	Focus on discrete services will not deliver fundamental change at CHUFT
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Challenges addressed only for discrete services; does not address wider issues at CHUFT and for services out of scope
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Precedent for approach elsewhere, relatively easy to implement
OUTCOME:		**Fail**	**Fails, has insufficient scale for transformation due to a focus on discrete services**

Scenario 9: Service-level chain type 3 – policies and procedures

Description

By this we mean…

- When another (specialist) trust provides the host trust with standard operating procedures and policies, on licence; the provider trust should have developed a set of replicable standard operating procedures based on evidence and best practice guidance
- No workforce, activity or accountability moves between trusts

Clinical (front line)	Corporate	Governance	Investment required	Example
• Trust 'buys in' and implements the procedures and policies from another provider • Existing workforce is required to operate in a new and different way, though workforce may not change	• Introduction of alternative providers standard operating procedures and policies • Provision of the service is still by the original team, though job roles and skill mix may be altered	• No transfer or accountability to the provider of policies and protocols, though they may provide inspection and oversight	• Policies and procedures may need to be purchased from the provider under a franchise agreement, the cost of this can vary considerably • There will be additional cost associated with training	• ACC vanguard – National Orthopaedic Alliance is developing a 'kite mark' for services, based on the opportunity identified in Getting it Right First Time

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Fail	Doesn't deliver transformational change as there is a focus on individual service improvement
	Improve links to (and integration with) community services and improve transition	Fail	Has the potential to fragment links, creates inconsistencies between services
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Fail	Improvement in access, quality, sustainability is piecemeal and lacks sufficient scale
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Does not deliver scale of change to ensure financial sustainability
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	Merely sharing policies in a subset of services unlikely to deliver fundamental change at CHUFT
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Stabilisation requires wider organisational change than individual service improvement
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Relatively easy to implement, though some challenges around ensuring compliance
OUTCOME:		**Fail**	**Fails, does not address structural issues at CHUFT**

Scenario 10: Management contract – single service

Description

By this we mean…

- An alternative organisation is sought to take over management of a particular service (or set of services) within a host organisation; the host trust retains the activity, workforce and accountability for the service, although the service is managed on behalf of the host trust

Clinical (front line)	Corporate	Governance	Investment required	Example
• Service in question moves to be managed in its entirety to a new provider under contract, for a time-limited period • Workforce is likely to be retained in original form, though would report into management contract owner	• Standardised practices could be brought across wholesale from the organisation that is managing the contract. Allows sharing of back office functions to a greater degree including procurement practices and operational and clinical policies and procedures	• Accountability of the service in its entirety moves to the contract manager • Often used in the case of significant service failure • Host trust holds contract provider to account; regulator holds host trust to account for service	• Minimal from the perspective of the host trust, though dependent on the management contract financial agreement income from the operated service may be forfeited	• Extended form of buddying arrangement, where an alternative provider manages an entire service on behalf of a host trust (not outsourced)

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Fail	Insufficient scale to deliver transformational change
	Improve links to (and integration with) community services and improve transition	Fail	In isolation, has the potential to fragment links, creates inconsistencies between services
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Fail	Improvement in access, quality, sustainability is piecemeal and lacks sufficient scale
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Unlikely to support financial sustainability, potential for further instability due to limited scale of services for inclusion
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	Focus on discrete services will not deliver fundamental change at CHUFT, may distract
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Focus on discrete services unlikely to positively impact on stability of CHUFT; fragmenting
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Should allow for the realisation of benefits within the specified timeframe
OUTCOME:		**Fail**	**Fails so does not proceed as a standalone options; potential enabler for other scenarios**

Scenario 11: Management contract – whole organisation

Description

By this we mean…

- An alternative organisation is sought to take over management of the host trust resulting in pooled organisational executive control; host trust Board holds management to account for performance. The host trust retains activity, workforce and accountability to regulators
- Potential for back office consolidation, and the implementation of standard operating procedures in all areas at the host trust

Clinical (front line)	Corporate	Governance	Investment required	Example
• Clinical services come under the management of the contracted organisation; potential to have significant change • Could result in changes to policies and procedures for frontline workforce	• Standardised practices could be brought across wholesale from the organisation that is managing the contract. Allows sharing of back office functions to a greater degree including procurement practices and operational and clinical policies and procedures	• Accountability for the performance of the organisation under contract moves to the contract holder • Often used in the case of serious organisational failure • Regulator holds the contract owner to account	• Potentially significant for the managing organisation, in terms of implementing new operating procedures • Deficit support may be required from national bodies at the outset of the contract	• ACC vanguard – Foundation Healthcare Group: Examining how a trust that is not viable can be supported through pooling organisational sovereignty (part of developing a Foundation Group) • Hinchingbrooke is an example of the risks associated

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Pass	Single management allows for the delivery of ambition of the STP and transformational change
	Improve links to (and integration with) community services and improve transition	Pass	Increased consistency of approach across a range of services
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Pass	Supports workforce sustainability and improved quality, potential to improve access
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Pass	Rapid implementation supports financial sustainability within compressed timeframes
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Pass	Supports fundamental change at CHUFT through holistic approach
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Pass	Stabilisation in the short term supported through single governance approach
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Should allow for the realisation of benefits within the specified timeframe
OUTCOME:		**Pass**	**Facilitates rapid change and consolidation, sufficient scale for transformational change**

Scenario 12: Joining an existing foundation group

Description

By this we mean…

- Working with one of the four accredited Foundation Groups to join as a member of the group; the most likely options would be one of the two London-based Foundation Groups (Royal Free London and Guys and St Thomas's)

Clinical (front line)	Corporate	Governance	Investment required	Example
• Dependent on membership option chosen (range being developed); some of these include wholesale adoption of clinical operating procedures and standardisation of practices • Spectrum from buddying to merger for membership options	• Dependent on membership option chosen (range being developed); some of these include wholesale adoption of standard operating procedures • For many options there are likely to be significant back offices synergies sought, moving to shared back office functions	• Dependent on membership option chosen, but in most cases individual organisations retain accountability for quality and performance • NHS Improvement is developing a regulatory approach to foundation group members	• Dependent on membership option chosen, but there is investment required from the trust becoming the centre of the foundation group to codify operating model and procedures • Dedicated resource required to pass through the NHSI accreditation process	• Four foundation groups have now been accredited by NHS Improvement - all of which have had to identify initial partners; they are now in a position to open discussions with other potential partners

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Pass	Has the potential to allow for transformational change of services
	Improve links to (and integration with) community services and improve transition	Pass	Supports creation of consistent approach across services, requires adaptation to local context
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Pass	Supports improvements in quality and workforce sustainability
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Vanguards experience show that time to join the group mean this may not be achievable
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	Dependent on the scale of the membership option chosen; untested as to whether these will be sufficient to drive fundamental change
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Time taken to join does not support short-term stabilisation at CHUFT
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Fail	Uncertainty on time to join mean benefits may not be realised as required
OUTCOME:		**Fail**	**Fails, timeframes and uncertainty prevent progression to shortlist**

Scenario 13: Forming a foundation group

Description

By this we mean…

- One of the trusts using the Long Term Partnership as the basis to enter into the NHS Improvement accreditation process to become a Foundation Group

Clinical (front line)	Corporate	Governance	Investment required	Example
• Requires codification of clinical services and the development of a clinical standard operating procedures by the trust forming the foundation group • May involve the reassessment of current procedures and policies and any which require updating	• Corporate services may undergo significant transformation, including the organisation of services into 'headquarters' and 'site-level' functions • Range of services provided and capabilities will have to increase to provide group level functions	• New group level governance arrangements will be required, for the spectrum of different group membership options • Accountability for performance and quality at 'owned' sites are the responsibility of the foundation group organisation	• Potentially significant investment to prepare the organisation to pass through the NHSI accreditation process • Legal and professional support required to develop new organisational forms	• Four foundation groups have now been accredited by NHS Improvement • NHSI has recently encouraged South Warwick to form a foundation group to support Wye Valley

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Pass	Can deliver coordinated transformational change locally delivering ambition of STP
	Improve links to (and integration with) community services and improve transition	Pass	Increased consistency of approach for a wide range of services within the group
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Pass	Supports creation of a sustainable workforce, quality improved through SOPs, access reviewed
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Pass	Significant opportunities to deliver efficiencies through the formation of a group (i.e. back office)
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Pass	Formalises governance procedures and allows for shared standard operating policies
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Pass	Timelines mean that a Foundation Group would need to be formed before admitting CHUFT
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Examples should accrue within compressed timescales
OUTCOME:		**Pass**	**Holistic approach that may deliver transformation in line with STP ambitions**

Scenario 14: Organisational merger, focus on back office

Description

By this we mean…

- Merger between the two trusts, where back office functions are consolidated or jointly procured but front line clinical services remain in their current form

Clinical (front line)	Corporate	Governance	Investment required	Example
• Some shared clinical services, but relatively little impact on frontline services	• Full back office consolidation, including movement to shared services and functions	• Governance remains separate and the individual sites are accountable for quality and performance • Regulators would consider merged trust as one organisation	• Significant investment required for any merger, with additional resource dedicated to developing business cases and implementing integration • Potentially some transitional funding available – though likely to be extremely limited	• Historical mergers often took this form, for example Epsom and St Helier, which retains a Medical Director on both sites and services are not highly integrated

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Fail	No alignment with STP priorities as clinical reconfiguration is excluded from consideration
	Improve links to (and integration with) community services and improve transition	Fail	No impact on clinical services therefore no change
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Fail	Limited impact on workforce sustainability, no impact on quality and access
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Pass	Delivers back office benefits that can support financial sustainability
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	Doesn't deliver transformational change for clinical services at CHUFT
Timeline	Owing to the scale of challenges at CHUFT scenarios must enable and support stabilisation in the short term	Fail	Insufficient to support stabilisation as clinical services are excluded, a core part of the challenges being faced
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Fail	Clinical and patient benefits are not realised as transformation in this area is specifically excluded
OUTCOME:		**Fail**	**Lack of a clear, shared clinical vision is a common cause of merger failure**

Scenario 15: Organisational merger, focus on back office plus some clinical integration

Description

By this we mean…

- Merger between the two trusts, with back office consolidation and joint procurements, plus consolidation of some front line clinical services; services to be consolidated likely to either specialist services or those with challenging requirements to meet clinical standards

Clinical (front line)	Corporate	Governance	Investment required	Example
• Some clinical consolidation and harmonisation of practices and standardisation across sites • May retain separate Medical Directors	• Full back office consolidation, including movement to shared services and functions	• Single set of governance arrangements for the merged organisation, accountable for performance and quality • Regulators consider merged organisation as a single entity	• Significant investment required for any merger, with additional resource dedicated to developing business cases and implementing integration • Potentially some transitional funding available – though likely to be extremely limited	• Chelsea and Westminster's acquisition of West Middlesex: here there was no reconfiguration of services and only a limited level of integration

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Pass	Clinical integration allows for realisation of ambition and transformation in key areas
	Improve links to (and integration with) community services and improve transition	Pass	Service integration offers a chance for redesign and improving of transition and links
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Pass	Service redesign in selected areas can improve quality and access; facilitates shared workforce
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Pass	Back office efficiencies can be realised within specified timeframe
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Pass	Shared governance and integration design provides an opportunity to increase quality
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Pass	Allows for focus on overall organisational governance in addition to service integration
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Scale and phasing will ensure that benefits can be realised within timeframe
OUTCOME:		**Pass**	**Allows for transformation change that delivers benefits within specified timeframes**

Scenario 16: Organisational merger, focus on back office plus full clinical integration

Description

By this we mean…

- Merger between two trusts with full consolidation of both front line clinical and back office functions; services become joined across both sites with a level of reconfiguration likely to form part of the plans

Clinical (front line)	Corporate	Governance	Investment required	Example
• Full clinical services consolidation, including a reconfiguration of service and centralisation where appropriate • Services and specialties are fully integrated and offered across sites from a single rota • Single Medical Director	• Full back office consolidation, including movement to shared services and functions	• Single set of governance arrangements for the merged organisation, accountable for performance and quality • Regulators consider merged organisation as a single entity	• Significant investment required for any merger, with additional resource dedicated to developing business cases and implementing integration • Potentially some transitional funding available – likely to be somewhat limited	• Royal Free's acquisition of Barnet and Chase Farm included a reconfiguration of services between sites and full integration of front line clinical services and back office functions, based on the 'Royal Free way' standardised approach

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Pass	Consolidated form allows for the realisation of STP ambition and enables transformation
	Improve links to (and integration with) community services and improve transition	Pass	Service integration offers a chance for redesign and improved links; improved consistency
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Pass	Enables shared workforce, redesign of services allows for improved quality and access
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Pass	Compressed timelines achievable dependent on phased implementation
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Pass	Merger and integration process can drive fundamental change in standards
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Pass	Shared governance and integration design provides an opportunity to increase quality
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Initial benefits released within specified time period, phased approach required
OUTCOME:		**Pass**	**Allows for transformational change at the scale of the ambition and objectives of the LTP**

Scenario 17: Acquisition (full)

Description

By this we mean…

- Identification of a target trust by the acquirer (which may be driven by regulators); this scenario shares many characteristics of 'full' organisational merger but is driven by the acquirer's strategy and vision

Clinical (front line)	Corporate	Governance	Investment required	Example
• Full clinical services consolidation, including a reconfiguration of service and centralisation where appropriate • Services and specialties are fully integrated and offered across sites from a single rota • Single Medical Director	• Full back office consolidation, including movement to shared services and functions	• Single set of governance arrangements for the merged organisation, accountable for performance and quality • Regulators consider merged organisation as a single entity • Under certain circumstances it is possible for NHS Trusts to acquire NHS Foundation Trusts	• Significant investment required for any merger, with additional resource dedicated to developing business cases and implementing integration • Potentially some transitional funding available – likely to be somewhat limited	• Royal Free's acquisition of Barnet and Chase Farm included a reconfiguration of services between sites and full integration of front line clinical services and back office functions, based on the 'Royal Free way' standardised approach

Outcome

Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Pass	Consolidated form allows for the realisation of STP ambition and enables transformation
	Improve links to (and integration with) community services and improve transition	Pass	Service integration offers a chance for redesign and improved links; improved consistency
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Pass	Enables shared workforce, redesign of services allows for improved quality and access
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Pass	Compressed timelines achievable dependent on phased implementation
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Pass	Merger and integration process can drive fundamental change in standards
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Pass	Shared governance and integration design provides an opportunity to increase quality
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Initial benefits released within specified time period, phased approach required
OUTCOME:		**Pass**	**Allows for transformational change at a significant scale, with one organisation leading**

Scenario 18: Vertical integration

Description

By this we mean…

- Integration between an acute hospital trust and one or more community services providers to increase the range of services on offer

Clinical (front line)	Corporate	Governance	Investment required	Example
• Relatively minor change to front line acute services, but would allow for more effective integration between acute and community services	• Brings together the acute and community corporate functions • Some consolidation of services and functions possible, with a move to shared services and functions	• Single set of governance arrangements for the merged organisation, accountable for performance and quality • Regulators consider merged organisation as a single entity	• Investment required to bring organisations together and standardise policies and procedures	• Symphony (South Somerset) PACS vanguard is a collaboration between Yeovil District Hospital NHS Foundation Trust, south Somerset Healthcare GP Federation, Somerset CCG, and Somerset County Council, seeks to integrate services and implement a whole population budget

