

**Proposed changes to adult elective
(planned) orthopaedic surgery at
Colchester and Ipswich Hospitals
Building for Better Care**



Version 2.1

Supporting information for public consultation

18 February 2020

Contents

1.	Introduction and Background	1
1.1	Purpose of this pre-consultation business case.....	1
1.2	Structure of this document.....	1
1.3	Arrangements for development and oversight	2
2.	Strategic Case	5
2.1	The national context	5
2.2	The local context.....	7
2.3	The East Suffolk and North Essex NHS Foundation Trust	9
2.4	The case for change	12
2.5	Policy and commissioning response to the challenge	17
2.6	Safety and sustainability of medium sized district general hospitals	18
3.	Clinical Case	21
3.1	Development of a shared clinical vision	21
3.2	Themes from the clinical strategy.....	24
3.3	Improving access to elective care	26
3.4	Elective Care Centre for orthopaedics	28
3.5	Orthopaedic Trauma Services	38
3.6	Proposed model of care	42
3.7	Workforce Issues.....	49
4.	Estates options to support clinical service reconfiguration	53
4.1	Facilities for elective (planned) orthopaedic surgery	53
4.2	Non-financial options appraisal	58
5.	Communications and Engagement	62
5.1	Pre-consultation engagement.....	62
5.2	Stakeholder engagement.....	63
5.3	Public consultation communications and engagement plan.....	69
6.	Assurance of service change	69
6.1	The Secretary of State’s four tests.....	70
6.2	East of England Clinical Senate Independent Review	71
6.3	Building for Better Care programme governance.....	73
6.4	Programme timeline	78

Tables

Table 1: Current CQC ratings for ESNEFT	7
Table 2: Key data for Ipswich and Colchester Hospitals.....	10
Table 3: ESNEFT’s Commissioners	12

Table 4: Principal catchment Tier 2 local authority areas (Public Health England 2017).....	13
Table 5: Elective Orthopaedic Inpatient Activity Projections.....	31
Table 6: Elective Orthopaedic Daycase Activity Projections	31
Table 7: T&O theatres required in 2025 (when an Orthopaedic Centre would be newly opened).....	32
Table 8: T&O theatres required by 2041.....	32
Table 9: Non-elective Trauma Inpatient Activity Projections.....	41
Table 10: Trauma Arthroplasty Performance 2018.....	41
Table 11: Workforce Issues, associated risks and plans for mitigation.....	52
Table 12: Summary of longlist to shortlist option sifting	60
Table 13: Summary of shortlisted options	61
Table 14: Programme Milestones – Business Case Two	78

Figures

Figure 1: Governance Structure – Pre-consultation Business Case Two (Elective Care).....	3
Figure 2: The Suffolk and North East Essex vision	8
Figure 3: ESNEFT Catchment Populations	11
Figure 4: Patients potentially affected by travel to a Centre for Elective Orthopaedics	11
Figure 5: Map showing the local area served by ESNEFT including main and community hospital sites .	13
Figure 6: Projected growth in proportion of population aged 65-84 and >85 to 2036	14
Figure 7: Suffolk and North East Essex STP Clinical Vision	21
Figure 8: East Suffolk and North East Essex NHS Foundation Trust’s Strategy	22
Figure 9: Future Care Model.....	22
Figure 10: Current theatre allocation for Trauma and Orthopaedics	33
Figure 11: Post-ECC theatre allocation for Trauma and Orthopaedics	33
Figure 12: Projected bed occupancy for a 48-bed Orthopaedic Centre in 2041.....	36
Figure 13: Projected bed numbers required for the Orthopaedic Centre in 2024/25.....	37
Figure 14: Projected bed numbers required for the Orthopaedic Centre in 2029/30 (mean 40 beds)....	37
Figure 15: Projected bed numbers required for the Orthopaedic Centre in 2041/42 (mean 50 beds)....	37
Figure 16: Trauma Arthroplasty - % THR at Colchester Hospital.....	41
Figure 17: Trauma Arthroplasty - % THR at Ipswich Hospital.....	42
Figure 18: Redesign existing space at Colchester: Option 2.....	53
Figure 19: New build at Ipswich and new build day surgery unit at Colchester: Option 3A.....	54
Figure 20: New build at Ipswich and new build day surgery unit at Colchester: Option 3B.....	55
Figure 21: New build and day surgery at Colchester: Option 4B	56

Figure 22: Longlist sifted to shortlist using Hurdle Evaluation Criteria 60

Figure 23: Project Governance Structure for Business Case development..... 74

Figure 24: Governance Structure for Estates Design Development and Operational Commissioning. 74

Appendices

- 1: Feedback from Stakeholder Engagement
- 2: Equality Analysis (EA)
- 3: Travel Impact Assessment (TIA)

Foreword

We are pleased to present this case for change which sets out the rationale and evidence for changing how adult elective orthopaedic services are configured in the best interests of patients.

Suffolk & North East Essex Integrated Care System is already demonstrating its effectiveness as a health and social care system which has been recognised nationally in 2018 through the award of capital development funding of £69.3 million for our Building for Better Care Programme.

This proposal is a vital part of the ongoing transformation of health and social care across our Integrated Care System, following the successful merger of Ipswich and Colchester hospitals, and will help us to deliver sustainable hospital-based services for the future. As part of the Building for Better Care Programme, we propose to build a new centre for adult elective orthopaedics and to replace the day surgery and endoscopy units on the Colchester Hospital site.

During our pre-consultation engagement we have been speaking to the patients, carers and the public we serve, and with our stakeholders, and listening to their thoughts on our proposals. We are confident that the findings from this phase, and our detailed discussions with our clinicians, helped us to gain the support of the East of England Clinical Senate following their independent review of our change proposals. Successful completion of the NHS England / NHS Improvement assurance process should allow us to launch the public consultation early in 2020.

Our governing bodies and board fully support development of this single elective care centre for orthopaedics which will provide:

- Around 48-56 high-specification inpatient beds built to latest standards;
- Up to 6 brand new state-of-the-art laminar flow operating theatres;
- Improved capacity and facilities for orthopaedic trauma at both main sites; and,
- A focus on joint replacement and revision work in the new centre – e.g. hips, knees, etc.

Key benefits for our patients and staff as a result of the new centre will include:

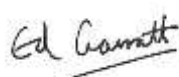
- Shorter waiting times for surgery and shorter stays in hospital;
- Reduced risk of cancellation of surgery;
- Better clinical outcomes from the standardisation of care;
- Improved patient and staff experience of the physical environment;
- Creation of opportunities for training, education, research and innovation;
- Support for new models of care to reduce the need for travel to hospital facilities;
- Delivery of clinically and financially sustainable hospital-based services; and,
- Support for the ongoing transformation of health and social care across the ICS.



Dr Hasan Chowhan
Chair NEE CCG



Dr Mark Shenton
Chair I&ES CCG



Dr Ed Garrett
Chief Officer



Helen Taylor
Chair ESNEFT



Nick Hulme
Chief Exec ESNEFT

1. Introduction and Background

This section describes the purpose and structure of this paper. It also introduces ESNEFT and the work that led to the development of this document.

1.1 Purpose of this pre-consultation business case

1.1.1 This paper describes how STP capital funding of the ‘Building for Better Care’ programme will support developments in elective care that deliver patient benefits and contribute to clinical and financial sustainability across the Suffolk and North East Essex Integrated Care System (ICS). It includes the strategic rationale for change, a description of the elective care strategy for the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) with improved care pathways and new models of care, a description of the capital estates projects which support these clinical service models along with an assessment of the risks and benefits and identification of the preferred way forward.

1.1.2 The formation of ESNEFT is the most important transformation programme in the Suffolk and North East Essex plan to deliver sustainable, high quality acute and community healthcare for the ICS. The merger has created a platform for extensive transformation with the extended clinical teams formed now able to offer services at scale, enabling significant improvements in quality of care, better access to clinical trials, help to address staff shortages and delivery of greater efficiency with patient volumes exceeding those of many tertiary centres.

1.1.3 The STP capital investment is essential to allow the restructuring of key elective and emergency pathways and to create a stable, community-integrated and responsive Trust serving around 800,000 people. The investment in acute reconfiguration is a key element of the wider transformation plan to deliver improved clinical pathways. This is made possible by investment to improve access to integrated urgent and emergency care; diagnostic imaging; and, high quality elective facilities. Much of the STP/ICS plan is dependent on these care pathway optimisations and without the capital investment, the merger would just have been a corporate transaction that would not have unlocked the opportunities for clinical transformation and would not deliver the benefits of improved quality, access and experience for patients.

1.1.4 The STP capital bid covered the following schemes:

- Emergency and Urgent Care Pathway
 - Diagnostic Imaging (MRI and CT)
 - Estate rationalisation
 - Day case elective care
 - Inpatient elective care
- Business Case One (Stream One)**
(No public consultation required)
- Business Case Two (Stream Two)**
(Following public consultation)

1.2 Structure of this document

1.2.1 This paper is structured as follows:

Section 1: Introduction and background. This section introduces the East Suffolk and North Essex NHS Foundation Trust (ESNEFT), the East Suffolk and North East Essex Integrated Care

System (ICS) and the work developing the Pre-consultation Business Case (PCBC).

Section 2: Strategic case. This section sets out the context within which ESNEFT delivers its services and the 'strategic rationale' for the proposed reconfiguration of elective care.

Section 3: Clinical case. This section describes the emerging elective care strategy for ESNEFT and the post-merger opportunities for reconfiguration to improve elective care pathways along with the potential benefits for patients, families, carers and the newly created ICS.

Section 4: Estates options to support clinical service reconfiguration. This section describes the issues to be addressed and the estates options, which could support the reconfiguration of elective care along with an assessment of the risks and benefits of each option and identification of the preferred way forward.

Section 5: Communication and engagement. This section details the process undertaken to engage the public, staff and other stakeholders during the pre-consultation phase and demonstrates how their feedback shaped the development of potential options.

Section 7: Assurance of service change. This section provides evidence that the proposals comply with the Government's tests for service change and NHS assurance checks.

1.3 Arrangements for development and oversight

- 1.3.1 The design and scope of the new elective care services has been achieved by collaborative working with all stakeholders across ESNEFT and the wider health and social care system. Relevant groups of consultants and senior nurses recommended an initial approach of identifying the top conditions for patients using existing adult elective orthopaedic inpatient services, and studying the pathways these patients followed. This approach has enabled a focus on evolving existing pathways for real patients into a single centre for elective orthopaedic surgery model, before consideration of the actual physical building required, which is intended to make transition into a new environment seamless and effective from the start.
- 1.3.2 Professionals from across the health and social care system were an integral part of the pathway mapping work, providing direction on crucial design elements needed for the transformation and ensuring our patients would receive the right care, in the right place, safely. Those involved included, (but were not limited to): therapists, radiographers, consultant surgeons, consultant anaesthetists, nurses, commissioners, GPs and ambulance team leaders.
- 1.3.3 A formal project board was put in place reporting to the established programme board with named senior stakeholders from across the system, together with defined work-streams offering a 360° approach to project delivery. These work streams are:
- Clinical Pathways, Activity, Finance & Workforce
 - Engagement & Communications
 - Estates Design & Build
- 1.3.4 A formal governance structure, illustrated below, has been established to manage the process of pre-consultation engagement and to provide oversight of the strategic analysis and the development of the PCBC. Regular updates have been provided to the relevant governance boards and, at the working level, key operational staff have been kept informed and felt involved in project progress.