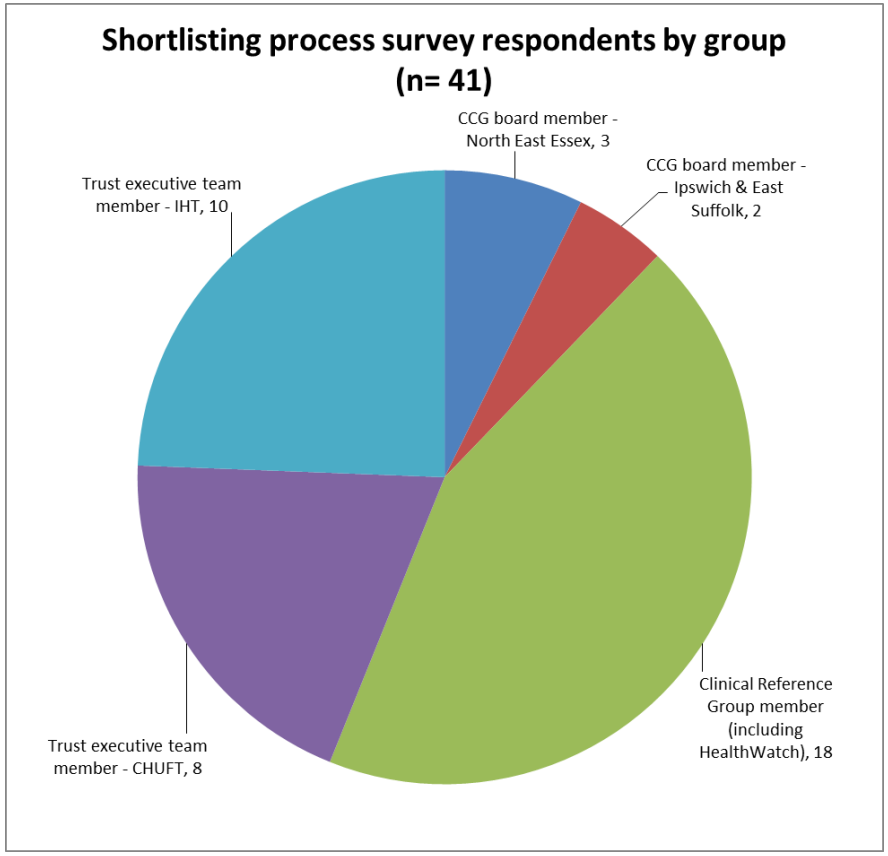
Outcome

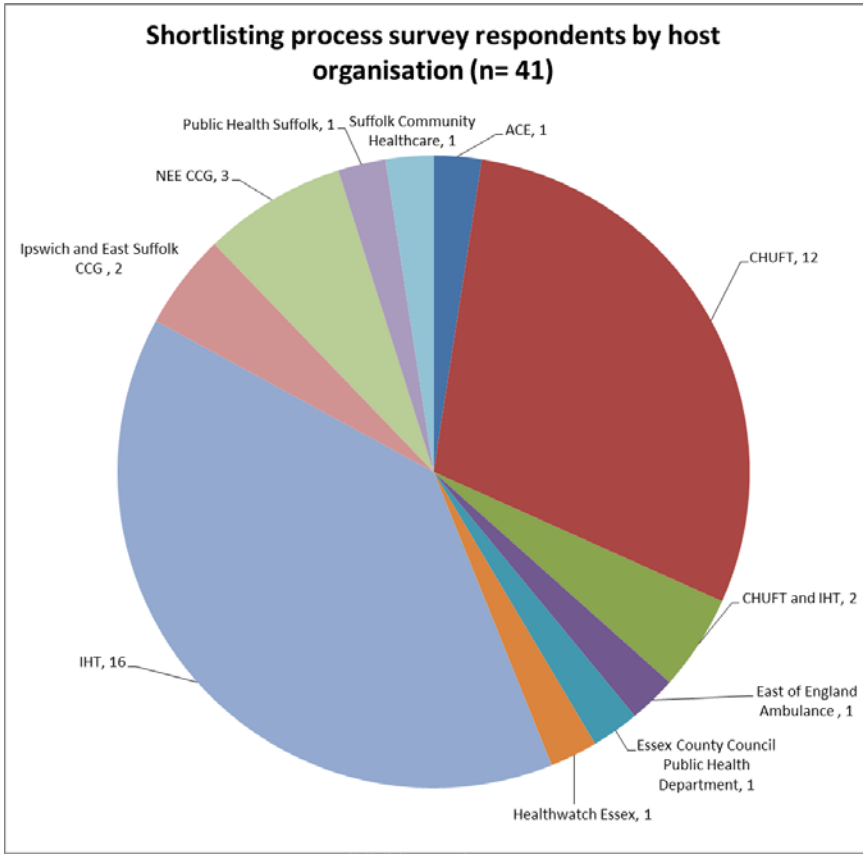
Area	Criteria	Outcome	Rationale
Alignment with STP	Support the delivery of STP priorities, including the proposed acute reconfiguration	Fail	Does not meet the ambitions for acute services outlined in the STP due to focus
	Improve links to (and integration with) community services and improve transition	Pass	Improves links, though primarily at a single organisation as opposed to within the system
Ambition of the LTP	The scenario must align with the ambition and objectives of the LTP	Fail	As a standalone scenario it does not support the LTP between IHT and CHUFT; may improve access
Sustainability	The scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT	Fail	Some efficiencies could be realised, but unlikely to be at the scale for significant stabilisation
	The scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT	Fail	As focus is not on acute services, required fundamental change at CHUFT is not possible
Timeline	Owing to the scale of challenges at CHUFT, scenarios must enable and support stabilisation in the short term	Fail	Without a focus on acute services at CHUFT stabilisation is unlikely
	Clinical and patient benefits should be realised within compressed timescales (1-3 years)	Pass	Initial benefits released within specified time period, phased approach required
OUTCOME:		**Fail**	**Fails as a standalone option as does not reflect the ambitions and objectives for the LTP**

Section 14

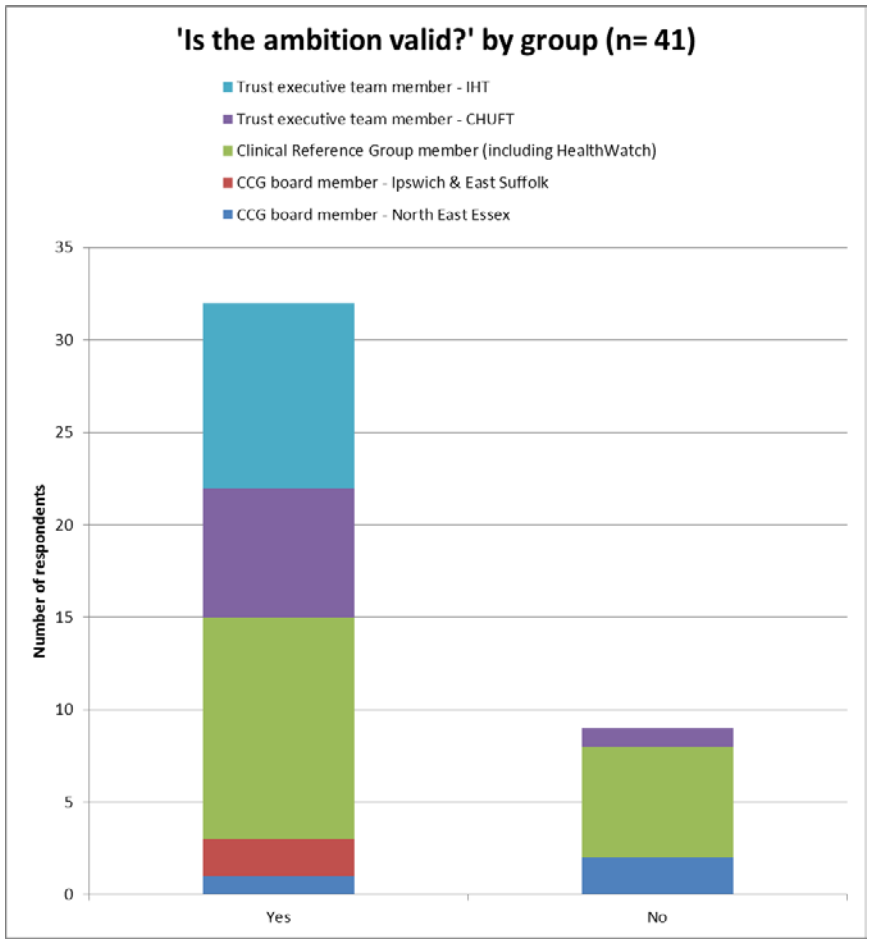
APPENDIX D: SHORTLISTING SUBGROUP ANALYSIS

Respondents





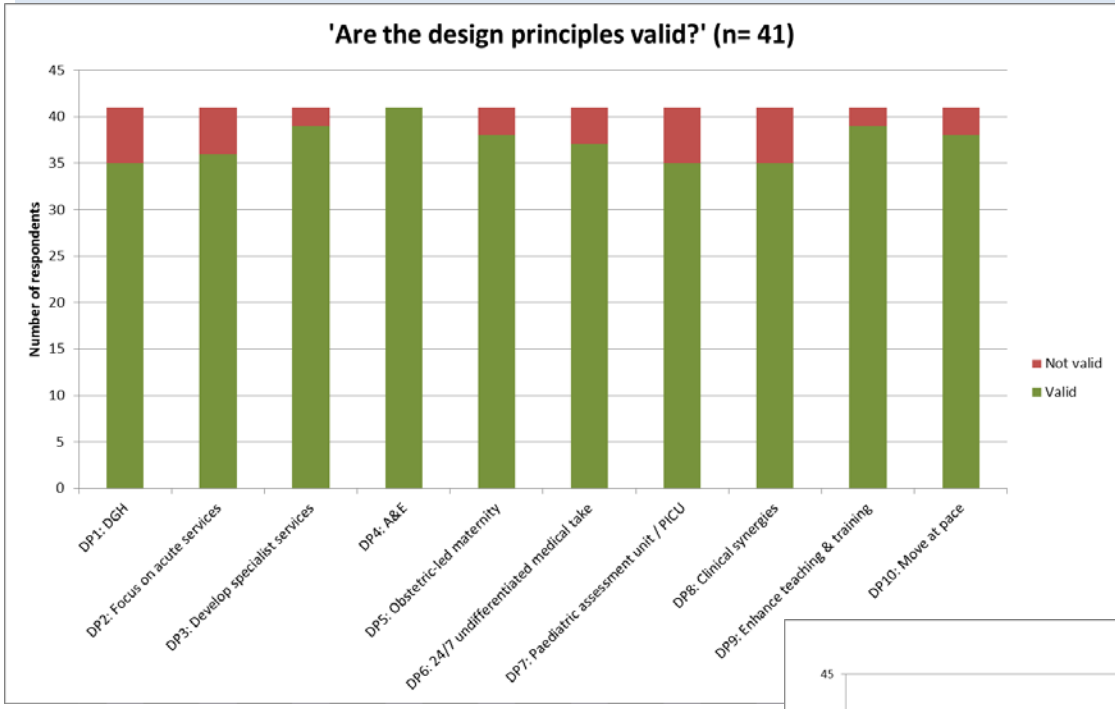
Ambition & objectives

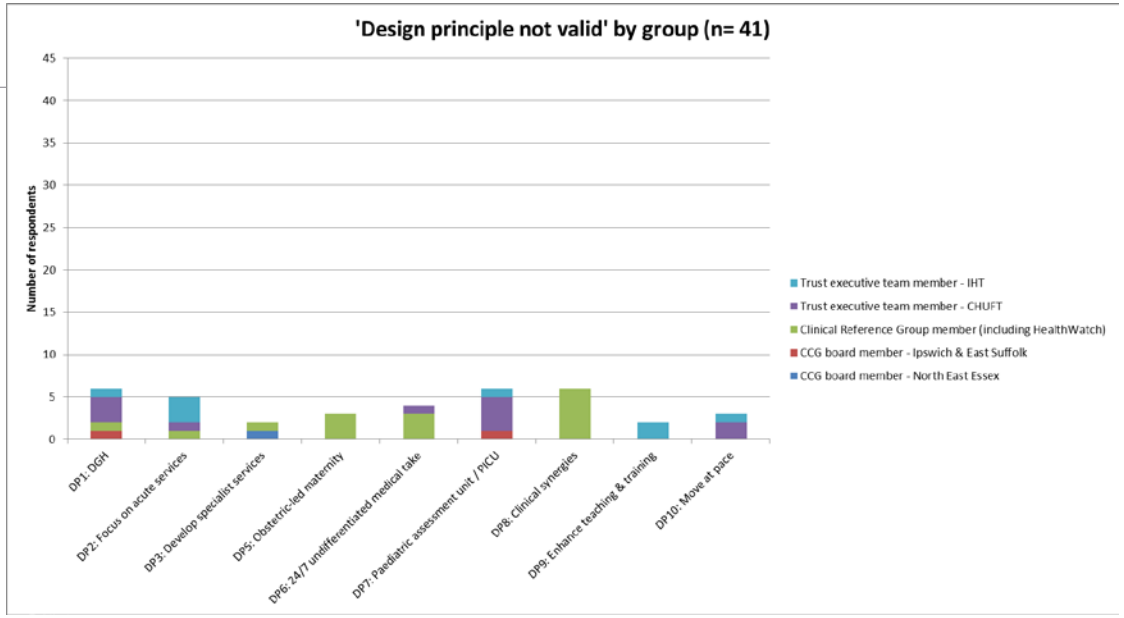


Comments

- I do not think that the Partnership will have to deliver a wider range of services. Once the work has been completed designing the Clinical pathways ,the System will have a greater understanding about the range of services required to meet the needs of the population. This could be more or less.
- Provided that the wording for objective 3 is changed as discussed on the 28th, then the objectives will reflect the STP.
- 3. "wider" implies we are only going to add new services. There are some services that may need to be centralised and lost to another provider. This may be clinically appropriate. Likewise, there are some services we may be able to repatriate from a tertiary provider, e.g. complex cardiac device implantation from Papworth/CTC. We need a better range of local services.
- The 4 objectives are basically fine, but if we're seeing the partnership through an 'STP lens', then I think the objectives need to reference the need for acute services to be 1) better integrated within a wide context of health and care and 2) for the locus of care to be 'out of hospital by default, wherever possible'.
- I think objective 3 is poorly worded as the ambition for the residents of East Suffolk and North Essex may be in part be best achieved by a reduction in some services being performed at the acute trusts.
- In terms of a wider range of services wording to be made clearer around what this means as increasingly our strategy if to shift services out of an acute hospital into the community.
- Although I agree with the objectives match the STP plan should we be more explicit about improving quality, patient safety and patient outcomes? i.e. be explicit about patient safety
- I agree with 1,2, and 4. However, I think 3 is not worded correctly and needs to reflect more the needs of the local population rather than more services. I would prefer that the core services are provided to a high standard than more being provided
- The STP promotes self care and independence, therefore it cannot be assumed that 'a wider range of services' is required
- The STP also describes the formation of a community provider (community, GP Fed, SCC, mental health) ICO type model, it is important that this element is not overlooked whilst attention is focussed on acute hospital merger options
- A wider range of services is too generic. It does not describe the requirement to review what services can be provided outside of the hospital setting or the benefits of the partnership in making good services more sustainable.

Design principles





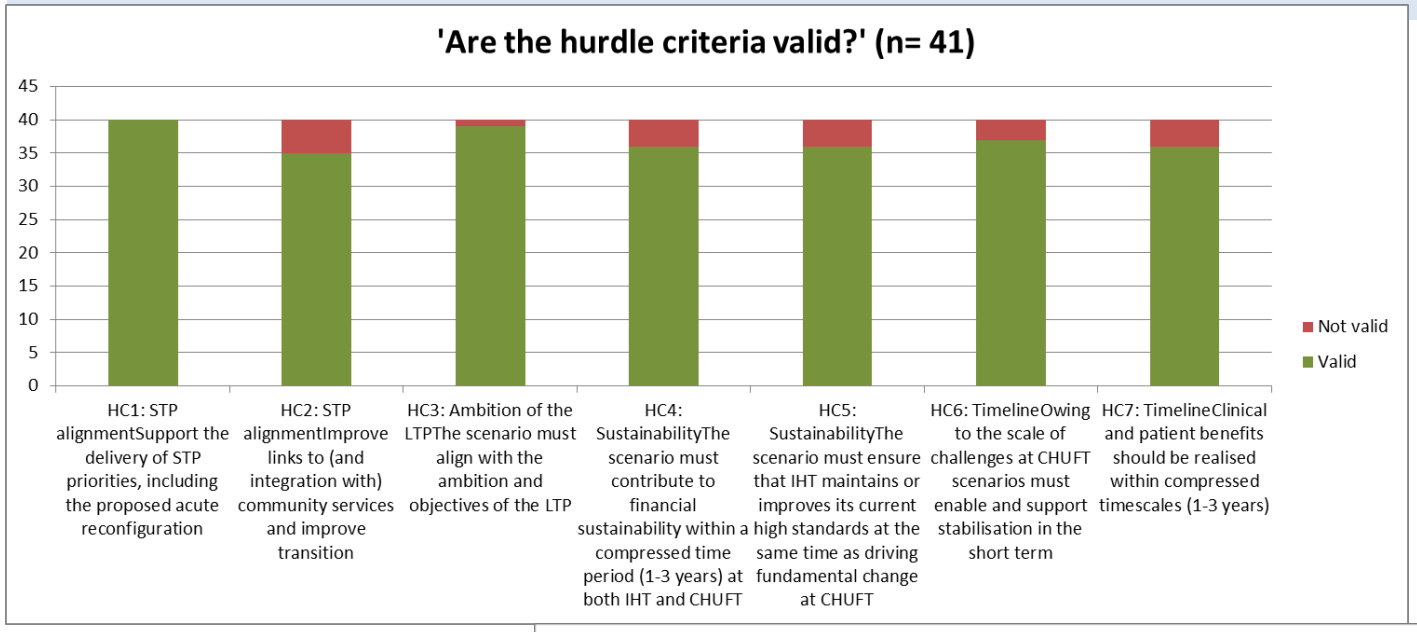
Design principles – comments 1

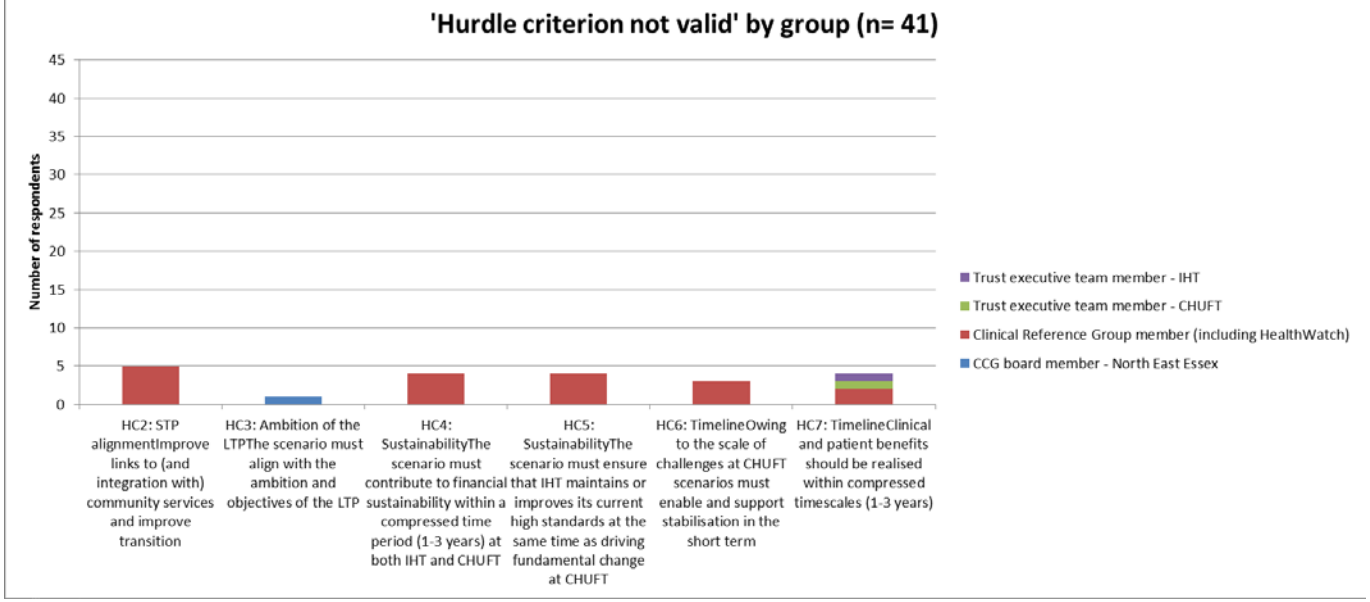
- On some of the above I would need evidence to base my decision on. I would like a more detailed discussion on A&E, Maternity, DGH and Paeds before giving a yes no answer.
- PICU will not happen i think we mean in patient paeds service
- operate acute services at 2 sites, omit PICU part of statement-- add in we will continue to provide acute paediatric service on each site --whether both are 24/7 is another matter but need to tie in with maternity services, move at pace--omit to minimise disruption part of this sentence think we need to ensure the patient into each of these statements
- Not sure what this exactly means
- there are assumptions about which I think we may need a more open mind given the challenges and the final statement may be an ambition which none will disagree with but everyone will see it differently
- Paediatric intensive care is a specialist service requiring larger scale than we will achieve through the LTP.
- I would not like to limit the scope of either organisation to solely providing acute care. We would not have sufficient joint population to warrant a PICU
- We need to adjust the wording as discussed for some of the points above. The DGH reference needs to be combined with the delivery of acute services.
- I understand that some feel the "district general" term is superfluous given the other principles. However, dropping this principle because it is technically a duplicate may give the wrong communication. The staff and public are concerned that STP changes will result in them losing their DGH (whatever they believe that means). Keeping the principle reinforces that we are committed to both hospitals being a DGH. Add: We will ensure that the training of our future clinical workforce is embedded into all service provision.
- In would be useful to give a little more detail to the phrase ‘obstetric-led maternity services on both sites’. Does this mean full services (including for example caesarean section capacity). Equally the phrase ‘24/7 undifferentiated acute medical take at both sites’ is ambiguous. Does this mean that specialist services for example acute cardiac management, but be divert from one hospital leaving just undifferentiated condition? It would be useful to have an explanation of the phrase ‘maximise clinical synergies and adjacencies’ Patient quality and safety should be considered as a design principle. Another design principle should be not destabilising other partner organisations such as primary care and community services. "
- See my earlier comment. I think the design principles - if seen through an STP or 'whole system' lens - has to reflect the need for better integration of services across health and care and also for the locus of care to be 'out of hospital by default'. I also wonder if there is a lack of overt 'patient-centeredness' in these principles. Do you need something about putting the best interests of patients, or of population-health needs, at the centre of decision making? And one further thought - where does patient choice come into the new design and the plan for sustainable services? (this may be a bit of an academic question, post-Lansley, but I'd have thought it needs some consideration - both in the context of the acute partnership and the wider STP).

Design principles - comments 2

- I think that the proposal to continue to operate as district general hospitals does not adequately describe the approach to alliance working at IHT that will see many of the services we currently provide changing such that these are delivered in a different way in the community. Our approach will increasingly take a much more important role in supporting improvements in public health and managing risk in the community to prevent increases in activity occurring. The term 'district general hospitals' is too limiting for our agenda.
- Focus on acute services - not invalid but need to reflect the broader picture of our outreach direction and community services. I am not sure the case for teaching and training has yet been made. Instinctively it should be valid but I'm not sure it is clear cut enough to be hardwired into design principles.
- Not just focused on delivering acute care.
- the ideology in the statement is fine but it is poorly worded.
- The paeds one doesn't make sense. There is more likely to be two PAUs and focus be on whether there needs to be two inpatient units suggest take this out. The DGH one needs to be clearer what we mean by a DGH and not sure adds value as the further points below it explain what the core functions to be definitely preserved on each site are.
- I am concerned about service interdependency. Vascular and trauma network models do not bode well for centralisation of other services, within the partnership, and the creation of a 'park and ride mentality. Most specialities will need a meaningful presence on both sites
- continue as DGHs but also look much more widely could consider not providing ED 24/7 on both sites e.g. close 1 place late night ?same with maternity don't need to aspire to paeds ICU Sorry, just being provocative about ED/maternity! Lots of comments to make but have come up in the CFG and Board-to-Board meeting as well
- Does obstetric - led maternity include for e.g. elective & emerg c- sections in both sites ? Does undifferentiated means that all medical services will be on both sites e.g. cardiac & stroke ? The phrase 'synergies & adjacencies needs more detail and explanations Patient safety, quality of care & patient experience need to more prominent in the design principles.
- Specialist services should be based upon needs of the locality and not necessarily on demonstrable improvement
- We will provide less simple care and seek to move that in to the community (see STP document page 8) We will focus on more complex and specialist care (see STP document page 8)
- In would be useful to give a little more detail to the phrase ‘obstetric-led maternity services on both sites’. Does this mean full services (including for example caesarean section capacity). Equally the phrase ‘24/7 undifferentiated acute medical take at both sites’ is ambiguous. Does this mean that specialist services for example acute cardiac management, but be divert from one hospital leaving just undifferentiated condition? It would be useful to have an explanation of the phrase ‘maximise clinical synergies and adjacencies’. Patient quality and safety should be considered as a design principle. Another design principle should be not destabilising other partner organisations such as primary care and community services.
- There is a principle missing regards ' we will optimise opportunities to work/merge/integrate with other statutory providers in our system across mental health and communities
- 1. This principle does not promote the need to do things differently 2. Need to include community element - to support developing a sustainable, skilled workforce and may need to outreach to get benefits from admission avoidance initiatives. 3. Need to change language used so more understandable.