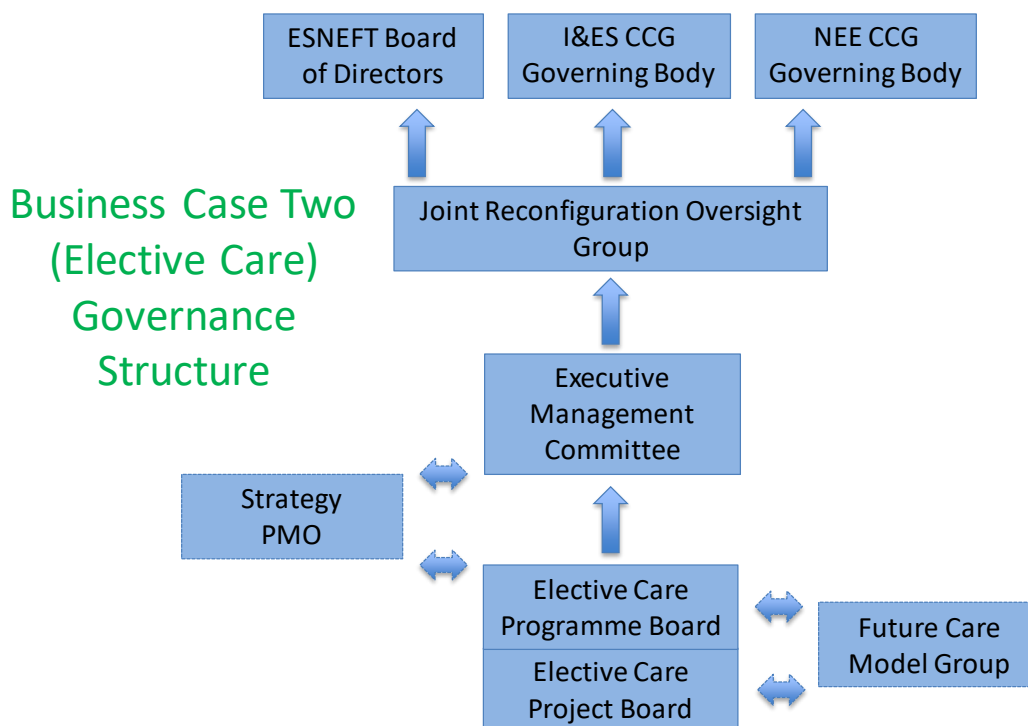


Figure 1: Governance Structure – Pre-consultation Business Case Two (Elective Care)

Joint Reconfiguration Oversight Group

1.3.5 The I&ES CCG and NEE CCG Governing Bodies and the ESNEFT Board of Directors authorised the formation of a Joint Reconfiguration Oversight Group to maintain a strategic overview of ICS clinical reconfiguration projects and to provide advice to their respective Governing Bodies and Board, who will jointly oversee the governance of the public consultation, and the decision making and approvals process. This group is chaired by the ICS lead/Chief Officer for the CCGs and the ESNEFT Chief Executive, supported by the Deputy Chief Officer for the CCGs and ESNEFT’s Director of Strategy, Research and Innovation, Director of Communications and Engagement, Director of Estates and the Director of Clinical Strategy Implementation. This group has significant clinical representation in the form of the chairs and clinical leads of both CCGs along with the ESNEFT Chief Medical Officer. It also has patient representation in the form of the chief executives from both Healthwatch Essex and Healthwatch Suffolk.

Future Care Model Group (Clinical Reference Group)

1.3.6 A clinically-led Clinical Strategy Advisory Group was established in June 2018 to lead the development of the clinical services strategy (and to identify the clinical requirements for supporting strategies such as ICT, Estates and Quality) for consideration by the Board in January 2019. Following adoption of the new ESNEFT Strategy this group was re-named the Future Care Model Group and became a clinical reference group to develop and validate new models of clinical care. The group meets monthly chaired by the Medical Director and reports to the Executive Management Committee (EMC). The group includes all the most senior clinicians at ESNEFT along with representatives of the Medical Staff Committee, GPs and commissioners.

Strategy Programme Management Office (PMO)

- 1.3.7 The key purpose of the Strategy PMO is to ensure that the trust strategy developed in a co-ordinated way to the agreed timescale ensuring that it informs, and is informed by, the Suffolk and NE Essex ICS plan. The group is responsible for the preparation of the final documentation and will oversee its communication. The PMO meets weekly and is chaired by the Executive Director of Strategy, Research and Innovation. The PMO includes the Medical Director, the Director of Communications and Engagement, the Director of Human Resources and Organisational Development, the Director of Estates and Facilities, the Director of Clinical Strategy Implementation, the Programme Director, the Associate Directors of Finance along with senior representatives from other corporate functions.

Elective Care Programme Board

- 1.3.8 The Programme Board's role is to provide oversight for Elective Care and to ensure compliance with agreed targets, including delivery of the benefits identified in project charters. The programme board, chaired by the Director of Operations with responsibility for Elective Care and the Deputy Chief Officer/Chief Transformation Officer – Suffolk CCGs, reports to the Executive Management Committee (EMC).

Elective Care Project Board

- 1.3.9 The Elective Care Project Board's role is to provide oversight for Business Case Two (Elective Care) and to ensure compliance with the agreed project scope, including delivery of the benefits identified in the funding application. The project board, chaired by the Director of Operations with responsibility for Elective Care and the Deputy Chief Executive/Director of Strategy and Transformation – Suffolk & NEE CCGs supported by the Director of Clinical Strategy Implementation and reports to the Elective Care Programme Board. The project Board includes the Clinical Directors for the Division of MSK and Specialist Surgery and the Division of Surgery and Anaesthetics along with local GPs and other senior clinical and managerial representatives.

Elective Care Centre Working Group

- 1.3.10 The Elective Care Working Group is chaired by the Clinical Director for MSK and includes consultant orthopaedic surgeons, consultant anaesthetists, senior nurses and AHPs representing both main sites along with the Director of Clinical Strategy Implementation, the Associate Directors of Operations and Nursing for MSK and Specialist Surgery and representatives of the various corporate functions such as workforce, communications, ICT, finance, commissioning and information.

Elective Care Centre Engagement Group

- 1.3.11 The Elective Care Centre Engagement Group meets fortnightly and is chaired by the Director of Communications and Engagement. The group includes the Director of Clinical Strategy Implementation, the Head of External Engagement, the Head of Communications for the CCGs, the ESNEFT membership engagement officer and an external academic with expertise in public engagement and consultation.

2. Strategic Case

This section sets out the national and local context within which ESNEFT delivers its services and the 'strategic rationale' for the proposed reconfiguration of elective care.

2.1 The national context

NHS Five Year Forward View (2014)

2.1.1 The NHS Five Year Forward View was published in October 2014 and set out a new shared vision for the future of the NHS based around the new models of care required to meet the changing needs of patients, new treatment options, and specific challenges such as mental health, and support for frail older people. One of the underpinning principles of the 'Five Year Forward View' strategy is that the NHS will "take decisive steps to break down the barriers of how care is provided" to dissolve the traditional barriers between primary and acute boundaries, physical and mental health boundaries, and health and social care boundaries. The future will see more care provided locally with some services provided in specialist centres. This will be supported with investment into health technology and improvements in the NHS' ability to do research and use innovation. The gap between resources and patient need continues to grow and the vision seeks to ensure money is invested wisely.

2.1.2 The NHS Operational Planning and Contracting Guidance (2016/17 – 2020/21) to deliver the Forward View sets out the clear list of national priorities and longer-term challenges for local systems. This set a requirement for the NHS to produce a one-year organisational Operational Plan for 2016/17, consistent with the emerging STP, and a five-year Sustainability and Transformation Plan (STP) to drive the Five Year View forward.

2.1.3 The 'must dos' for local systems included:

- Returning the system to aggregate financial balance with secondary care providers delivering efficiency savings through the Lord Carter productivity work programme;
- Improvement against and maintenance of referral to treatment standards and achievement of access standards for A&E, ambulance waits and cancer targets;
- Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020;
- Quality and productivity improvements.

Next Steps on the Five Year Forward View (2017)

2.1.4 The NHS England business plan from 2017 took on the form of Next Steps on the NHS Five Year Forward View. This document reviewed the progress made and set out a series of practical and realistic steps to deliver a better more joined up and more responsive NHS in England. The document reinforced the focus on: involving and consulting with patients and the public; promoting equality and reducing health inequalities; and, the quality of services including improvements in access. A key commitment was support for STP proposals that seek to split 'hot' emergency and urgent care from 'cold' planned surgery clinical facilities to allow efficient use of beds for planned surgery, avoiding the risk of cancelled operations from emergency admissions.

NHS Long Term Plan (2019)

- 2.1.5 A new ten-year plan for the NHS to improve the quality of patient care and health outcomes was published in January 2019 and set out how the £20.5 billion budget settlement for the NHS will be spent. The plan focuses on building an NHS fit for the future and includes measures to prevent heart attacks, stroke and dementia and to improve access to mental health services.
- 2.1.6 The additional spending will need to deal with current pressures and demographic changes as well as new priorities. Organisations will need to:
- Return to financial balance;
 - Achieve cash-releasing productivity growth;
 - Better manage growth in demand for care;
 - Reduce variation across the health system;
 - Make better use of capital investment and its existing assets to drive transformation.

Sustainability and Transformation Partnerships

- 2.1.7 Sustainability and Transformation Partnerships (STPs) were announced in NHS Planning Guidance published in December 2015. NHS organisations and local authorities in different parts of England (44 in total) have come together to develop ‘place-based plans’ for the future of health and care services in their area. Final plans were submitted in October 2016.
- 2.1.8 STPs offer a new way of working for health and social care services locally, focusing on delivering health and care services defined by local area boundaries, not by local organisational boundaries. The aims are to:
- Improve the health and wellbeing of local people;
 - Improve the quality of local health and care services;
 - Deliver financial stability and efficiencies throughout the local health care system.
- 2.1.9 From April 2017, STPs became the single application and approval process for accessing NHS transformation funding. The proposals in this PCBC are in line with the STPs primary objectives. Following publication of the NHS Long Term Plan (2019), STPs/ICs must develop and implement their own five-year strategies, which set out how they will turn the ambitions into local action.