Hurdle criteria

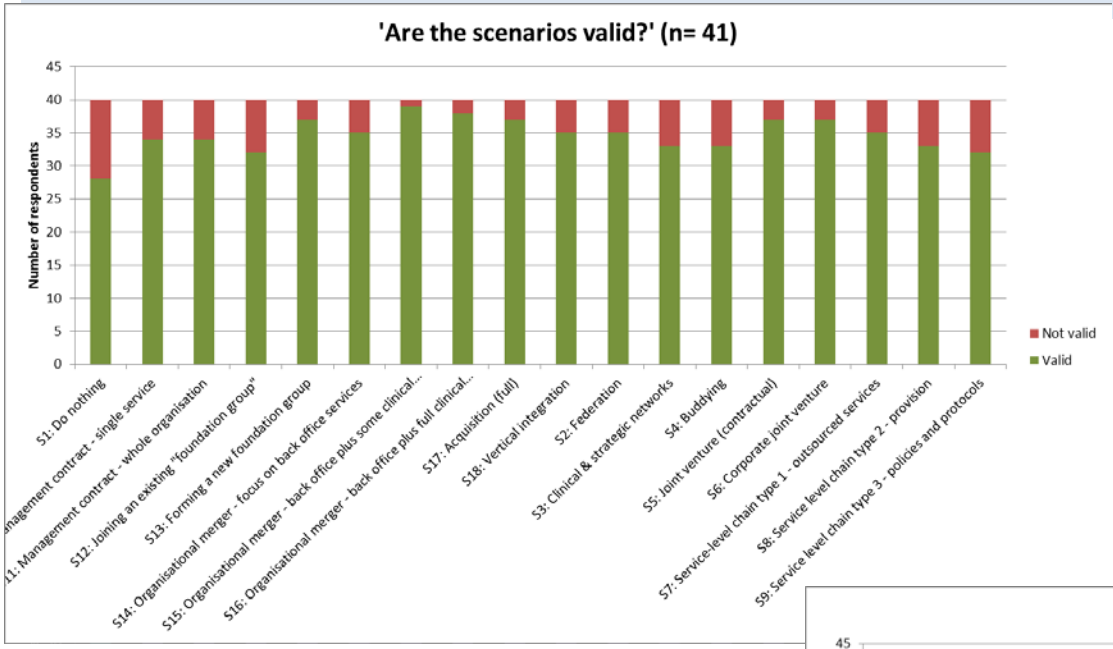


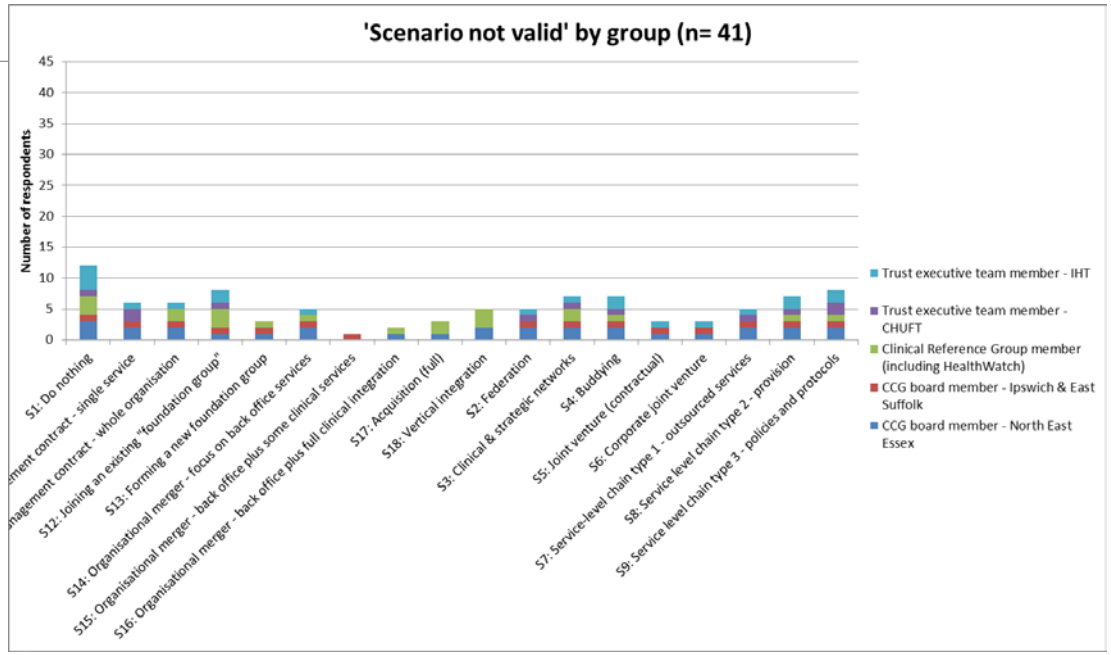


Hurdle criteria comments

- STP- Referring back to 5.This is dependant on the benefits this would deliver. Timeline- Although there is an urgency time wise we should not dismiss more radical options that might deliver greater benefit in the long run.
- some of these hurdles may be difficult to achieve albeit they fit the "proposed" timelines
- we cannot compromise medium term benefits for short term
- It is difficult to see how the second criterion will be met by any of the scenarios. This criterion is given as 'improve links to (and integration with) community services and improve transition'. As a hurdle criteria the danger is that all scenarios would be excluded. Consideration should be given to rewording it around the lines: 'not inhibit the formation of links to…..'. The fifth criterion states 'the scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT'. None of the scenarios on their own will be able to ensure this. Consideration should be given to changing ensure to something like 'offer the possibility to maintain and improve standards'. The sixth criterion is difficult to understand; 'owing to the scale of challenges at CHUFT scenarios must enable and support stabilisation in the short term'. The commentary given does not help understanding. Consideration should be given to rewording this to make the meaning clear. The fourth criterion is highly complex: the scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT. This would involve detailed modelling, expertise and time to assess in a meaningful way. As there is a simple consideration in the Evaluation criteria consideration should be given to assessing the financial impact at that stage only.
- I would query the overt focus on CHUFT as being the poor performing end of the partnership. Whilst this may have some truth at the current time, it risks a) ignoring good care/strengths at CHUFT and b) the risk that performance at IHT cannot be sustained, either as result of the impact of the partnership, or just because of other as-yet-unknown events or circumstances. The hurdle criteria should take account of both current and future scenario. There may also be a negative impact upon perceptions of CHUFT, which could act to the detriment of the exercise (though we also mustn't understate the scale of the challenge.
- Timeline: can the system afford to wait 3 yrs?
- Would suggest that timeline for some more progressive and transforming changes is likely to be ongoing beyond the 3 years mentioned.
- Query longer term.
- Money is a problem but essentially a political problem the organisation should focus on delivering quality care and good governance
- happy with all these the only thing I question is the "compressed" timescale - sometimes good things take a long time to develop, so this might be putting undue/unhelpful pressure into the system. But I appreciate that there have got to be some time-constraints
- ? out of the scope working with other partnerships
- Must be radical enough to achieve sustainable change
- It is difficult to see how the second criterion will be met by any of the scenarios. This criterion is given as 'improve links to (and integration with) community services and improve transition'. As a hurdle criteria the danger is that all scenarios would be excluded. Consideration should be given to rewording it around the lines: 'not inhibit the formation of links to…..'. The fifth criterion states 'the scenario must ensure that IHT maintains or improves its current high standards at the same time as driving fundamental change at CHUFT'. None of the scenarios on their own will be able to ensure this. Consideration should be given to changing ensure to something like 'offer the possibility to maintain and improve standards'. The sixth criterion is difficult to understand; 'owing to the scale of challenges at CHUFT scenarios must enable and support stabilisation in the short term'. The commentary given does not help understanding. Consideration should be given to rewording this to make the meaning clear. The fourth criterion is highly complex: the scenario must contribute to financial sustainability within a compressed time period (1-3 years) at both IHT and CHUFT. This would involve detailed modelling, expertise and time to assess in a meaningful way. As there is a simple consideration in the Evaluation criteria consideration should be given to assessing the financial impact at that stage only.
- the documentation and criteria are very hospital to hospital focussed (understandable) - however we should not miss the wider opportunities here to create a longer term sustainable model/organisational form with community partners
- The requirement to realise clinical and patient benefits within 3 years may mean a scenario is chosen that will limit implementation of future change that would have greater benefits in the longer term.

Scenarios


'Are the scenarios valid?' (n= 41)
Number of respondents
45
40
35
30
25
20
15
10
5
0
S1: Do nothing
S11: Management contract - single service
S11: Management contract - whole organisation
S12: Joining an existing "foundation group"
S13: Forming a new foundation group
S14: Organisational merger - focus on back office services
S15: Organisational merger - back office plus some clinical...
S16: Organisational merger - back office plus full clinical...
S17: Acquisition (full)
S18: Vertical integration
S2: Federation
S3: Clinical & strategic networks
S4: Buddying
S5: Joint venture (contractual)
S6: Corporate joint venture
S7: Service-level chain type 1 - outsourced services
S8: Service level chain type 2 - provision
S9: Service level chain type 3 - policies and protocols
Not valid
Valid


'Scenario not valid' by group (n= 41)
Number of respondents
45
40
35
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S1: Do nothing
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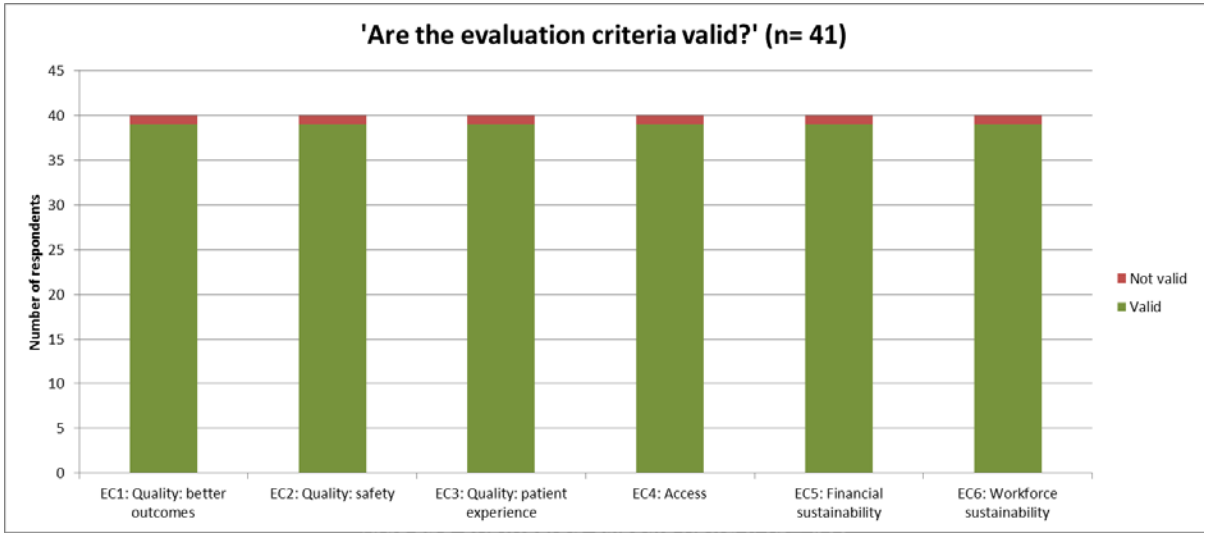
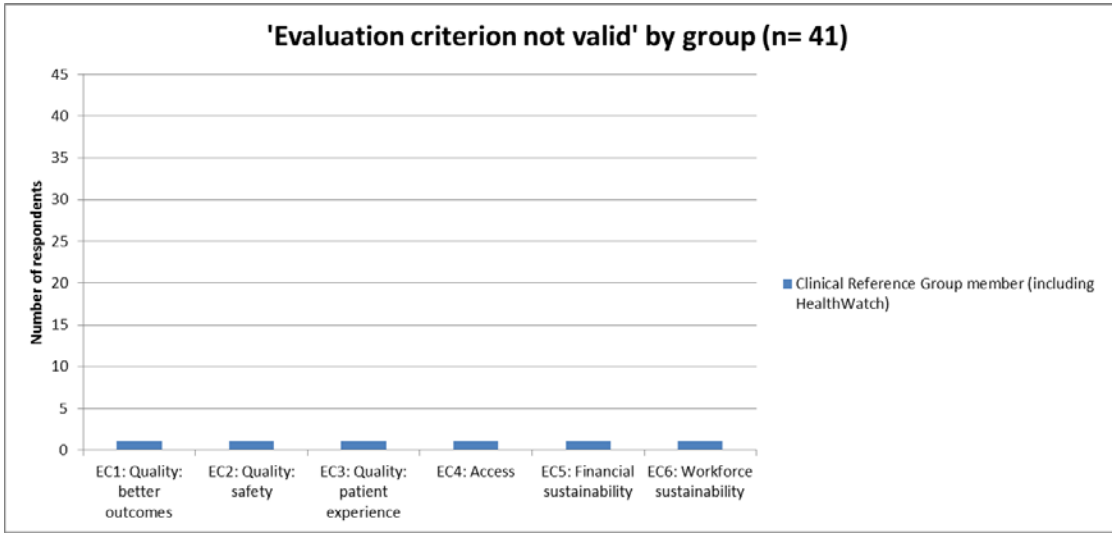
S3: Clinical & strategic networks
S4: Buddying
S5: Joint venture (contractual)
S6: Corporate joint venture
S7: Service-level chain type 1 - outsourced services
S8: Service level chain type 2 - provision
S9: Service level chain type 3 - policies and protocols
Trust executive team member - IHT
Trust executive team member - CHUFT
Clinical Reference Group member (including HealthWatch)
CCG board member - Ipswich & East Suffolk
CCG board member - North East Essex

Scenarios comments

- All of them are valid until the detailed cost /benefit work is completed to eliminate those that do not improve the Quality of service to the public and original objectives of this piece of work.
- Some of these options appear highly unlikely to be feasible however I have tried to answer the questions of whether they are valid... happy to discuss as find this section quite difficult to judge
- Do nothing is not a possible scenario as neither organisation is sustainable and both would loose control of it's own destiny. Buddying is difficult as managerial and clinical accountability is vague
- Buddying - I think this option is less objective over time as we have a shared CEO/chair, so not independent Policies & Protocols - This feels like sharing in the normal sense and would happen anyway. Contractually it would be difficult to measure the benefits. Management contract - single services - I think this is outsourcing/ sub contracting. Whilst vertical integration is valid - I think this option is comparing apples & pears.
- I have marked Federation and Clinical & Strategic Networks as not valid as I do not think making arrangements without contractual agreements represent a different option to the "Do nothing" option - they are simply informal arrangements within the "Do nothing" option
- No change is not an option as neither trust viable on it's own Circle taking over Hinchingbrooke has not been a success Full acquisition of (presumably) CHUFT by IHT will face morale issues and a feeling of disengagement by CHUFT form top to bottom.
- Clearly do nothing isn't a valid scenario. Given the scale of change required.
- A wide range of scenarios are usefully put forward for consideration. The final scenario 'Vertical integration' would appear to be excluded under scope set out on slide 6 'out of scope of this partnership programme is any improvements that can be achieved through working in partnership with other organisations'. It may be logical to exclude this option.
- It seems reasonable to put all options on the table (and I have no particular view or expertise upon which to differentiate between them), but I would encourage you not to start this process from the wrong end, by considering form before function. We need to start with function (i.e. patient/population health needs) and then arrive at a judgement re form.
- No for some of the options as they will not go far enough to dealing with the issues. The option for vertical integration should also include horizontal integration
- Joining an existing foundation group logistically due to distances involved and different in structure and services would not likely bring about the aims of the STP. Isn't logical.
- I do not believe that the "not valid" scenarios will achieve the benefits that have previously been discussed as the rationale for considering LTP, i.e. quality, financial sustainability and access.
- Clinical and strategic networks are too vague to deal with cross site working. Buddying has no leverage to effect change. Service level 2 and 3 will allow effective work force stability. Foundation group - London is a long way from Suffolk.
- Find this very difficult, they all sound plausible. I favour something contractual, otherwise long-term solutions may not work. But, what do I know!
- Out of scope of the Long-Term Partnership is other organisation as described in the presentation
- Is there an option for both vertical integration with community and primary care services and also horizontal integration between acute Trusts
- Do nothing / minimal change.- I'm not so sure this is an option for either organisation if it wishes to be sustainable in delivering services Service level chain type 2 and 3 - I'm not sure if this would add any value or improve services either clinically or non-clinically Joining an existing "foundation group". - This would add no value to delivering the step change required in clinical service delivery or in dealing with the financial liabilities of both trusts in the 1-3 years mentioned.
- Do nothing may have to be on the list but is not really an option
- "A wide range of scenarios are usefully put forward for consideration. The final scenario 'Vertical integration' would appear to be excluded under scope set out on slide 6 'out of scope of this partnership programme is any improvements that can be achieved through working in partnership with other organisations'. It may be logical to exclude this option.
- The current contract for community services in Suffolk will end on 30th September 2017. IHT is currently in dialogue with other Suffolk based providers to form an ICO to deliver the community contract 1st October 2017 onwards - how will this model be affected by the organisational form that is preferred through this process?