The Naylor Review (2017)

- 2.1.10 The Naylor Review (NHS Property and Estates: why the estate matters for patients) was published in March 2017 and identified the scale of the challenge to ensure the NHS has the buildings it needs but also the scale of the opportunities within the estate. Naylor called on STPs to develop robust capital plans, aligned with clinical strategies to maximise value for money and address backlog maintenance issues. The report indicates that the costs of backlog maintenance across all STPs could be as much as £10 billion.
- 2.1.11 The government response to the review (January 2018) agreed with the primary conclusion that the NHS “must manage and use its estate more efficiently and strategically, whether by selling land and buildings that it no longer needs to deliver clinical services or using it to develop new services in line with modern thinking or to provide housing for NHS staff”.

The Carter Report (2016)

- 2.1.12 In February 2016, Lord Carter presented his independent report for the Department of Health ‘Operational Productivity and Performance in English NHS Acute Hospitals: unwarranted variations’. This report focused on key areas of potential efficiency gains and made recommendations as to how these could be achieved between 2016 and 2020. The report identified that the NHS could save circa £5 billion if the unwarranted variations in running costs, sickness absence, infection rates and prices paid for supplies and services were addressed. Of this saving £2 billion was associated with the workforce budgets and potential savings that could be achieved through better use of clinical staff, reducing agency costs and staff absence and good people management practices.
- 2.1.13 In response to the report, NHSI introduced the concept of the ‘Model Hospital’ as a strategic data and information tool to support improvement and demonstrate what ‘good’ looks like. The estate is also identified in the Carter Report as one of the areas trusts should focus on as part of an overall drive to increase productivity and improve efficiency. The impetus to achieve provider-level efficiencies through estates planning has since been incorporated into planning guidance as part of the ‘must do’ priorities for achieving financial sustainability of the NHS.
- 2.1.14 The projects in the Building for Better Care programme will deliver some efficiencies in relation to space utilisation and ratio of clinical to non-clinical space. Uniformity of service provision has also been an important focus for the Trust across the two hospital sites in terms of future models of care in line with the Carter recommendations on reducing unwarranted variation. New facilities and leading edge models of care will support workforce and clinical sustainability and the recruitment and retention of staff leading to a reduction in bank and agency costs.

Care Quality Commission

- 2.1.15 The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England including monitoring, inspecting and rating services. Provision of care is assessed in five domains. The CQC visited both main hospital sites (and the community hospitals in Ipswich and East Suffolk) in July 2019 and the first ESNEFT ratings published in January 2020 are detailed in the following table.

	Safe	Effective	Caring	Responsive	Well-Led	Overall
ESNEFT	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Colchester Hospital	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Ipswich Hospital	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Community Hospitals	Good	Good	Good	Good	Good	Good

Table 1: Current CQC ratings for ESNEFT

2.2 The local context

Sustainability & Transformation Partnership (STP)

- 2.2.1 The Suffolk and North East Essex STP, formed in 2016, developed a five-year plan to improve the health and care of local people and bring the system back into a financially sustainable

position. The STP plan set out to deliver the vision for people across Suffolk and North East Essex to live healthier, happier lives by having greater choice, control and responsibility for their health and wellbeing. The plan has three priorities for creating a sustainable healthcare system: resilient communities; managing demand; and, acute reconfiguration.

2.2.2 Within the STP, the respective North East Essex and Suffolk strategic estates partnerships have formed a single strategic estates forum to oversee the changes required. The changes with direct relevance flow predominantly from the Hospital Reconfiguration and Transformation programme which aims to reconfigure the estate to reduce running costs; support the delivery of care in appropriate settings; ensure providers meet estate and related compliance requirements; release surplus estate and improve utilisation of the remaining estate.



Figure 2: The Suffolk and North East Essex vision

Suffolk & North East Essex Integrated Care System (ICS)

2.2.3 An increasing national and local focus on developing integrated models of care has been coupled with a strong emphasis on delivering more care in the community. The focus on integrated care increasingly involves hospitals working in partnership with community services, social services and with general practice to deliver joined up care. Since its inception, the STP developed rapidly with strong relationships between partner organisations. In May 2018, NHS England and NHS Improvement formally designated the STP as a shadow Wave 2 Integrated Care Systems and in April 2019, Suffolk and North East Essex became an Integrated Care System.

2.2.4 At the heart of the ICS are three locality alliances that cover Ipswich and East Suffolk, West Suffolk, and North East Essex. Each alliance includes NHS, local authority and voluntary sector representation. The ambition is to improve health, wellbeing and care functions for the areas they serve and provide community services for local people closer to home by bringing local organisations together under new commissioning arrangements. The alliances are committed to working together to integrate care and to create one clinical community which will have significant scale - 953,000 residents across two counties; three acute hospitals; eight community hospitals; 104 GP practices; two mental health trusts; with spending of £2.4 billion of public funds each year. The ICS is designed to deliver system plans to integrate care and deliver a seamless experience and better outcomes for patients.

2.3 The East Suffolk and North Essex NHS Foundation Trust

2.3.1 East Suffolk and North Essex NHS Foundation Trust (ESNEFT) was formed on 1 July 2018 through the merger of Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust. The formation of ESNEFT is a major transformation programme in the STP plan creating sustainable, high quality acute and community healthcare for the population in the area. The merger has created a platform for extensive transformation with the extended clinical teams formed now able to offer services at scale, enabling significant improvements in quality of care, better access to clinical trials, help to address staff shortages and delivery of greater efficiency. The merger also provides a strong platform for ESNEFT to support and shape the medium-term transformation of the health and social care system in the region. For example, working in close partnership within the ICS, providers will be able to:

- Support the drive towards integrated care. Work constructively with other providers across the East of England to secure and maximise the local delivery of tertiary work;
- Work with academic and NHS partners to secure the full potential of academic partnerships and establish ESNEFT as a centre excellence for research, education, and innovative, clinically-led services that improve the health and wellbeing of patients.

2.3.2 The service portfolios of the two pre-cursor trusts were very similar, except that since 2017 Ipswich had also been responsible for the provision of community health services in East Suffolk. The trusts had a history of working together in the provision of services including:

- Complex vascular services, provided from the Colchester Hospital site;
- ENT on-call services, provided on an alternate night and weekend basis from each site;
- Interventional radiology services, with an integrated on-call rota covering both sites;
- Orthodontic services with the Ipswich service providing for North East Essex referrals;
- Spinal surgery, provided from the regional centre on the Ipswich Hospital site; and
- Pathology Services with both pre-cursor trusts (and West Suffolk Hospitals) being partners in the integrated North East Essex & Suffolk Pathology Service (NEESPS).

2.3.3 The Trust provides hospital and community health care services for Colchester, Ipswich and local areas from Colchester and Ipswich hospitals, Aldeburgh, Clacton, Halstead, Harwich and Felixstowe community hospitals and Bluebird Lodge near Ipswich. Both Colchester and Ipswich hospitals have major Accident and Emergency (A&E) Departments. Key facts and figures for the Ipswich and Colchester Hospital and community services in 2018/19 which now form part of the Trust are summarised in Table 2 on the following page.

East Suffolk and North Essex NHS Foundation Trust 2018/19			
Local catchment	742,757		
Turnover (2018/19)	£ 704,722,000		
Employees (Headcount)	10,000+		
	Colchester Hospital	Ipswich Hospital	ESNEFT Totals
Bed numbers	549	560	1,109
Elective admissions	48,720	52,198	100,918
Emergency admissions	49,181	45,633	94,814
A&E attendances	102,623	89,693	192,316
Community attendances	-	436,780	1,427,898
Outpatient attendances	403,221	587,897	

Table 2: Key data for Ipswich and Colchester Hospitals

Catchment population

2.3.4 The widely accepted definition of the catchment population needed to support most specialist services normally available at major regional hospital is 1 million, and the referral population for some of ESNEFT’s specialist services (such as radiotherapy and spinal surgery) already exceed that, while ESNEFT currently serves a local catchment population of around 800,000. However, a number of factors could push the immediate catchment over 1m:

- The local baseline population is forecast to grow significantly by 2041 taking ESNEFT close to the 1m population threshold.
- There is major reconfiguration across the three hospitals in South Essex comprising the MSB Group (Mid Essex (Chelmsford), Southend and Basildon). The three acute hospitals in Norfolk (Norfolk & Norwich, Queen Elizabeth (King’s Lynn) and James Paget (Great Yarmouth)) have also agreed to work more closely together. As clinical services are reconfigured, and specialist services move, then for a segment of the population ESNEFT may become the closest major acute centre.
- Braintree DC is included in the 1.2 million catchment of MSB Group because services are commissioned by Mid Essex CCG (though Colchester is the nearest acute hospital). It will be important to develop attractive services for this segment of local population.

2.3.5 An examination of the geographic overlaps between the catchment areas of the two former trusts was undertaken to establish the extent to which the catchments overlapped for adult admitted patients and outpatient referrals. The analysis showed that only 6% of referrals originated from the overlapping 80% catchment area. In other words, whilst many of the services provided by the former trusts were similar, they were in fact provided to different but complementary catchment populations with loyalty largely to their nearest hospital. This tradition of patient loyalty to their nearest hospital, highlighted again during pre-consultation engagement, is an important factor influencing the preferred location for new developments. The proposal to create a Centre would leave choice of provider unchanged but would result in a small reduction in choice of site for an element (adult elective inpatient care) for orthopaedics for a relatively small number of patients (1,400) more than offset by the benefits offered.



Figure 3: ESNEFT Catchment Populations

Specialist services

2.3.6 Colchester and Ipswich already provide a number of specialist services. Although some clinical specialities cross-refer patients, there are services which one site currently provides where the other site refers to different tertiary providers due to previous clinical network arrangements. Referral patterns will be harmonised where appropriate to allow specialist services to be provided as locally as possible to keep patient travel time to a minimum. In certain specialities, the combined activity generated from both sites will allow the trust to work with commissioners to develop options to offer new specialist services that are not currently available locally.