Evaluation criteria





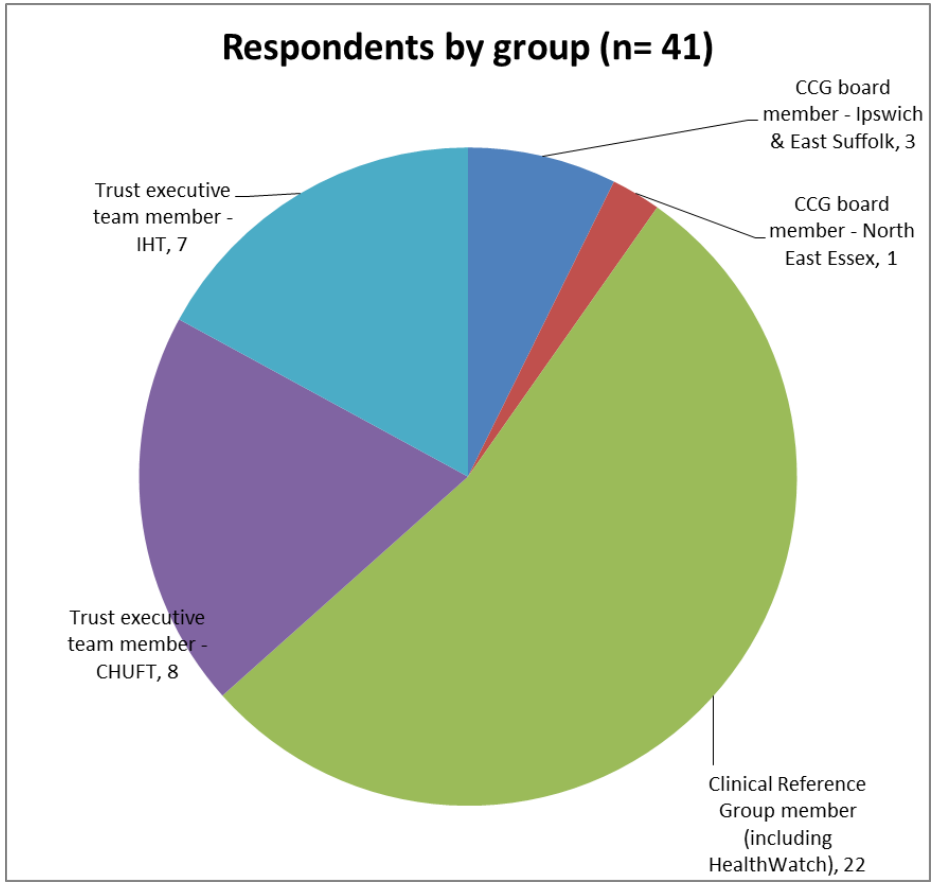
Evaluation criteria comments

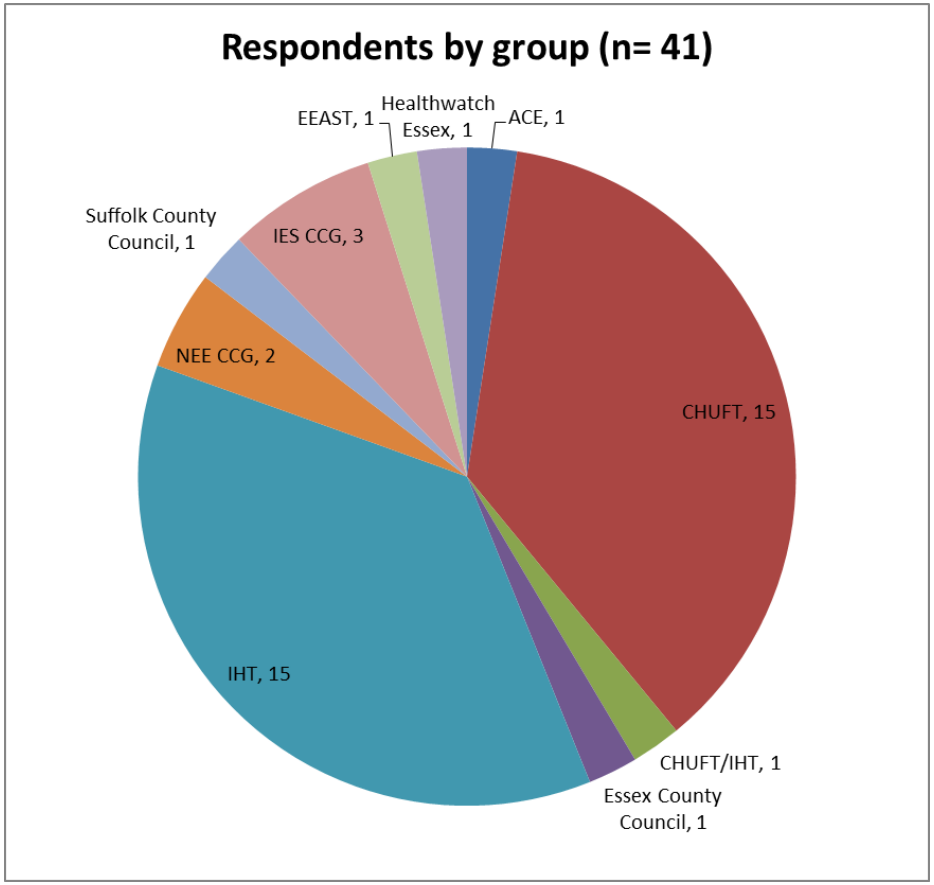
- Deliverability is also valid
- Deliverability shouldn't be a criteria - we should use this as a go/no once the benefits are clear
- The scenarios are very high level. At this level it is not clear that the scenarios of themselves will affect quality or access. Naturally the action taken under any of the scenarios could support or inhibit quality or access. Consideration might wish to be given to supporting clinical leadership. This is in part covered by quality, access and a sustainable workforce but a separate category might be useful.
- These strike me as all being valid. The temptation is to add to them further, although I realise this just makes them harder to apply. That said, I have some thoughts which may be relevant: The seamless pathway criterion is good, but it isn't just a question of 'health and social care' - it needs to be all sectors of health (acute, primary, mental, community) as well as social care and beyond. This could include voluntary sector, self-care and carers. Somehow the role of the latter needs an acknowledgement as having a part to play in the future sustainability of acute health and care (and beyond). (I don't think this is a soft outcome, either. For example, we know that the acute sector picks up the tab for higher costs for people with SMI (Serious Mental Illness) who have worse health outcomes for physical conditions than the rest of the population; or consider the costs to the acute sector of frailty elderly populations who are unsupported in the community or by social care). Access - isn't just important for people with the greatest health needs (as stated) it is also about considering the needs of people who face the greatest barriers (and putting in place mitigations). Workforce - the partnership has to avoid a beggar-thy-neighbour scenario. Solutions to recruitment and retention have to be whole system, otherwise the overall future is unsustainable.
- I think the list of criterion is valid, but I do not see how we can apply them to the scenarios and know the effect they will have as the scenarios as they are so high level. Leadership is so essential and needs to be included.
- Please note, i have scored the scenarios above as valid ONLY if they reflect the STP not just the LTP!! The wording needs to Change!
- The scenarios are very high level. At this level it is not clear that the scenarios of themselves will affect quality or access. Naturally the action taken under any of the scenarios could support or inhibit quality or access. Consideration might wish to be given to supporting clinical leadership. This is in part covered by quality, access and a sustainable workforce but a separate category might be useful.
- Deliverability is not in the above list but is valid.

Section 15

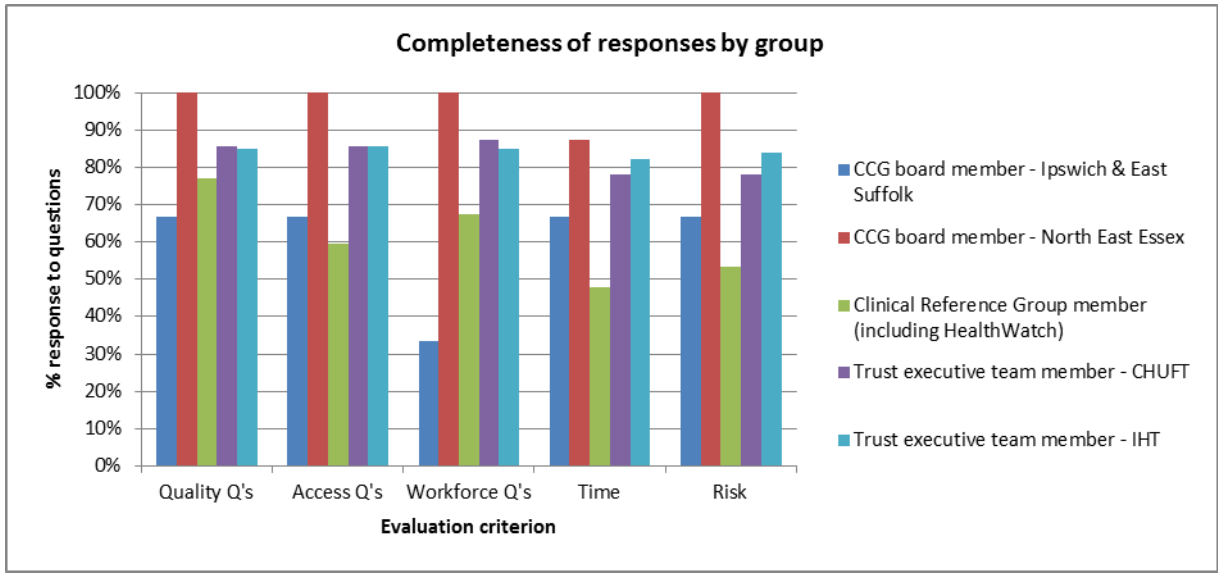
APPENDIX E: SHORTLIST EVALUATION SUBGROUP ANALYSIS

Respondents

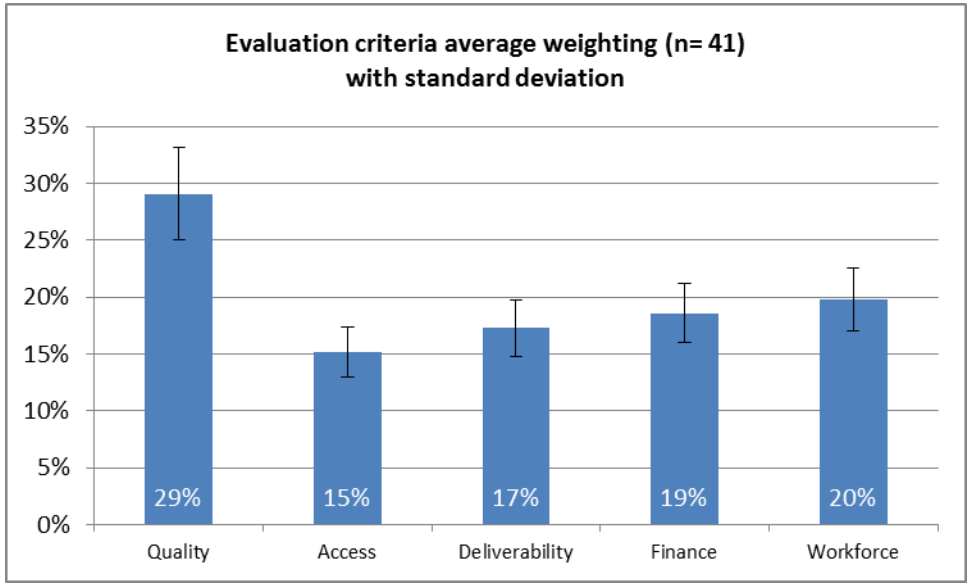


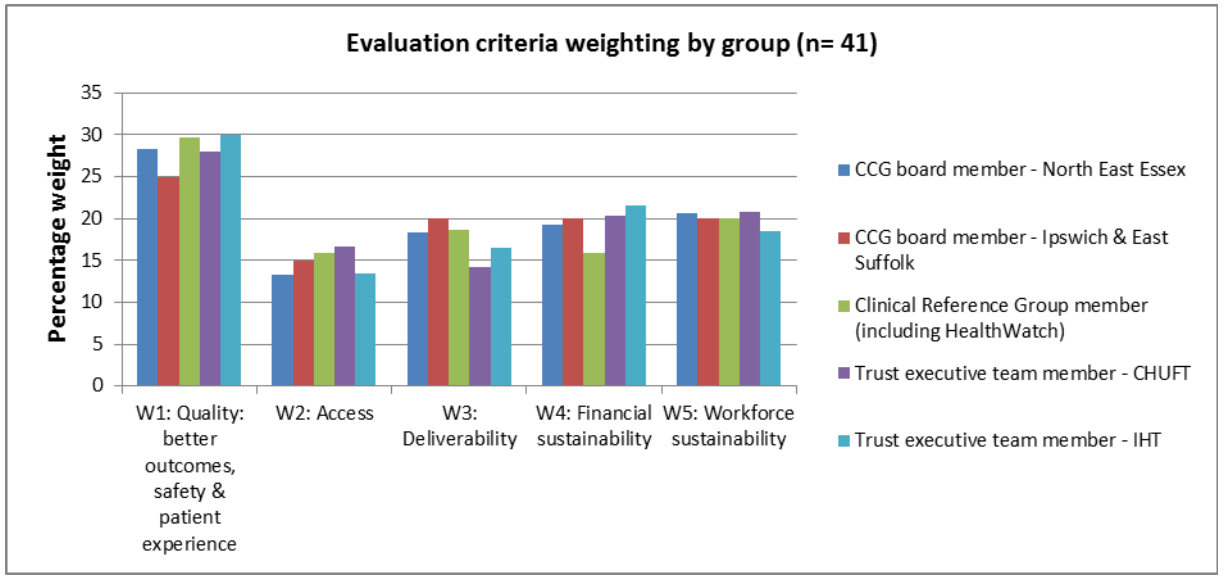


Completeness of response

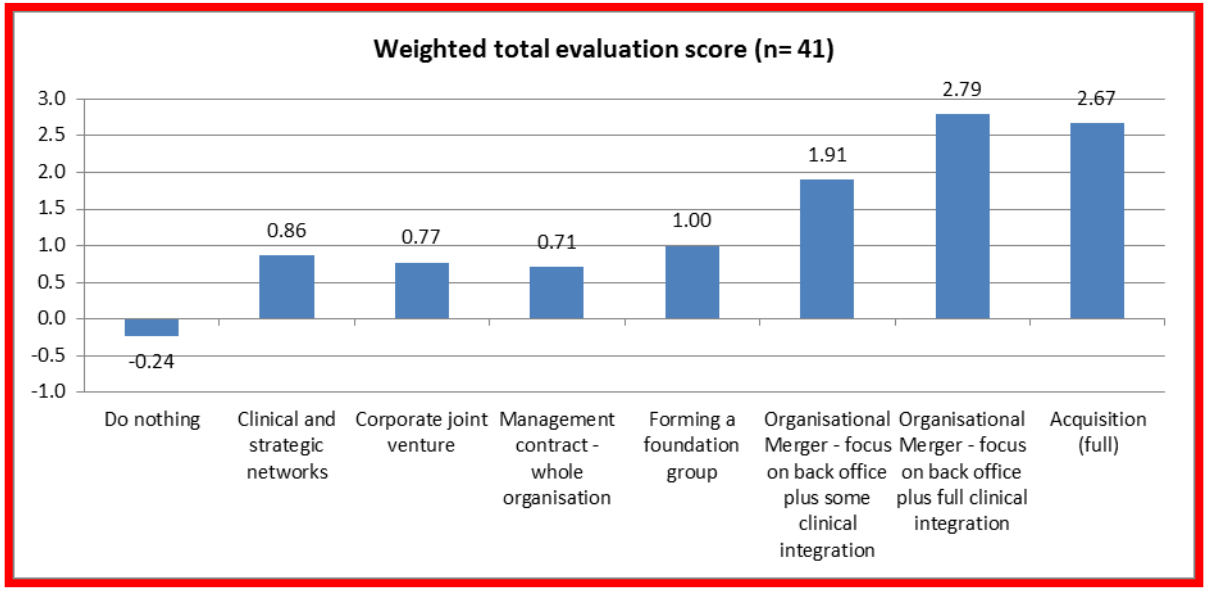


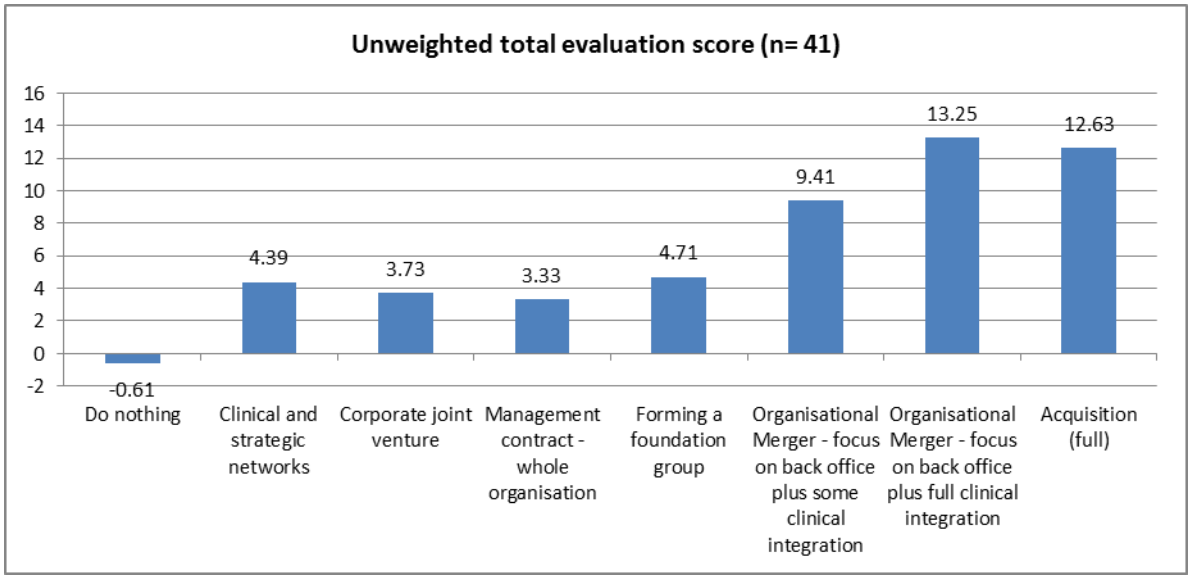
Evaluation criteria weightings



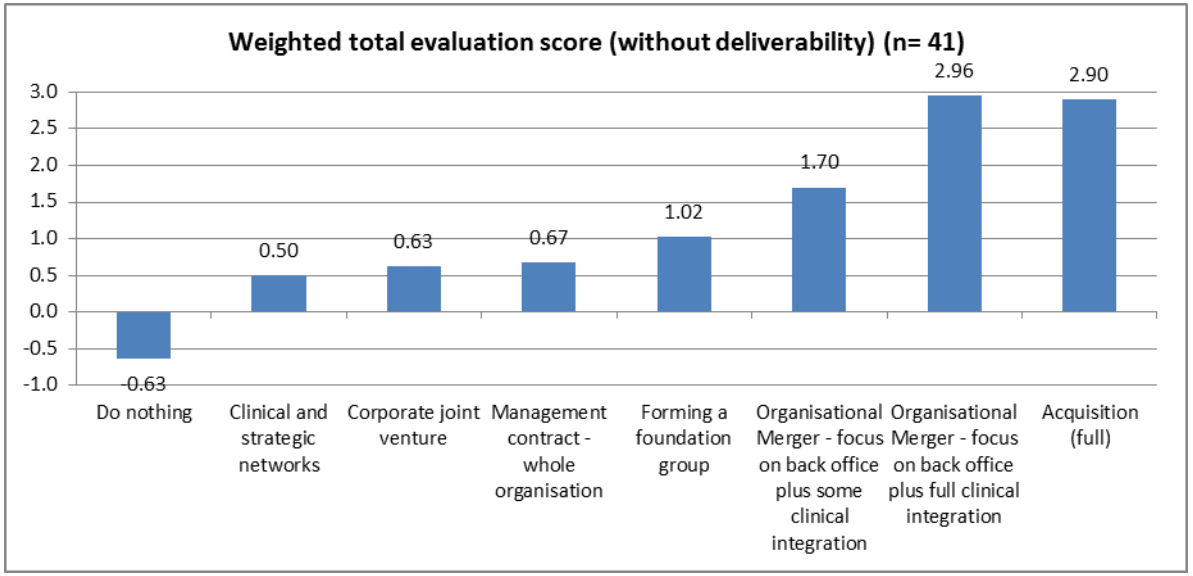


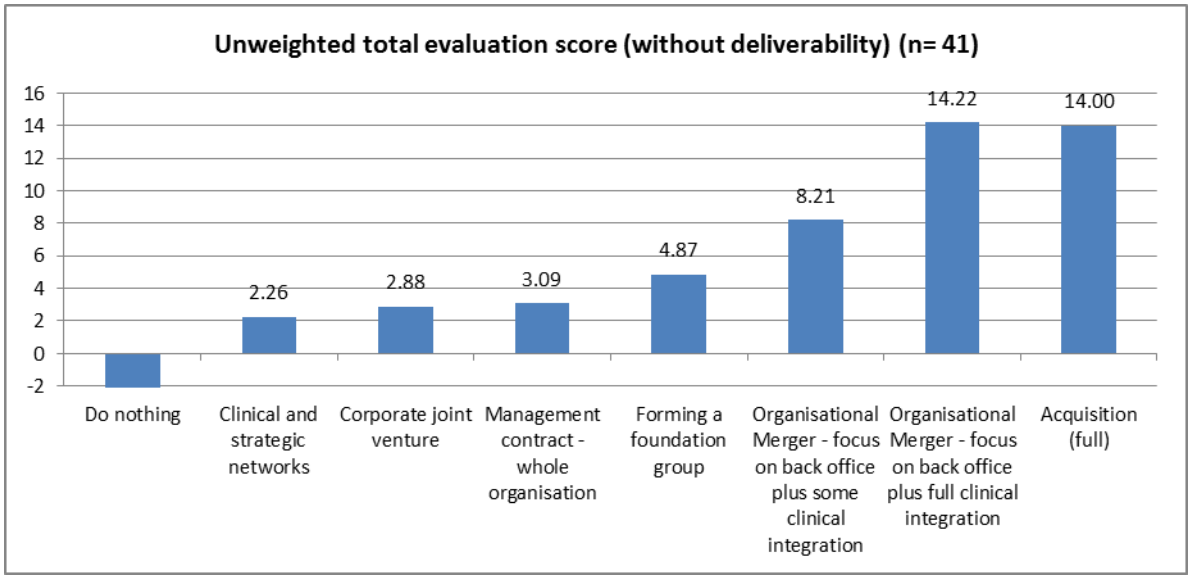
Summary evaluation



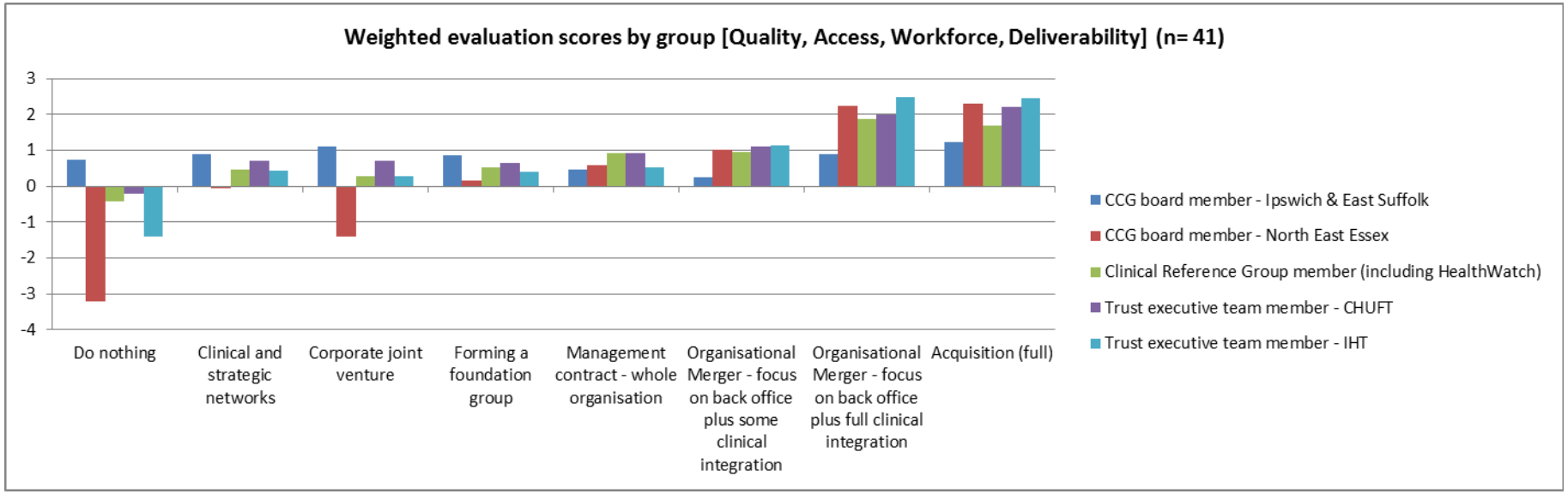


Summary evaluation excluding deliverability criteria

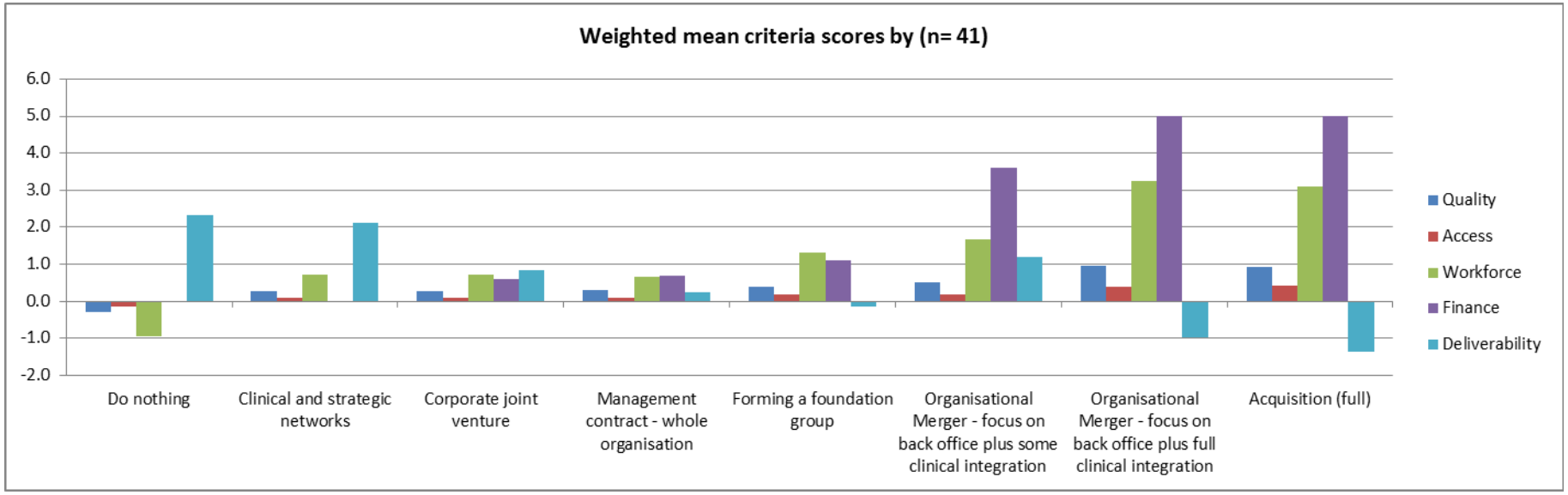


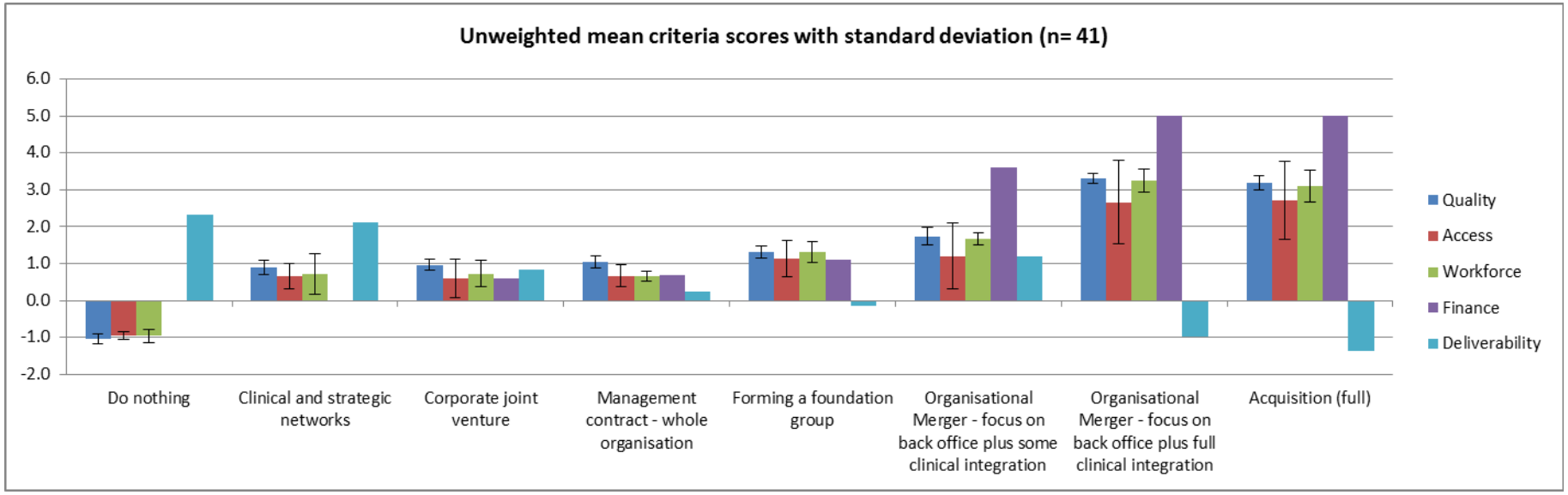


Weighted evaluation by group

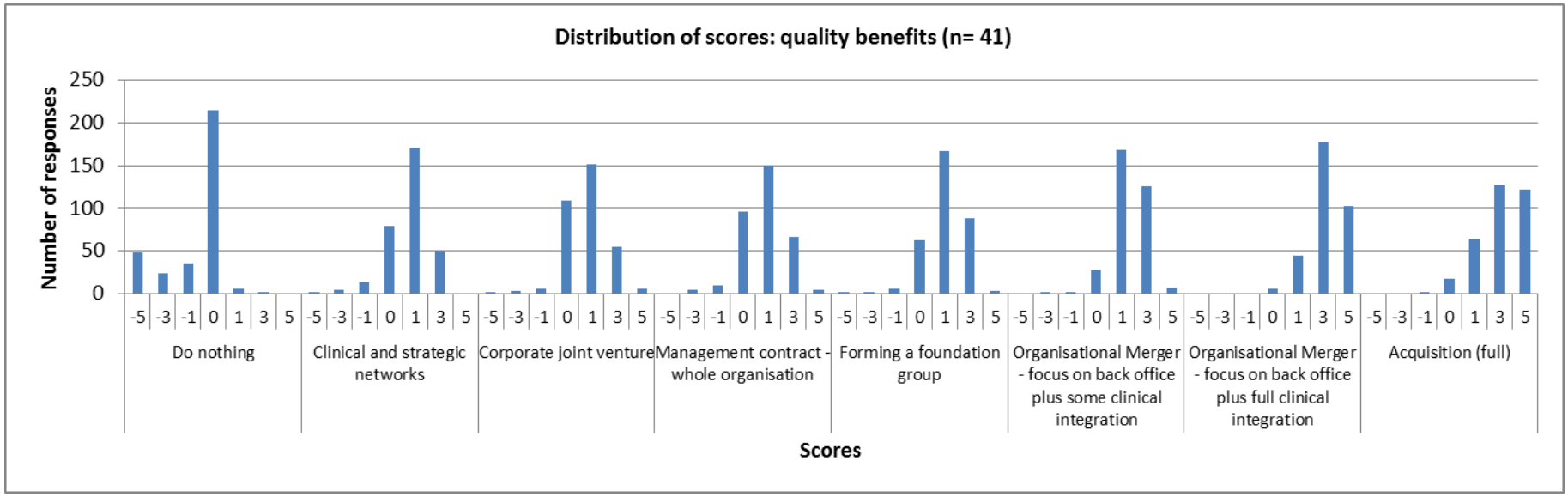


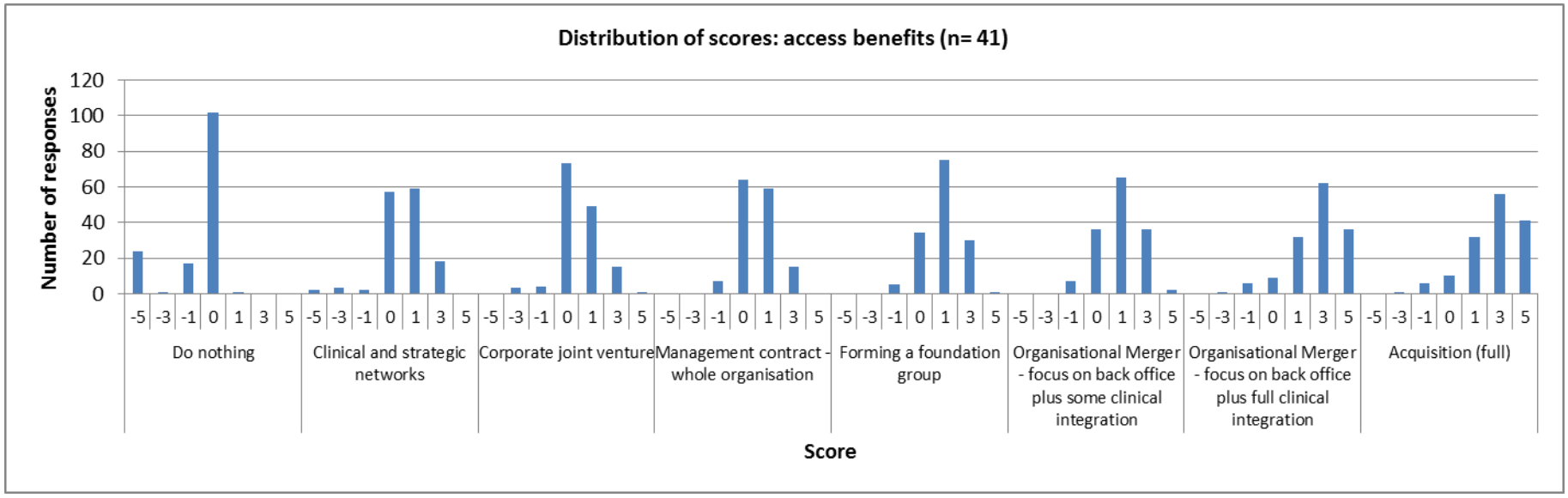
Mean scores with standard deviation



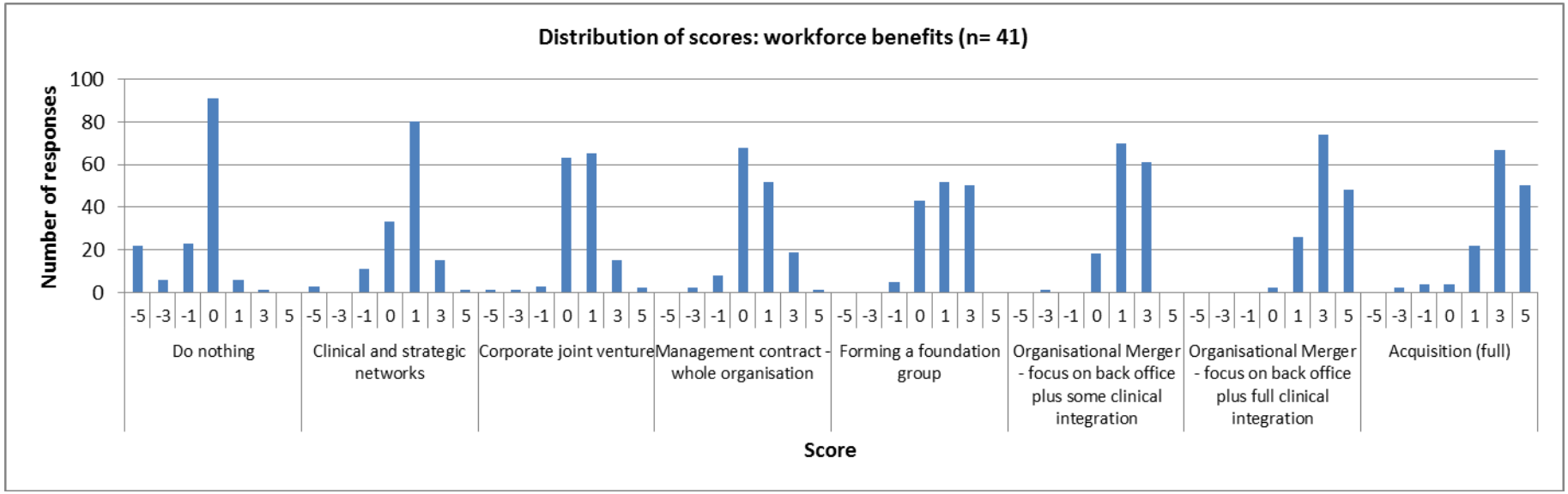


Distribution of scores (unweighted)

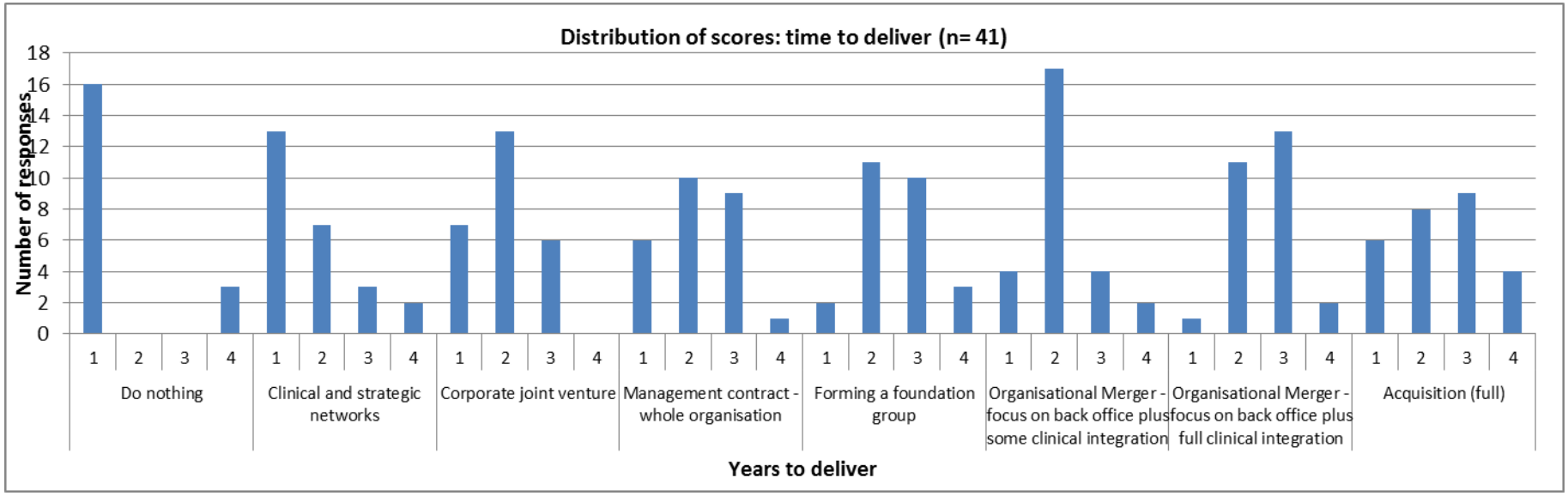


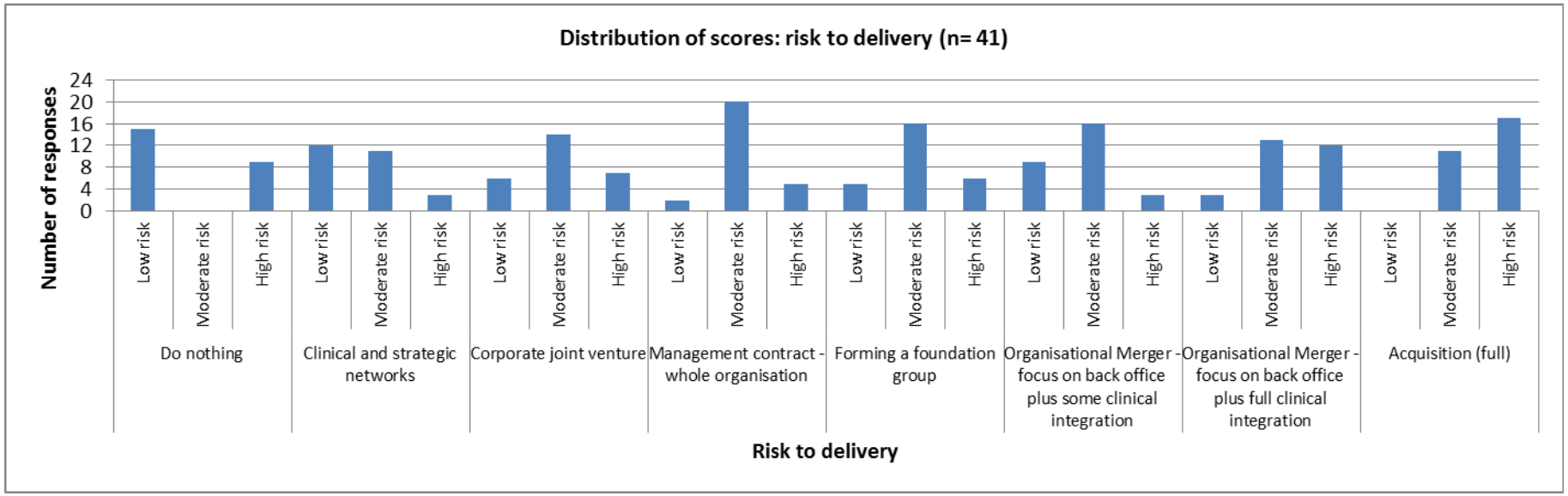


Distribution of scores (unweighted)



Distribution of scores (unweighted)





Comments on quality benefits 1

I suppose what I am expressing here is a wariness of contracting as a route to improved governance and hence quality. What counts here is clarity and solidity of governance as a route to better quality. (That said, good governance is not just a function of structures; it is about people applying sensible and proportionate processes).

Presumably coordinated IT investment is easier to achieve when the ties between the two organisations are stronger.... but this is just a presupposition.

I think my underlying assumption is that scenarios with closer and stronger integration implies closer and better co-ordination, which is turn reduces variation.

My assumption here is that the likelihood implementing effective 7 day is increased through closer and stronger integration, hence the stronger projected gains in the at the bottom of the table.

This was an interesting question. Compliance is partly a function of governance; it is also just everyday management and leadership. Compliance should be the bottom line of each scenario....?

I am assuming that closer integration implies easier management of rotas. This falls down (of course) if there is clinical disenfranchisement as a result of the scenario, but this is difficult to predict?

Again, my assumption here is that separating elective from emergency will require stronger management, which I have associated with closer and strong organisational integration.

See my comment to Qual 8 - am assuming that structural change at scale requires strong a strong organisational base. Query - whilst the case is often made that delivering at scale produces better clinical outcomes, it is worth questioning the extent of wider benefits to the patient and adopting a critical stance in the face of this assumption - am thinking of Shumacher's 'small is beautiful'(!) plus the fact that basic care needs are essentially local and often not best dealt with in an acute setting.

Again, my assumption is that the stronger an organisational link is, the easier it would be to reduce variation. BUT - as before, if integration leads to disenfranchisement then these benefits may be lost

See comment to qual9

for all these options-- there is an element of distraction from BAU- and hence a risk of loss of quality which is difficult to quantify

intelligent data will help inform areas of focus- not sure if IT is the main answer to avoidable variation!

Change needs to be radical

From my perspective, it would depend on how much time, effort, resource was required for each of the scenarios and how much time, effort and resource was taken away from managing the day to day operational needs and improvement

Good quality IT investment should always help, but, it also needs to be coordinated with the rest of the system

Again, good join up of IT can do the job, but, it needs good use of the data by managers and clinicians together. It should work no matter the organisational form

The more control over a larger and more sustainable workforce the better

Comments on quality benefits 2

Improved clinical management by clinicians with senior managers could come from being in a larger group

Networks and standards already exist - it would need change in management offer alongside clinicians to grasp this nettle

Ditto above

Some IT investments may be only cross-site if the vendor is supplying one Trust, eg Cardio-Resp software was offered for free to CHUFT if we merged with IHT since IHT has a site license.

See QAL2

Full cross-site cover only completely realisable with full clinical integration.

Compliance increases with degree of joint working/planning

See QAL5

Responses provided are the anticipated impact 18-24 months following implementation. Most mergers/changes to organisational structure result in quality deterioration in the first instance.

The quality gain will be relative to the quantum of capital investment and training in new systems rather than the enabling organisational model. Greater organisation integration will increase the ability for strategic capital planning and investment and improve flexibility in prioritising capital.

7 day working may be achieved through flexible use of workforce by rostering across hospital sites/re-aligning clinical specialties.