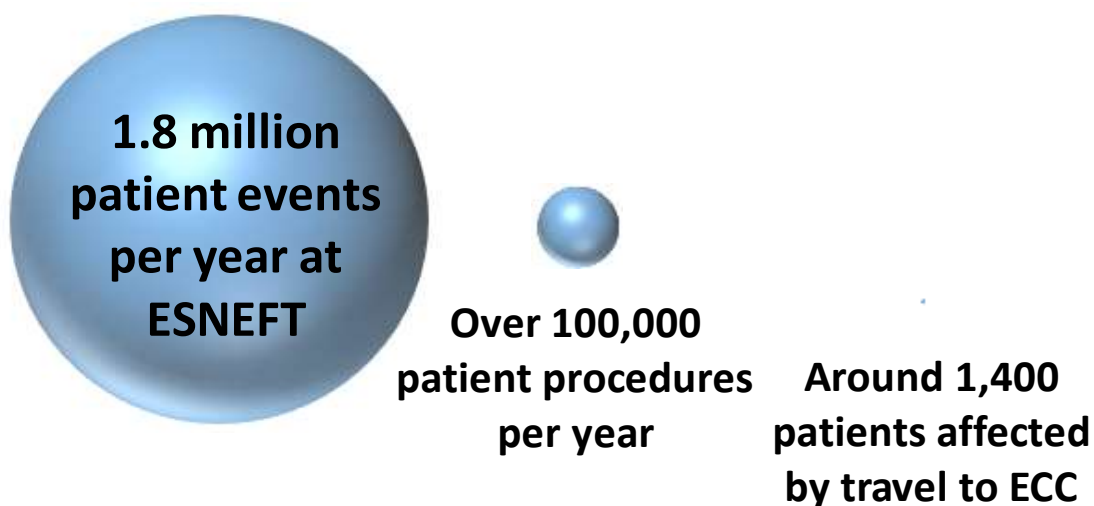


Figure 4: Patients potentially affected by travel to a Centre for Elective Orthopaedics

Commissioners

CCG Title	Contract Type	%
NHS Ipswich and East Suffolk CCG	NHS Acute and Community	40.7%
NHS North East Essex CCG	NHS Acute and Community	36.0%
NHS Mid Essex CCG	NHS Acute and Community	3.7%
NHS West Suffolk CCG	NHS Acute and Community	1.4%
Other CCGs	NHS Acute and Community	1.4%
NHS England – Midlands and East (East of England)	NHS England Specialised Services	12.7 ¹ %
NHS England – Midlands and East (East of England)	NHS Health & Justice, Public Health, Secondary Dental, Armed Forces	1.8%
Other commissioned income	Various	2.3%

Table 3: ESNEFT’s Commissioners

Fixed points

- 2.3.4 In supporting the case for the partnership and the formation of ESNEFT, the STP agreed that both main hospital sites in Colchester and Ipswich would retain the following as ‘fixed points’ in any clinical reconfiguration: full 24/7 Emergency Department services; undifferentiated 24/7 medical emergency admissions; and, 24/7 consultant-led maternity services.
- 2.3.5 The retention of these services on both hospital sites means that a number of related clinical speciality and diagnostic services will also need to be provided on both sites as part of the emergency core services; therefore, the scope for radical clinical service reconfiguration is significantly reduced. Options such as a ‘hot/cold’ split of services across sites; and, centralisation of consultant-led maternity services have therefore not been included in developing the strategic case since these are largely precluded by the commitment to provide these ‘fixed point’ services on two sites.

STP/ICS capital schemes

- 2.5.8 A total of £69.3m in sustainability and transformation (STF) capital funding was allocated to the hospitals in April 2018 (subject to business case approval) for a number of service improvement and clinical reconfiguration schemes. As the NHSI and HM Treasury approvals process needs to reflect the totality of STP/ICS capital funding, the working assumption is that these schemes will form a “whole” amounting to £69.3m of capital investment; however, to prevent potential delay of the investment not subject to a requirement for public consultation, two business cases streams have been developed. Whilst Business Case One (Emergency Care) is already well advanced, preparation of Business Case Two (Elective Care) would only follow if there is a decision to proceed following public consultation on the proposal for an orthopaedic centre.

2.4 The case for change

- 2.4.1 This sets out the context within which ESNEFT delivers services and the strategic rationale for clinical reconfiguration. In summary, the healthcare burden is growing at an unsustainable rate.

¹ Of which approximately 0.1% relates to elective orthopaedic activity and the remainder to specialist spinal.

The catchment population is growing, and becoming older

2.4.2 ESNEFT serves a catchment population of around 800,000 including the large towns of Colchester and Ipswich, extensive rural populations and smaller market towns, traditional coastal resorts, major port facilities, universities and armed services garrisons. There is some outward flow of patients to the Norfolk & Norwich Hospital and James Paget Hospital in the north, West Suffolk Hospital, to the west, and Broomfield Hospital in Chelmsford to the south. Population projections and housing growth plans in ESNEFT’s catchment are significant. The growth rates are particularly high in the population aged 65+ and 85+. The main population served is drawn primarily from six second-tier local authorities as shown in the table below.

Population (000s)	Male	Female	2016 estimate	2036 estimate	% growth
Babergh DC	43	46	89	97	9%
Colchester BC	91	93	184	219	18%
Ipswich BC	68	68	136	148	8%
Mid Suffolk DC	49	50	100	112	12%
Suffolk Coastal DC ²	61	64	125	133	6%
Tendring DC	68	73	141	162	16%
ESNEFT Catchment	-	-	776	871	12%

Table 4: Principal catchment Tier 2 local authority areas (Public Health England 2017)



Figure 5: Map showing the local area served by ESNEFT including main and community hospital sites

Greater numbers of people with complex health and care needs

2.4.3 Older patients account for the majority of health expenditure. Nearly two-thirds of people admitted to hospital are aged over 65 and this group accounts for nearly 70% of all hospital emergency bed days³. When they are admitted to hospital, older people tend to stay longer and are more likely to be readmitted.⁴ The portion of ESNEFT’s catchment population already in this age group exceeds national averages and, according to ONS predictions for ESNEFT’s

² Suffolk Coastal DC and Waveney DC merged to form East Suffolk DC in April 2019. The data relates to the Suffolk Coastal catchment only because the Waveney catchment is largely served by the James Paget Hospital.

³ King’s Fund (2011), “Older people and emergency bed use: exploring variation”, Candace Imison et al.

⁴ King’s Fund (2012), “Continuity of care for older hospital patients: A call for action”, Jocelyn Cornwell et al.

catchment area, this 65+ cohort projected to grow by 50%, from 184,000 to 276,000, over the next 20 years. Over the same period, the population aged 80-89 is expected to grow by 80% to 74,000 and the population aged 90 or over is expected to grow by 162% to 24,500.

- 2.4.4 People with one or more long-term conditions are already the most important driver of demand for NHS services. Those with more than one long-term condition have the greatest needs and consume more healthcare resources. The 30% with one or more of these conditions account for £7 out of every £10 spent on health and care in England⁵.
- 2.4.5 Because older people are more likely to experience long term conditions and because of the ageing population, demand for healthcare is expected to continue to rise. Specifically, the number of frail older people with significant complex physical health, mental health and social care needs will continue to rise.

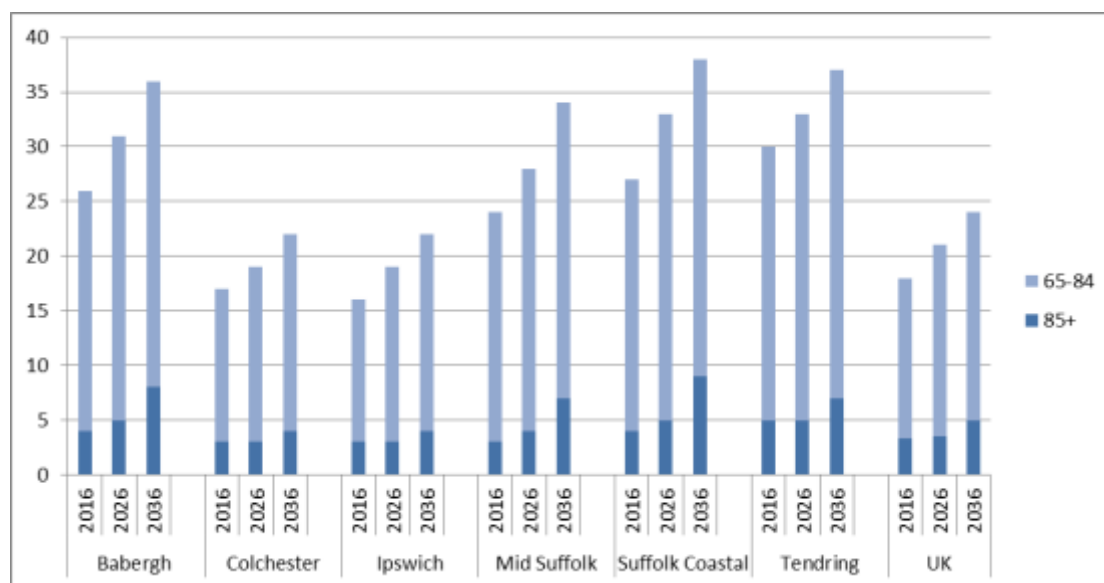


Figure 6: Projected growth in proportion of population aged 65-84 and >85 to 2036

- 2.4.6 Constrained resources coupled with growing demand are placing substantial and increasing strain on the health and social care system and, in particular, on acute hospital services.

Workforce sustainability

- 2.4.7 It is becoming increasingly difficult to attract and retain staff in all health service sectors. The experience locally is consistent with national reporting, where it is projected that across the NHS with no action an additional 190,000 staff will be required by 2027 but, with current rates of recruitment, only 72,000 will be recruited. The NHS planning guidance reconfirmed the commitment to seven-day working which would have required a 14% increase in the workforce across both hospital sites before the merger.
- 2.4.8 Additional local factors affecting recruitment and retention include the proximity to London and the legacy of regulatory action at Colchester Hospital. These pressures are not unique to the acute sector; recruitment and retention challenges are also being faced in the community and general practice sectors. In addition, estimates from Health Education England (HEE) and

⁵ Department of Health (2012), "Long Term Conditions Compendium" (3rd edition)

local workforce partnerships indicate that many of these staffing shortages are likely to worsen over the next five years.

2.4.9 Several clinical and clinical support specialties are already experiencing long-term recruitment challenges. This affects medical, nursing and allied health professional staff in a number of specialties (including acute medicine, emergency medicine, gastroenterology, endoscopy, respiratory medicine, radiology, pathology and older people's care). Many of these staff shortages are likely to worsen for reasons beyond the control of the new organisation. The workforce for many services will be unsustainable and care to patients will be under threat until the model of service delivery is changed; this must be underpinned by training and the development of new roles to change the skill-mix of staff.

2.4.10 Without the recent merger, the workforce would have been unsustainable and it would have been much more challenging to change the existing model of service delivery. Neither precursor trust would have been able to sustain 24/7 rotas for smaller specialities and, as neighbours, the hospitals competed with each other for the same pool of local staff. The two smaller trusts were also less able to offer recruits a broad variety of training and development experiences and were not well placed to attract the best trainees on deanery approved training schemes. However, since the merger clinical recruitment has improved and both clinical and nursing vacancies have reduced along with spending on clinical agency/locum staff. This improvement is somewhat masked by the pension issue and a higher level of non-clinical posts held vacant to provide non-recurrent support to the delivery of cost improvement plans.

Consequences of local demographic factors

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

- **Impact of a growing population.** The baseline population served by the new trust is forecast to grow in official population estimates by an additional 112,000 (14.1%) by 2041. These projections are expected to be revised upward to take into account the expected housing growth identified in borough and district plans with over 80,000 new homes planned to be in place by the mid-2030s.
- **Impact of an ageing population.** The population served by the new trust is diverse with disproportionately skewed age structures tending towards a larger population of older people in the rural and coastal areas. This 65+ population is the fastest growing cohort and includes the highest users of T&O services.
- **Economically inactive populations.** Linked to the overall growth of the population, higher than average dependency scores particularly reflect the higher proportion of economically inactive members of the population – both children and older people.
- **Life expectancy and underlying morbidity.** There are significant variations in life expectancy, linked to levels of deprivation. The Health Profiles show that in Tendring in particular there are significant underlying factors affecting overall health outcomes.
- **Deprivation.** The levels of deprivation in some parts of Tendring and Ipswich in particular are amongst the worst in the country; these groups require sophisticated strategies to engage them in preventative health care and wellbeing. This factor is

compounded by the effective lack of access to any public transport in Tendring.

- **Minority ethnic groups.** The 2011 census identified lower than national average numbers of people for minority ethnic groups locally: Colchester and Ipswich have ethnic minority populations closer to national average. ESNEFT recognises that services must be more responsive to the needs of black and minority ethnic (BME) groups.
- **Rurality and transport challenges.** The rural catchment area, and river estuaries, create specific issues for parts of the population in accessing care and these issues will become more acute as the transport network is put under growing population pressure.

2.4.12 Both main hospital sites currently experience significant periods where peak emergency acute pressures affect the organisation's ability to sustain both elective and emergency care. An example of this would be the regular use of elective orthopaedic beds and theatre lists for trauma patients at Ipswich leading to the cancellation of elective activity (often on the day of admission). Population growth, particularly in the older, generally frailer, population will exacerbate these pressures due to the higher proportion of these patients needing care and their higher level of acuity. However, initiatives to respond flexibly to help deliver national access standards are easier to deliver at the scale of the new merged organisation. Experience in East Suffolk, where ESNEFT is the community services provider, has allowed greater integration with, and strengthening of, community care. This has supported changes to patient pathways to reduce the need for acute care. Equally, early experience of the new model of urgent & emergency care since the co-located UTC opened at Colchester has been promising. These models will be test cases for how effectively this shift of care can be delivered.

2.4.13 The impact of these demographic challenges means that, without significant change to the way in which the health and social care model operates, the numbers of acute emergency admissions will continue to rise, requiring more beds, staff and hospital-based infrastructure. This model is not sustainable without significant additional investment in staff and facilities, which is most unlikely to become available. However, there are indications that merger has helped ESNEFT to improve recruitment and to develop stronger education and training offers to staff facilitated by stronger partnerships with local education providers to increase the pace at which new roles can be developed to close current and future workforce gaps.

The resulting financial burden is unsustainable

2.4.14 Alongside increases in demand and patient expectations, providing healthcare is also increasingly expensive. New drugs, technologies, standards and treatments are typically more expensive than those they replace. Taken together, the impact of increasing costs and demand is creating a ratcheting financial pressure for NHS providers. These challenges are faced at the same time as the NHS is experiencing its most challenging economic environment since it was created. The Five-Year Forward View⁶ identifies a funding gap of £30bn a year by 2020/21 (approximately 22% of costs in 2020/21) of which the Government has committed to provide £8bn in additional funding to continue the drive towards integrating health and social care and ensuring the NHS provides services on a 7-day basis⁷.

⁶ NHS England (October 2014), "Five-Year Forward View"

⁷ NHS England (4 June 2015), "Five-Year Forward View: Time to Deliver"

2.5 Policy and commissioning response to the challenge

2.5.1 The scale of the challenge facing the health and social care system has been widely recognised and the Five-Year Forward View provided a comprehensive vision for the NHS in 2020.

A relentless focus on efficiency

2.5.2 Having broadly achieved its objective to deliver substantial recurrent efficiency savings of 4% per year since 2008/9 generating £20bn in productivity improvements, the NHS faced a further most significant challenge to deliver another £22bn a year by 2020/21 and a tariff deflator of 2-4% has been used for the last few years to reduce provider income.

2.5.3 The latest guidance⁸ has recognised the scale of the challenge now felt by providers and made 2019/20 a re-set year for the financial framework. The tariff efficiency requirement has been reduced to 1.1%. That said, trusts with a deficit control total are expected to deliver an additional efficiency of 0.5% to be retained by the trust to support financial recovery. However, for most trusts, the opportunities to generate significant traditional efficiency savings are largely exhausted, and increasingly a transformational approach is required across the health and social care system to address the challenge.

Increased focus on developing integrated models of care

2.5.4 An increasing national and local focus on developing integrated models of care is coupled with a strong emphasis on delivering more care in the community. The focus on integrated care will increasingly involve hospitals working in partnership with community services, social services and with general practice to deliver joined up care. The recent designation of the Suffolk and North East Essex STP as a Wave 2 Integrated Care System (ICS) is an indicator of the progress that has already been made in partnership working.

A sustained drive for higher quality and better outcomes

2.5.5 Patients and the public have high expectations for the quality and safety of the care they receive. There is a high level of public interest, and an increasing level of public and regulatory scrutiny of the quality of care provided by the NHS. This is underpinned by a growing number of standards, many requiring additional investment, and a drive to centralise specialist services. The high-profile Francis⁹, Berwick and Keogh reports are illustrative of the focus in the NHS on quality and quality assurance.

2.5.6 For core hospital services, a key current focus is to ensure that patients have access to hospital care, delivered by consultants with the requisite sub-specialty skills, 7-days a week, and (where appropriate) 24-hours a day. Nationally set clinical standards for 7-day services present all acute providers with a challenging need for investment¹⁰.

2.5.7 For specialist services, there is good evidence¹¹ that an increasing number of clinical services are better concentrated in fewer centres undertaking higher volumes of activity. As a result, the drive to consolidate services as a means of raising quality and improving value for money

⁸ NHS England and NHS Improvement (10 January 2019), "NHS Operational Planning and Contracting Guidance 2019/20"

⁹ "The Mid Staffordshire NHS Foundation Trust, Public Inquiry", Sir Robert Francis, The Stationery Office, 2013

¹⁰ NHS England (2013), six of the ten from "Clinical Standards for Seven Day Working" by Jatinder Harchowal

¹¹ The King's Fund (November 2014), "The Reconfiguration of Clinical Services – What is the Evidence?"

is now a well-established trend:

- For major trauma^{12,13}, cancer¹⁴ surgery¹⁵ and myocardial infarction¹⁶ the benefits of centralisation of care are also based on sound evidence;
- There has been considerable change in the structure of vascular services¹⁷ nationally since 2009, either through consolidation onto a single site or through clinical networks. It is no longer acceptable to provide vascular cover outside a fully centralised service or a formalised clinical network with a designated single site for all arterial interventions.
- Modernising Radiotherapy services with the introduction in 2018¹⁸ of minimum number of consultants per tumour group and minimum number of cases per clinical oncologist.
- There is increasing recognition that complex gynaecology and maternity services should be co-located with the provision of Level 2 (HDU) and Level 3 (ITU) care.

2.5.8 Getting It Right First Time¹⁹ (GIRFT) is now a national programme designed to improve medical care within the NHS by reducing unwarranted variations; however, GIRFT began as a pilot within orthopaedic surgery led by orthopaedic surgeon Professor Tim Briggs. The programme now comprises 40 surgical and medical specialities, each led by a prominent speciality clinician. Speciality reports look at a wide range of factors, from length of stay to patient mortality, and individual service costs through to overall budgets and provide insights for participating trusts.

2.6 Safety and sustainability of medium sized district general hospitals

2.6.1 The STP's clinical vision outlines a continuum of care from self-help and independence through community-based care to hospital care, with an intention to shift care towards self-help and away from hospital care where this can be achieved safely and with high quality. The impact of this movement is that the services that continue to be provided in hospital settings are going to become increasingly complex.

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

- The lack of clinical viability for small and low volume services. Where the local DGH site catchment population does not generate sufficient demand to support the number of clinical experts or facilities required to sustain 24/7 services, patients have to travel to larger, more distant centres for some procedures. For Colchester Hospital patients this is mainly to Basildon or London and for Ipswich Hospital to Norwich or Cambridge.
- The development of increasing sub-specialisation of medical and surgical services. With a move away from generalist services, there is less ability for specialists to cross-cover

¹² "An Evaluation of the Effect of Trauma-Center Care on Mortality". Mackenzie E et al. N Engl J Med 2006

¹³ Relationship between Trauma Center Volume and Outcomes. Nathens A et al. JAMA. 2001; 285:1164-1171

¹⁴ "Cochrane Database of Systematic Review" (14 March 2012)

¹⁵ "Outcomes, research and surgeons". Birkmeyer JD. Surgery 1998; 124: 477-83

¹⁶ "Why does primary angioplasty not work in registries? Quantifying the susceptibility of real world comparative effectiveness data to allocation bias". Sen, S. American Heart Association (Nov 2012)

¹⁷ "Provision of Vascular Services". VSGBI 2012

¹⁸ "Specification - Adult External Beam Radiotherapy Services delivered as part of a Radiotherapy Network", NHS England, 2018

¹⁹ <http://gettingitrightfirsttime.co.uk>

and take part in shared clinical support rotas to provide care for emergency patients. The different rota arrangements that have developed over time at Colchester and Ipswich have made harmonisation of models of care problematic in some specialities.

- Evidence regarding improved clinical outcomes. For specialised procedures, larger centres undertaking a higher number of treatments often have better outcomes. This can lead to smaller units being unable to meet national standards with the result that these previously locally delivered services are lost to larger centres.
- The difficulty attracting the right quality of staff to sustain services in DGH settings.
- The increasing use of high cost capital assets in the delivery of specialist treatments, for example the increasing use of laparoscopic surgery, interventional radiology and surgical robots, where the economics of capital investment and return are only justified if larger catchment populations for services are considered.
- The need to change the way in which services are provided to meet the evolving needs of local people which may involve delivering services in alternative settings. The activity most likely to move into the community (or in certain cases online) is the more routine work that means hospital activity is becoming increasingly complex and non-elective.