The second scenario Clinical and strategic networks is not part of the shortlisted seven scenarios. Our assumption is that by closer integration and getting better control of the system resources and operational procedures we anticipate the quality will only get better.

Our above response only relates to the impact on system resilience and not on quality as the QAL2 only asks the impact on system resilience. Creating one IT system with joint investment can only be better from a system perspective.

Joint IT investment from a system perspective can only benefit patients and likely to lead to improved quality.

We are not convinced that there is enough evidence out there that 7 day working improves quality. However this is one of the goals of the NHS. Our assumption is that closer organisation integration is likely to facilitate 7 day working.

This will depend on the reasons for non compliance in the current scenario. Our view is that closer integration of a system is likely to facilitate better compliance with standards.

Closer integration is likely to facilitate economies of scale. This could have a positive impact on the quality of care provided.

Due to the following three guiding design principles in our view it is not possible to separate elective & emergency flows. We will continue to provide A&E services on both acute hospital sites We will continue to have obstetric-led maternity services on both sites We will have a 24/7 undifferentiated acute medical take at both sites Hence we have not graded against this question as we feel the question is not applicable.

Unity is strength. Hence closer integration will help to meet national standards better.

Comments on quality benefits 3

Having unified structure, system and process will help standardisation of practice. Hence in our view this is likely to impact on quality in a positive way.

Same as above

Do nothing STRUCTURE could still potentially lead to improvements if repopulated with same quality staff as in other proposed structures. Intrinsic merit of structures is relatively marginal

need to link crucially with vertical community and social care systems .This may be problematic if these are not common

Comments on access benefits

What this requires it appropriate incentivisation in terms of service delivery and outcomes (and an appropriate system of payments), which is arguably deliverable under any form, although my previous comments to the qual questions may also apply.

My assumption here is that service redesign may be easier under a new organisation form, although it is arguably the case that this could proceed under current or lower level changes, with the right drive and incentives.

This is a tricky one to answer. There is no reason why organisations cannot be organised or redesigned to integrate care. Arguably, the current structure does not promote this. New structures could promote this, but only if the right incentives are applied. The risk is that a new organisation sucks up resource and retains ownership of clinical pathways, rather than releasing these to community and primary care. But this is impossible to predict! Depends on the vision and ability/determination to implement this.....

See my comments to Acc3

As under the Qual questions, my assumption is that closer and stronger organisational integration will aid standardisation, which should in turn increase effectiveness.

Requires integration with community services

The ability to engage in prevention is already available

Much sub specialisation exists already through shared working arrangements. The challenge is increasing the generalism of Drs

The scenarios of hospitals being key players in ACOs is already happening and only full merger or acquisition allowing more sustainable workforce availability would add

Full realisation of combined workforce most likely with most merged scenario

Some repatriation and change in job plans most likely to happen with greatest merger scenario

This would depend on the vision commitment and focus of the system to make this happen.

As question 3

The acute system management structure is unlikely to have major impact on prevention. What we need is system wide joint working and all partners prioritising prevention to sustain current level of NHS services.

By closer integration it is possible to develop sub specialisation in the two sites of the acute system. However if access means closer facilities, then this is unlikely as some patients have to travel far to get the services required.

There are multiple community providers and two local authorities providing social care across the new NHS landscape in the STP area. Hence it is unlikely to improve access as integration might not be easy.

Economies of scale and increased clinical expertise will facilitate repatriation and help sustaining services in the local area.

With increasing integration of IT services across the Trusts will lead effective clinical teams.

Potential Loss of clear focus as shifts away from PH county level approach

sub specialisation may marginally reduce access

Increased complexity might reduce local focus

Comments on workforce benefits

The reduction of funding from HEEoE will not be compensated by any scenarios

If there is a positive development in the way of sharing good practice and implementing new systems & protocols for the acute collaboration this will have a favourable impact on the clinical & managerial culture.