Consequences for ESNEFT

- 2.6.3 Some services at both precursor trusts managed relatively small numbers of patients due to the specialised nature. In some cases, these services were not meeting, or were unlikely to meet in the future, minimum national guidance or accreditation standards. For example, this might relate to the minimum numbers of cases to be seen per year or the minimum number of staff in post. Therefore, change in provision was required for these fragile services to adapt to the changing clinical standards and to improve the quality of care. Some specific examples of services affected were: radiotherapy – and the impact of the National Review²⁰ on low-volume tumour sites; hyper-acute stroke units – where national advice is to increase the population covered; and, services which are fragile at two separate sites due to low overall specialist staffing numbers, such as: foot and ankle surgery; and, oncology for less common tumours.
- 2.6.4 Other services are subject to external accreditation or reaccreditation, often to increasingly stringent standards. An example of this is in endoscopy where neither Colchester nor Ipswich Hospital meets the standards required for continued accreditation by the Joint Advisory Group on Gastro-intestinal Endoscopy (JAG) although Ipswich is currently accredited. Accreditation is important to ensure high quality patient care but also to attract and retain the right staff.
- 2.6.5 Attempting to sustain some low volume and fragile services would not have been feasible without the merger. The consequence of these services not being provided locally would be longer travel times and access difficulties for patients to the detriment of their experience of care. The merger and creation of the new, larger organisation offers an opportunity to consider clinical service reconfiguration across sites to save and strengthen existing services and potentially provide some new specialist services locally in due course through repatriation.
- 2.6.6 The consequence of these factors is an increasing focus in hospital settings on complex and emergency work requiring the 24/7 levels of expertise to maintain consistent, safe services.

²⁰ “Modernising Radiotherapy Services in England”. NHS (England), 28 October 2016

This requires clinical services at sufficient scale to sustain a range of sub-specialist expertise, staff emergency rotas and to invest in modern facilities and equipment.

- 2.6.7 In the long-term, whilst the forecast growth in the population of the catchment served by ESNEFT is significant, in the context of the other drivers, the model of provincial hospital sites operating in isolation is not likely to enable the delivery consistent high-quality care or to be economically viable. Therefore, re-configuration of services to achieve scale efficiencies and to remove unnecessary duplication has been explored by the clinically-led Clinical Strategy Group.
- 2.6.8 The work of the Clinical Strategy Group (now called the Future Care Model Group) confirmed that the 'fixed points' along with: outpatients; diagnostics; pre-operative assessments; day surgery; trauma surgery; and, follow-up appointments should remain conveniently available at the local hospital (or a community location where practicable). Development of the future model of care identified that patients often have to travel to their local hospital many times before they are admitted for elective surgery and services should plan to reduce the number of attendances required by developing 'one-stop' shops for patients where clinically appropriate.
- 2.6.9 Therefore, assuming STP capital is made available to facilitate clinical service reconfiguration, ESNEFT now has the opportunity to exploit improvements in some of the main determinants of clinical and financial sustainability following merger. Moreover, the development of the Alliances and the ICS with moves towards the adoption of a system control total mean that savings can also be made from redesign of the urgent and emergency care pathway at both acute sites with the creation of a single front door for access to urgent and emergency care.
- 2.6.10 The synergies created should deliver a more cohesive and efficient service model through standardisation of clinical practice and removal of cost variation. Specific benefits will include:
- Redesign of existing estate to enable delivery of new models of care, improve patient care and flow whilst allowing for increasing demand;
 - Rapid access to modern diagnostic services for patients requiring emergency care;
 - Consolidation of clinical services and release of further NHS Estate, consistent with the Government Response to the Naylor Review;
 - Provision of modern facilities suitable for patients and likely to support the recruitment and retention of staff to meet the care needs of the population;
 - Facilitation of sustainable elective day surgery and elective inpatient surgery (specifically supported by Business Case Stream Two).
- 2.6.11 The re-configuration of clinical services supported by the STP capital identified in this paper (and made possible as a result of the merger) should offer the greatest opportunity to deliver clinically and financially sustainable services across the new Integrated Care System (ICS).

3. Clinical Case

This section identifies the process that developed the future model of care to offer the best care and experience through the reconfiguration of services to increase integration and improve sustainability.

3.1 Development of a shared clinical vision

3.1.1 During preparation for the merger, there was extensive engagement with the trusts’ clinical communities and, in addition to non-face-to-face communication and programme governance meetings, there were: 25 meetings with patient groups; 25 meetings with primary care, commissioners and members of the Suffolk and North East Essex STP; 21 open staff meetings at the various hospital sites; nine presentations and discussions at Medical Staff Committees; 17 meetings with various staff partnership and local negotiating committees; four conferences or training days; at least eight updates at meetings of the clinical leads; more than 50 meetings with clinical speciality teams and many more meetings and discussions with individual clinicians. These meetings with clinical speciality teams and individual clinicians have continued at a similar rate since the merger to document the existing services, consider strategic opportunities and capture plans for clinical integration such as the potential to create an elective care centre. The template used to capture this information was circulated to clinical teams on both sites and developed from a first draft through a number of iterations to a final version, which was then formally agreed by both teams. This process evolved to include the medical, nursing and managerial leads as they were appointed. From this engagement, there is clearly a growing impetus to create a fully integrated care system to continue to improve patient care.

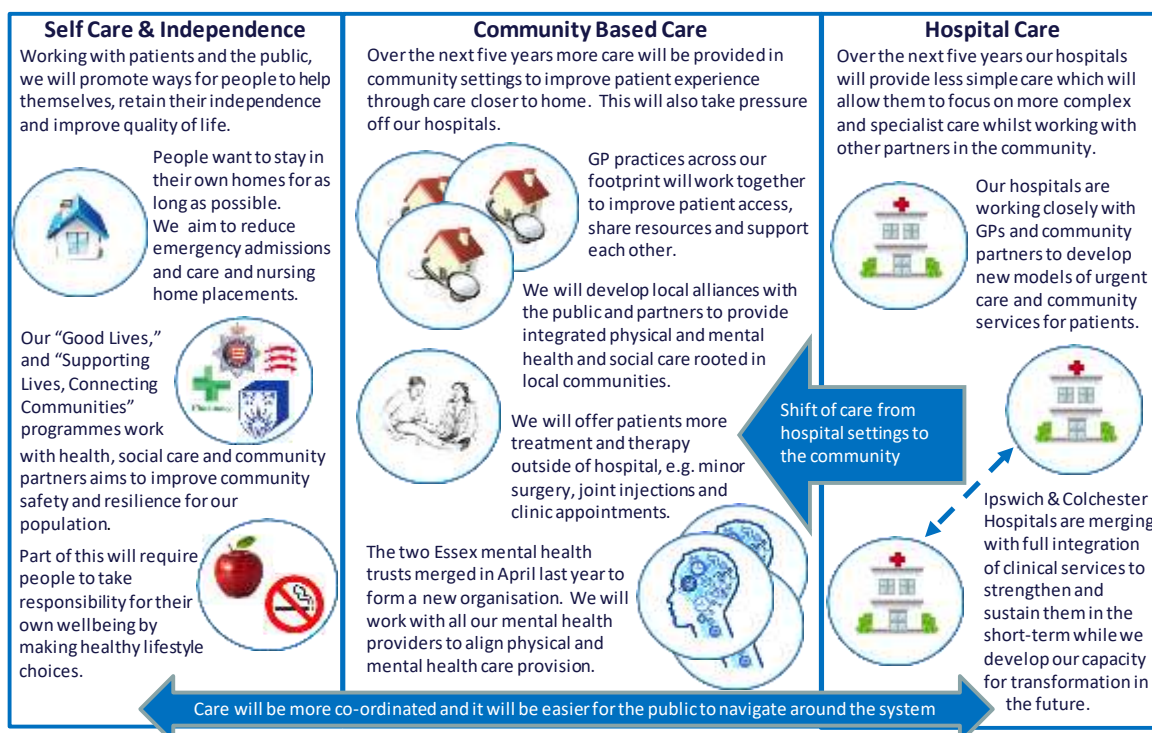


Figure 7: Suffolk and North East Essex STP Clinical Vision

3.1.2 The STP’s objective is to achieve viable acute hospitals across the integrated care system through the redesign of clinical pathways around outcomes, underpinned by innovation. This ambition is being met in a significant way through the merger that has created ESNEFT.

ESNEFT Strategy and the Future Model of Care

3.1.3 Integrating clinical services allowed ESNEFT to strengthen and sustain those services in the short-term whilst it developed capacity and detailed plans for future transformation. In developing its new strategy, ESNEFT continued to work in partnership across the health and care system to: enable people to stay well through healthy living; support people to care for themselves at home; and, provide convenient access to services in the local community

3.1.4 An outline clinical strategy was developed as the basis for the clinical operating model described in the case for merger approved by both boards at the end of March 2018. This was then developed further with patients, staff and system partners and the ESNEFT strategy to guide the approach to delivery between 2019/20 and 2023/24 was given final approval by the new Trust Board in August 2019. The Trust’s ambition is to offer the best care and experience and it has five strategic objectives to achieve this ambition:



Figure 8: East Suffolk and North East Essex NHS Foundation Trust’s Strategy

3.1.5 Embedded within this strategy is a model of care which sets out how ESNEFT intends to meet the external challenges articulated in the STP/ICS strategy and deliver the benefits outlined in the merger business case. This future care model forms an essential link between the strategy and annual operational delivery plans by illustrating how the organisation is intended to work.

Our health and care system will be focused on keeping people in control of their health and in their own home or returning them to home as soon as possible.

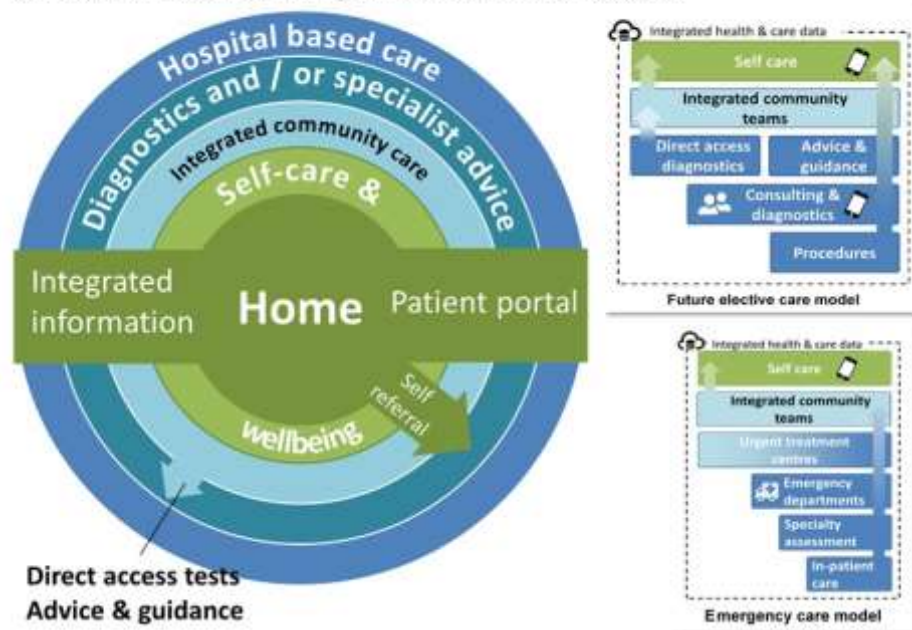


Figure 9: Future Care Model

- 3.1.6 To support the system in planning to deliver this vision, the STP prioritised a £69.3m capital bid for the new trust to fund infrastructure improvements for urgent and emergency care and to support any future reconfiguration of elective clinical services that would deliver significant benefits identified during public, staff and stakeholder engagement. Analysis undertaken during the development of the STP supporting the proposed approach to hospital services showed that:
- The local population is changing and there is a widening health and wellbeing gap.
 - There are significant care and quality issues and increasing demand for services.
 - It is becoming increasingly difficult to recruit and retain staff.
 - Providers are financially unsustainable – reflecting the finance and efficiency gap.
- 3.1.7 As has been noted, the focus of the merger was not to make any significant changes to the way that clinical services at the two acute hospital sites were configured in the short term. Both sites retain full 24/7 Emergency Department services; receive undifferentiated 24/7 medical emergency cases; and retain 24/7 consultant-led maternity services. These *'fixed-point'* services require a number of related clinical specialty and diagnostic services to be retained on both sites as part of the core emergency services of both hospitals.
- 3.1.8 This did not mean that some form of site differentiation would not eventually emerge as the preferred option from the clinical strategy development process and detailed planning for use of the STP capital funding of £69.3m. However, any proposals for significant clinical reconfiguration would require public consultation. This is why the business cases for the STP capital funding have been divided into two streams (Business Case One will not require public consultation and Business Case Two will probably require public consultation and means that no significant clinical service change could take place for at least two years).
- 3.1.9 Specifically, through the integration and reconfiguration of clinical services ESNEFT has the opportunity to deliver substantial benefits for patients that improve both outcomes and experience by:
- Delivering a comprehensive portfolio of sub-specialist acute services which are fully compliant with and, where achievable, exceed emerging standards of care;
 - Increasing the scale of delivery of specialty care through consolidation of services, enabling the maintenance of a comprehensive service portfolio and providing patients with access to the greatest range of high quality specialist services locally; and,
 - Offering patients improved access to cutting-edge treatments and innovative, clinically-led “best in class” care pathways.
- 3.1.10 The merger also provided a strong platform for ESNEFT to support and shape the medium-term transformation of the health and social care system in the region. For example, working in close partnership within the ICS, providers will be able to:
- Support the drive towards integrated care. There is ample evidence from the US and elsewhere that the most effective, patient friendly and cost-effective care is delivered in well-coordinated, integrated systems. Locally, integration has been enhanced through

partnership working and organisational merger and the combined catchment area now covers a sufficiently large area to establish a viable integrated care model;

- Work constructively with other major providers across the East of England to secure and maximise the local delivery of tertiary work through specialised commissioning;
- Work with academic and NHS partners to secure the full potential of our academic partnerships and establish ESNEFT as a centre excellence for research, education, and innovative, clinically-led services that improve the health and wellbeing of our patients.

3.2 Themes from the clinical strategy

Improving Access

3.2.1 In recent years, both pre-cursor trusts had struggled to see patients on time within core capacity on both elective and emergency care pathways. As a result, not only were patients waiting longer than they should but also unsustainable methods were being relied upon to provide the additional capacity. Integrating clinical services offers the opportunity to enable earlier access to emergency pathways and match elective capacity to demand. In ESNEFT improvements in access times for patients should be achieved in two ways:

- **Improving access to urgent and emergency care** through investment in infrastructure, changed models of care and sharing resources. Business Case One includes infrastructure support for changing urgent and emergency care pathways through the co-location of UTCs with the EDs, increased provision of diagnostic CT/MRI and the re-design of emergency/surgical/frailty assessment pathways. This allows the extension of best practice ways of working across both sites to reduce emergency admissions and waits for emergency surgery and to support the provision of a sustainable 24/7 emergency service.
- **Improving access to elective care** by combining services and matching elective capacity to demand across both sites. Improving access to elective care through improvements in infrastructure and sharing resources forms the basis of Business Case Two. Improved access will be delivered by improving the use of high value and/or scarce resources to allow a significant reduction in waiting times; by separating elective and emergency patient pathways to minimise the risk of short notice cancellations of elective surgery; and, by ensuring local access to state of the art facilities for daycase surgery.

Clinical integration

3.2.2 Combining the resources and skills in ESNEFT has strengthened and sustained services in the short-term and offers the opportunity to enhance them in the future. This will be achieved by:

- **Integration with community.** *The Five Year Forward View*²¹ has encouraged efforts to deliver more care out of hospitals and closer to home, with the aim of providing better care for patients, cutting the number of unplanned bed days and reducing net costs. ESNEFT now treats patients across a large geographical footprint. Although there were clear benefits of scale from combining the two pre-cursor trusts, it was imperative that patients should continue to be able to access high quality, specialist care locally. This is particularly important for older patients and those with complex needs, for whom travel

²¹ Five Year Forward View, NHS England. (2014). <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

may be very challenging. ESNEFT is now reviewing how services are delivered in the community and the opportunities for further development in terms of access to services in community hospitals and the provision of community nursing, therapy and social care.

- **Sustaining local services.** Although Colchester and Ipswich hospitals are centres for a range of specialist services, patients still have to travel long distances for some sub-specialty treatments. There is a national drive to increase the quality and consistency of specialist services by specifying minimum numbers of cases in national standards; this will effectively reduce the number of specialist centres. ESNEFT obviously has a higher volume of activity per service since the merger enabling minimum numbers to be achieved and therefore helping to keep services local. That said, some standards consider minimum numbers by site rather than by organisation so some reconfiguration may be required (whilst retaining local site access to outpatients, diagnostics and daycase surgery) to avoid the loss of specialist services to providers with higher inpatient volumes on a single site.
- **Enhancing local services.** Colchester and Ipswich both provide a portfolio of specialist services, some of which differ. Although patients are now referred across sites in some instances, there are some services which one site provides but the other site refers to different tertiary providers due to existing clinical network arrangements. Referral patterns are in the process of review and harmonisation to allow services to be provided as locally as possible for the population whilst keeping travel to a minimum. There are a number of factors governing the provision of specialist services such as regional commissioning intentions; achieving standards for specialist service delivery; recruitment and training of specialist staff; availability of suitable infrastructure; and, achieving the stipulated minimum numbers of cases (by site) to maintain fragile skills.

Using the scale of the new organisation

3.2.3 Both pre-cursor trusts had long-term vacancies across a number of specialties leading to high use of premium-rate locum and agency staff. One of ESNEFT's central aims is to retain and attract the best staff. By exploiting its scale, ESNEFT is able to offer more opportunities for training, development and career progression. This is achieved in several ways:

- **Cross-site working.** Many clinical teams now have the critical mass of staff needed to provide cross-cover, increasing the robustness of rotas and reducing the reliance on temporary staffing. In some instances, this has also increased the capacity of the service, helping to reduce waiting times and reduce the reliance on outsourcing and running additional out-of-hours sessions.
- **Single teams.** Combining clinical teams into single services in the new organisation has created the opportunity for greater sub-specialisation and clinical service development. This has the potential to make roles more interesting and attractive, enhancing recruitment and retention as well as creating more opportunities for career progression.
- **Streamlined recruitment.** ESNEFT is now the largest NHS employer in East Anglia and its ability to recruit as a single organisation is far stronger than two smaller DGHs, enabling services to offer more attractive posts within a larger scale service.
- **Better training.** There is now better access to more training opportunities through further sub-specialisation. There is also the potential for increased academic links to provide

further training opportunities. Additionally, it is anticipated that ESNEFT will be able to draw in better candidates to undertake the training roles and will also be able to offer rotations between sites and care settings (i.e. acute and community).

- **Alternative roles.** There is now a greater opportunity to develop alternative roles to help manage growing demand, address gaps in rotas and make posts more attractive.
- **Key worker and student facilities.** Rationalisation of the estate will release peripheral land with the potential to generate cash receipts for capital schemes and to develop better facilities to support key workers/students and to attract high quality trainees.
- **Research and innovation.** The increased scale of ESNEFT allows the trust to take part in more research and innovation. The team will be responsible for securing funding, fostering new partnerships and overseeing research and innovation activities including the creation of academic research posts and the extension of clinical trials for patients.
- **New on-call arrangements.** A number of specialities (e.g. Ophthalmology, ENT, Urology and Cardiology) are taking the opportunity to combine on-call arrangements to mitigate gaps in their rotas or to reduce their intensity, thereby reducing the burden on staff, improving retention and making posts more attractive to future recruits.

Cross-cutting themes

- **Redesign of pathways with community.** Work with commissioners and community partners to redesign pathways to provide greater support in the community, to reduce avoidable ED attendances, non-elective admissions and hospital outpatient attendances.
- **Repatriation of specialist/tertiary services.** Collaborate with neighbouring trusts to optimise flow of speciality activity and improve the trust's ability to offer new specialist services for the local population and to absorb other activity from the region.
- **Expansion of use of technology and self-service.** Implement patient-facing technology to increase self-care, compliance with treatment and to reduce DNAs. Standardise and automate administrative and clinical functions to reduce overheads and improve quality.
- **Improvements to end of life care.** To support the highest quality, holistic palliative and end of life care, including optimum symptom control, for adults and young people.
- **Consolidation of estate.** Rationalise the estate footprint and continue to match estate footprint to utilisation as care moves out of hospital into the community.
- **Identification of commercial opportunities.** Explore opportunities to expand private practice and to deliver specialist and corporate services in other hospitals. Consider developing links to overseas health systems to provide clinical training and consultancy.

3.3 Improving access to elective care

- 3.3.1 There are always advantages and disadvantages when considering the reconfiguration of services and this is particularly true when the reconfiguration involves consolidation of part, or all, of a clinical speciality onto a single site. The advantages usually include: increasing critical mass and sustainability; greater interdepartmental flexibility; availability of cross-cover; ability to sub-specialise; improved efficiency of delivery; and, the ability to take on more complex

cases. The most obvious disadvantage is always the increase in travel time for a section of the population who live furthest away from the proposed site with the related issues of the convenience of public transport links and the adequacy of the provision for car parking at the proposed site. This has the greatest impact on frequent attenders of which the NHS staff involved are usually those most affected. The negative public perception of the impact of service consolidation can be offset by good public engagement and the re-provision of other clinical services in a more convenient location and mitigated by phasing the changes and ensuring that those elements of clinical speciality services most frequently used are made as convenient as possible. In other words, a public consultation is most likely to be successful when a range of improvements in clinical services for the population in general can be balanced against an increase in travel for a small cohort on an occasional basis. Single-issue consolidation consultations are usually politically contentious and seldom succeed. This means that urgent and emergency services and frequently used points of delivery such as outpatients, diagnostics and day surgery should always be kept as local and convenient to access as possible and only those elective inpatient services centralised that offer significant benefits in terms of patient outcomes, clinical sustainability or shorter waiting times.