A larger clinical entity is likely to attract staff and will have the ability to retain them as opposed to two smaller organisations.

If one considers bigger is better an integrated entity is likely to provide better development opportunities.

With increasing integration it is possible to create single teams at speciality level.

There are two sides to the coin. Smaller organisation will create more opportunities for leaders and a larger organisation might have the resources to invest in leadership training. Hence there is unlikely to be any net impact.

Comments on deliverability

Hard to answer, here, and I'm conscious that my assumptions are largely based on preconceptions. Timescales I don't feel able to comment on.

deliverability will depend on shared vision, transparency of decision making, culture and leadership

There is no low risk option that I can see!

How quickly do you get certainty? Mergers rarely work, networks can easily become neglected, joint ventures between organisations delivering very different standards will not be joint

Perhaps TSA should have been included as a scenario alongside the full merger/acquisition option as the delivery timetable and risks of clinical integration may be lower where CHUFT/IHT merger is forced through in this way (lesser requirement for consultation).

We have not graded Do nothing as there is nothing to do! We have also not graded Clinical and strategic networks as this is not one of the chosen 7 options.

Section 16

APPENDIX F: FINANCIAL CASE

Developing separate financial submissions for NHSI for CHUFT and IHT

The main assumptions built into the NHSI submissions are shown below:

Area	CHUFT	IHT
Income	• Activity growth arising from demographic changes has been modelled and included from the Sustainability & Transformation Plan. • The trust plans to achieve its financial Control Total set by NHSI and its operational improvement trajectories and so has assumed 100% Sustainability and Transformation Funding (STF) will be realisable (£8.8m)	• Activity growth arising from demographic changes has been modelled and included from the Sustainability & Transformation Plan. • The trust has submitted a plan that does not achieve its financial Control Total set by NHSI but that will achieve its operational improvement trajectories. 100% of the Sustainability and Transformation Funding (STF) has been excluded from the plan (£7.1m)
Cost	• Pay inflation as per national guidance (1% award) • Incremental drift and other pay impacts as per local circumstances • Contributions to NHSLA to cover clinical negligence claims increase 10% (£1.3m) • Only cost pressures in the run rate have been recognised	• Pay inflation as per national guidance (1% award) • Incremental drift and other awards as per local circumstances • Contributions to NHSLA to cover clinical negligence claims increase 9.6% (£1.2m) • Only cost pressures in the run rate have been recognised
Cost Improvement	• Cost Improvement Plans of 5.5% in 2017/18 and a further 3.4% in 2018/19 are required to achieve the improvement in planned deficits in the baseline model.	• Cost Improvement Plans of 3.9% in 2017/18 and a further 3.8% in 2018/19 are required to achieve the improvement in planned deficits in the baseline model.
Capex	• Capex financed from set-aside depreciation and a requirement for borrowing from Department of Health to support capex and repayment of prior period borrowings	• Capex financed from set-aside depreciation after repayments of capital element of finance leases/PFI.
Other	• NHSI accepts the plans without requiring modification and supports the requirement for ongoing cash financing support.	• NHSI accepts the plans without requiring modification and supports the requirement for ongoing cash financing support.

The individual NHSI forecasts for each Trust are shown on the next two pages, followed by the combined baseline forecast for the 'do nothing' scenario

Developing separate financial submissions for NHSI: CHUFT forecast

Based on these assumptions, the financial base case for both CHUFT is as follows:

£'m	2016/17 Forecast	2017/18 Plan	2018/19 Plan
Clinical income	**255.8**	**263.2**	**264.4**
Other operating income	**23.3**	**19.4**	**19.6**
Income	**279.1**	**282.6**	**284.0**
Employee expenses	(192.6)	(189.3)	(185.0)
Operating expenses excl. employee expenses	(121.5)	(119.0)	(116.9)
Integration benefits	*tbc*	*tbc*	*tbc*
Total expenditure	**(314.1)**	**(308.3)**	**(301.9)**
Operating Surplus/(Deficit)	**(35.0)**	**(25.7)**	**(17.9)**
Financing costs	(5.4)	(5.1)	(4.7)
Deficit before Sustainability & Transformation Fund	**(40.3)**	**(30.9)**	**(22.7)**
Sustainability & Transformation Fund	8.6	8.8	8.8
Deficit after Sustainability & Transformation Fund	**(31.7)**	**(22.0)**	**(13.8)**
Cashflow:			
Operating cash flow	(16.5)	(7.6)	0.4
Investing cash flow	(12.0)	(12.1)	(12.3)
Financing requirements cash flow	27.9	19.6	11.9
Net Borrowing requirements:			
Revenue Support Loans/Working Capital	31.9	22.4	14.3
Capital Investment Loans	1.8	1.9	-
Total Borrowing	**33.7**	**24.3**	**14.3**
CIP		**17.0**	**13.2**
%age of expenditure		*5.5%*	*4.4%*

Developing separate financial submissions for NHSI: IHT forecast

Based on these assumptions, the financial base case for both IHT is as follows:

£'m	2016/17 Forecast	2017/18 Plan	2018/19 Plan
Clinical income	**252.6**	**262.0**	**267.0**
Other operating income	**26.0**	**22.9**	**23.1**
Income	**278.6**	**284.9**	**290.1**
Employee expenses	(177.2)	(181.2)	(183.3)
Operating expenses excl. employee expenses	(121.6)	(126.8)	(130.7)
Integration benefits	*tbc*	*tbc*	*tbc*
Total expenditure	**(298.8)**	**(308.0)**	**(314.0)**
Operating Surplus/(Deficit)	**(20.2)**	**(23.1)**	**(23.9)**
Financing costs	(6.9)	(4.1)	(3.1)
Deficit before Sustainability & Transformation Fund	**(27.0)**	**(27.2)**	**(27.0)**
Sustainability & Transformation Fund	6.9	-	-
Deficit after Sustainability & Transformation Fund	**(20.1)**	**(27.2)**	**(27.0)**
Cashflow:			
Operating cash flow	(8.1)	(13.0)	(13.3)
Investing cash flow	(8.2)	(9.8)	(9.8)
Financing requirements cash flow	16.4	22.9	23.1
Net Borrowing requirements:			
Revenue Support Loans/Working Capital	21.8	27.2	27.0
Capital Investment Loans	-	-	-
Total Borrowing	**21.8**	**27.2**	**27.0**
CIP		**12.0**	**12.0**
%age of expenditure		*3.9%*	*3.8%*

Combining the NHSI submissions to create the 'do nothing' scenario

Based on these assumptions, the financial base case for both trusts is as follows:

£'m	2016/17 Forecast	2017/18 Plan	2018/19 Plan
Clinical income	**508.4**	**525.1**	**531.4**
Other operating income	**49.3**	**42.3**	**42.7**
Income	**557.7**	**567.5**	**574.1**
Employee expenses	(369.8)	(370.4)	(368.3)
Operating expenses excl. employee expenses	(243.0)	(245.8)	(247.6)
Integration benefits	*tbc*	*tbc*	*tbc*
Total expenditure	**(612.9)**	**(616.3)**	**(615.9)**
Operating Surplus/(Deficit)	**(55.1)**	**(48.8)**	**(41.8)**
Financing costs	(12.2)	(9.3)	(7.9)
Deficit before Sustainability & Transformation Fund	**(67.4)**	**(58.1)**	**(49.7)**
Sustainability & Transformation Fund	15.6	8.8	8.8
Deficit after Sustainability & Transformation Fund	**(51.8)**	**(49.2)**	**(40.8)**
Cashflow:			
Operating cash flow	(24.6)	(20.6)	(12.9)
Investing cash flow	(20.1)	(21.9)	(22.1)
Financing requirements cash flow	44.4	42.5	35.0
Net Borrowing requirements:			
Revenue Support Loans/Working Capital	53.8	49.6	41.3
Capital Investment Loans	1.8	1.9	-
Total Borrowing	**55.6**	**51.5**	**41.3**
CIP		**29.0**	**25.2**
%age of expenditure		*4.7%*	*4.1%*

Section 17

APPENDIX G: ENGAGEMENT LOG

CoRG engagement

Organisation	Role Title	Date
North East Essex CCG	Co-chair	14th December 2016
IES CCG		14th December 2016
West Suffolk CCG		14th December 2016

CRG engagement

Organisation	Role Title	Date
CHUFT	CRG chairman	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Ipswich HT	Medical specialties – medical rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Ipswich HT	Medical specialties - nursing rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
CHUFT	Medical specialties – medical rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
CHUFT	Medical specialties – nursing rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Ipswich HT	Surgical specialties – medical rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Ipswich HT	Surgical specialties – nursing rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
CHUFT	Surgical specialties – medical rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
CHUFT	Surgical specialties – nursing rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Ipswich HT	Clinical support specialties – medical rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Ipswich HT	Clinical support specialties – nursing rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
CHUFT	Clinical support specialties – medical rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
CHUFT	Clinical support specialties – nursing rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017

Organisation	Role Title	Date
Ipswich HT	AHP rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
CHUFT	AHP rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Ipswich and East Suffolk CCG	Medical rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Ipswich and East Suffolk CCG	Nursing & AHP rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
North East Essex CCG	Medical rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
North East Essex CCG	Nursing & AHP rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
East of England Ambulance Trust	East of England Ambulance Trust rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Essex & Suffolk	Healthwatch rep	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Suffolk	Director of Public Health	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Essex	Director of Public Health	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
ACE	Managing Director	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
NEP	Invited but unable to attend	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
NSFT	Invited but unable to attend	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017
Community Services Partnership, Suffolk	Director of Nursing, Therapies and Governance	9th November 2016, 29th November 2016, 13th December 2016, 10th January 2017

General stakeholder engagement

Organisation	Role Title	Date
IHT	Trust Board	28th July 2016
NHS Improvement	Competition team	3rd August 2016
NHS Improvement	Competition team	4th August 2016
NHS England	Locality Director	9th August 2016
CHUFT	Dir. of Transformation	8th August 2016
CHUFT	Trust Secretary	8th August 2016
CHUFT	DOF	9th August 2016
IHT	Dir. of Workforce	10th August 2016
CHUFT	Dir. of Workforce	10th August 2016
NHS England	Area lead	10th August 2016
NHS Improvement	Area lead	10th August 2016
IHT	Managing Director	11th August 2016
IHT	Dir. Estates	12th August 2016
IHT	Dir. of Medicine	12th August 216
CHUFT	COO	15th August 2016
CHUFT	Managing Director	15th August 2016
CHUFT	Dir. Estates	16th August 2016
Essex County Council	Cabinet Member for Health	16th August 2016
CHUFT & IHT	Chairman	17th August 2016
CHUFT	Dir. of Nursing	17th August 2016
CHUFT	NED	18th August 2016
CHUFT	NED	18th August 2016
CHUFT	NED	18th August 2016
NHS England	Provider Appraisal Team	18th August 2016
CHUFT	NED	19th August 2016
CHUFT	NED	19th August 2016
IHT	Associate NED	23rd August 2016
IHT	Associate NED	24th August 2016
IHT	NED	24th August 2016
IHT	NED	24th August 2016
CHUFT	NED	24th August 2016
IHT	NED	24th August 2016
IHT	Trust Board	24th August 2016
Essex County Council	CEO	30th August 2016

Organisation	Role Title	Date
Suffolk County Council	Deputy HOSC chairman	30th August 2016
Suffolk County Council	HOSC chairman	30th August 2016
Suffolk County Council	Leader	30th August 2016
CHUFT	Governors	31st August 2016
North East Essex CCG	Chief Officer	31st August 2016
Suffolk CCG	Chief Officer	31st August 2016
Essex County Council	Leader	1st September 2016
Suffolk County Council	Health portfolio holder	1st September 2016
NHS Improvement	Provider Appraisal Team	16th September 2016
CHUFT	Trust Board	28th September 2016
IHT	Trust Board	29th September 2016
Suffolk CCG	Comms & Engagement Lead	
NHS Improvement	Competition team	7th October 2016
IHT	NED	10th October 2016
IHT	NED	10th October 2016
Suffolk County Council	HOSC	12th October 2016
Suffolk County Council	HOSC chairman	12th October 2016
Essex County Council	Deputy HOSC chairman	12th October 2016
IHT	Dir. of IT	13th October 2016
STP Communications & Engagement Network		19th October 2016
PAB		21st October 2016
NHS Improvement	Competition team	21st October 2016
Essex Members of Parliament		24th October 2016
Suffolk Members of Parliament		24th October 2016
CHUFT	Trust Board	27th October 2016

General stakeholder engagement (cont'd)

Organisation	Role Title	Date
CHUFT	Executive team	1st November 2016
IHT	Executive team	
CHUFT and IHT	Partnership Working Group – Collaboration ICT Workstream	3rd November 2016
Essex County Council	HOSC	9th November 2016
Healthwatch Suffolk	Chief Executive	14th November 2016
NHS Improvement	Programme Director, Essex Success Regime	15th November 2016
Suffolk County Council	Director of Public Health	17th November 2016
IHUG & IHT	Hospital User Group & Head of Patient Experience	21st November 2016
CVS Tendring	Comms Officer	22nd November 2016
CHUFT	Trust Board	23rd November 2016
CHUFT Patient Group		23rd November 2016
Essex County Council	Head of Comms	23rd November 2016
IHT	Trust Board	24th November 2016
Colchester Borough Council	Chief Executive	25th November 2016
Healthwatch Essex	Chief Executive	25th November 2016
North East Essex CCG	Chief Officer	25th November 2016
Suffolk CCG	CEO	25th November 2016
Suffolk County Council	Assistant Chief Executive	25th November 2016

Organisation	Role Title	Date
IES & WS CCG	Chief Officer	25th November 2016
EEAST	Senior Manager for Ipswich	25th November 2016
Suffolk County Council	Assistant Chief Executive of Suffolk County Council	25th November 2016
Ipswich Borough Council	Chief Executive	25th November 2016
Essex County Council	Director for Adult Operations	25th November 2016
CHUFT	Exec Directors	28th November 2016
IHT	Exec Directors	28th November 2016
EEAST	Comms Officer	12th December 2016
Suffolk Health & Wellbeing Forum	Chair's Representative	14th December 2016
Community Action Suffolk	Communications Officer	14th December 2016
Suffolk CCG	Comms & Engagement Lead	15th December 2016
Colchester Borough Council	Comms & Policy Officer	15th December 2016
CHUFT	Exec Directors	15th December 2016
IHT	Exec Directors	15th December 2016
CVS Colchester	Comms Officer	20th December 2016
CHUFT	Trust Board	21st December 2016
IHT	Trust Board	21st December 2016

Section 18

APPENDIX H: ABBREVIATIONS

Abbreviations

CHUFT	Colchester Hospital University Foundation Trust
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CSF	Critical success factor
DGH	District General Hospital
DToC	Detailed Transfers of Care
EEAST	East of England Ambulance Service NHS Trust
FBC	Financial Business Case
G&A	General and administrative expense
HWB	Health and Wellbeing
IHT	Ipswich Hospital Trust
LTFC	Long-Term Financial Model
LTP	Long-Term Partnership
NHSLA	NHS Litigation Authority
NSFT	Norfolk and Suffolk NHS Foundation Trust
OBC	Outline Business Case
OOH	Out of hours
PAB	Partnership Advisory Board
PESTLE	Political, Economic, Social, Technological, Legal, Environmental
RACI	Responsible, accountable, consulted, informed
RTT	Referral to Treatment
SOP	Strategic Outline Programme
STP	Sustainability and Transformation Plan
SWOT	Strengths, Weaknesses, Opportunities, Threats