3.3.2 Extensive engagement with clinical teams, patients their families & carers, other stakeholders and the general public over the last two years has highlighted many aspirations and some opportunities to improve services. Some of these aspirations are now achievable, following the allocation of STP capital funding, and decisions will have to be made in 2020, after public consultation, to ensure the window for release of capital funding is met. Whilst perhaps the most significant impact in the long term will come from changes in approach through: targeted prevention; the integration of care; and, the use of technology to shift care out of the hospital setting, it is always changes in hospital site that attract most attention. Therefore, as an indication of the potential opportunities available, the following sections highlight perhaps the most exciting speciality reconfiguration options that have been suggested. Clearly, no decisions have been taken and any changes that may be proposed would follow public consultation.

3.3.3 As previously mentioned, in supporting the case for the formation of ESNEFT, the STP agreed that both main hospitals in Colchester and Ipswich would retain the following fixed points in any service reconfiguration: full 24/7 Emergency Department services; undifferentiated 24/7 medical emergency admissions; and, 24/7 consultant-led maternity services. The retention of these services on both hospital sites means that a number of related clinical specialty and diagnostic services also need to be provided on both sites as part of the emergency core service; therefore, the scope for radical clinical service reconfiguration is appropriately constrained. Options such as a hot/cold split of services across sites; and, centralisation of consultant-led maternity services have therefore not been considered since these are largely precluded by the commitment to provide the fixed-point services on both main sites.

Clinical Drivers for Reconfiguration

3.3.4 Two important clinical drivers supporting an increase in the scale of operations through integration and reconfiguration of clinical services across sites are:

- The strong body of clinical evidence that hospital services should be concentrated in fewer specialist centres undertaking higher volumes of activity (cf. IOG and GIRFT). This consolidated activity should lead to improved patient outcomes; and,

- The critical mass of clinicians with the right skills, infrastructure, facilities and co-dependent services required for the sustainable delivery of safe, high quality care. This critical mass is achieved by consolidation of services (or more usually certain service elements such as inpatient surgery) at fewer sites facilitated by capital investment.

Rationale for the selection of adult elective inpatient orthopaedic surgery for consolidation

3.3.5 Funding for a Centre for Elective Orthopaedic Surgery on one site has offered commissioners and ESNEFT the opportunity to think strategically about the potential future configuration of clinical services across both main hospital sites to meet the predicted growth in demand from an increasingly elderly population. Elective Care Centres (ECCs) exist at a number of hospitals to deliver elective procedures that are scheduled in advance because they do not involve a medical emergency. Some ECCs offer access to ambulatory clinical services such as endoscopy, ophthalmology or routine daycase surgery; however, the Future Care Model Group has established that routine ambulatory care should be conveniently available for the local population at both main hospital sites so would not be suitable for consolidation on a single site. If routine elective daycase surgery is to remain available at both sites, elective inpatient surgery (where patients can retain local access to outpatients, diagnostics and follow-up care) may be suitable for consolidation in a single ECC; however, the predicted volume of activity would have to be high enough to justify a dedicated facility. The specialities with the high volumes of activity necessary would be General Surgery and Orthopaedics. Elective General Surgery is predominantly delivered as daycase surgery so would not meet the convenient local availability test if consolidated on a single site. Elective Orthopaedics on the other hand involves a significant proportion of planned inpatient surgery, which GIRFT recommends should be provided in specialist centres undertaking higher levels of activity. Therefore, it would be ideally suitable for consolidation and it is proposed that the single ECC should be designed to support adult elective inpatient orthopaedic surgery.

3.4 Elective Care Centre for orthopaedics

3.4.1 The full range of upper and lower limb orthopaedic surgery is currently available on both sites including sub-speciality interests such as revision arthroplasty. Ipswich Hospital is also the regional spinal centre providing specialist services for a population of 1.6 million. The 'Getting it right first time' (GIRFT) work led by Professor Tim Briggs CBE recommends changes to improve pathways of care, patient outcomes and experience often delivering significant cost savings. The key recommendation is that surgical sub-specialisation, with increased volume of service delivery for both individuals and units, is closely linked to improved patient outcomes. Other recommendations are that elective orthopaedic beds should be ring fenced and enhanced infection control provision adopted such as laminar flow theatres and antibiotic free wards. Professor Briggs recommends that regions should work as networks with the specialist unit in the centre. The British Orthopaedic Association and the Royal College of Surgeons are also in the process of setting standards for minimum delivery for individuals and units and it is anticipated that these will be used to commission services in the future. Neither Ipswich nor Colchester on their own carry out the number of procedures needed to be designated as a specialist 'hub' and, unless elective arthroplasty is consolidated, may not even qualify as 'spoke' units. This would result in the eventual loss of these services with local patients having to travel to the nearest designated specialist centre which would be likely to be in Cambridge or London.

However, if ESNEFT's elective orthopaedic activity were to be consolidated on a single site, it would carry out twice as many elective procedures as the next largest provider hospital and the potential would exist for ESNEFT to become a designated specialist elective orthopaedic hub in addition to the existing designation as the regional spinal centre. Consolidation of the elective orthopaedic activity for Ipswich and Colchester would also be likely to result in the progressive transfer of some specialist and complex work from other hospitals in the region to the centre. Access to trauma surgery, fracture clinics, orthopaedic outpatients, diagnostics, day surgery and follow-up care would continue to be available on both main sites. Conversely, without consolidation on a single site it would be more likely that others trust would be designated as the regional hubs which would result in a progressive loss of specialist and complex work from Ipswich and Colchester to that centre.

- 3.4.2 **Current model of care.** ESNEFT's elective arthroplasty is currently delivered across three sites from seven laminar flow theatres with the five NHS laminar flow theatres across both NHS sites providing approximately 350²² joints per annum from a nominal 8-hour working day, 5-day week. However, elective arthroplasty (assumed to include revision arthroplasty services) cannot be looked at in isolation. Therefore, for the purposes of calculating the number of theatres and inpatient beds that would be required, elective orthopaedic activity has been considered from the perspective of the total daycase and inpatient workload. The highest volume of arthroplasty is obviously for hip & knee but ESNEFT provides arthroplasty of other joints including high volumes of shoulder replacements; a small number of elbow replacements; a small joint upper limb replacement service; and, foot/ankle osteotomy and replacements. These lower volume procedures may be lost to ESNEFT if another trust were to be designated as the GIRFT regional centre. Arthroplasty includes total hip replacement (THR) for hip fractures because fractures around joint replacements often require revision arthroplasty techniques and complex implant systems that benefit from the availability of laminar flow. However, it has been assumed that this activity will stay on the site of admission as part of the trauma service (especially for frail older people) and would be carried out in a laminar flow theatre (i.e. not transferred to the elective care centre) so it has been excluded from the calculations that follow.
- 3.4.3 **Current numbers of orthopaedic consultants.** There are currently 27 orthopaedic consultants working in ESNEFT (excluding 2 semi-retired consultants) of whom 22 consultants require laminar flow for part or all of their practice (either inpatient or mixed inpatient and daycase).
- 3.4.4 **Current theatre numbers.** There are 10 NHS theatres are currently available (but not all dedicated to) trauma and orthopaedics (excluding spinal surgery) across the two sites delivering a total of 86 theatre 4-hour sessions per week. Inpatient activity is provided across five laminar flow and two non-laminar flow trauma theatres. Around 67 sessions are used each week for elective adult orthopaedics of which the 16-daycase sessions are carried out across three other theatres. Therefore, the total number of NHS theatres that supports elective inpatient orthopaedic activity at current rates of productivity is five (51 sessions). However, there are 11 sessions used for NHS arthroplasty work (of which some is daycase) in a local private hospital in Colchester known as 'The Oaks' and it has been assumed that the elective care centre should be designed with adequate capacity to absorb this work. It should also be noted that some daycase activity is undertaken during inpatient theatre sessions at Colchester for convenience.

²² National Joint Registry shows 1,766 major joint procedures completed in 2018 (or 67% of the 2,646 inpatient procedures).

- 3.4.5 **Current bed numbers.** Across the two sites, a total of 2 elective inpatient wards and 4 trauma wards are available to trauma and orthopaedics (including spinal surgery) providing a total of 26 elective and 54 trauma beds at Colchester and 28 elective and 55 trauma beds at Ipswich.

Activity and Capacity Modelling

- 3.4.6 Best available information has been used to establish the expected requirements for theatre and bed capacity starting with data and modelling supplied by the consultants from the National Joint Registry. This modelling was reconciled with the Trust's activity data and the patients treated were then mapped with ONS statistics used, by age, to establish a detailed prediction of future patient numbers by local authority area. In addition, current waiting lists were reviewed to ensure that any patients added to waiting lists over the constitutional standards were also included in addition to those patients actually treated. Agreed metrics were then used to establish the numbers of theatres and beds required. These metrics included length of stay, bed occupancy rates, patients (or joints) treated per operating list and theatre operating hours/days. The projected demand was calculated at a bed/theatre list level and then compared to the bed numbers required to deliver this at the national 92% occupancy rate and the number of theatre lists that would be available per annum under different scenarios.
- 3.4.7 A paper review of the number of theatres available and patients treated at four other sites was also carried out as a benchmarking check. The centres were selected as the best comparators for the proposed ECC following consideration of all trusts across the country. The comparator sites used were: Epsom & St. Helier (SWLEOC) (5/6 theatres and 54 beds); Northumbria Healthcare (excellent LOS); Robert Jones & Agnes Hunt (Oswestry) (scale efficiencies); and, Wrightington, Wigan & Leigh (Barn theatre with 4 operating spaces and 44 beds). A number of factors skew productivity per theatre when looking at other sites, such as the model of care, design of facilities, use of trainees and casemix. A clinical visit has been carried out to SWELEOC to review the design of their facilities and the model of care adopted and visits are planned to other centres as any OBC is developed. In relation to bed requirements, a detailed predictive model was developed and demonstrated to the clinical leadership team working with existing patient admissions, including time of arrival and discharge projected forwards to include growth in patient numbers, to evidence the actual number of beds that would be required in reality to deliver suitable care to patients over the years modelled out to 2041.
- 3.4.8 **Activity projections.** There is a range of activity projections available depending on the assumed growth rates. The Office of National Statistics (ONS) estimates an average annual population growth rate to 2041 across all ages in North Essex will be 0.8% and in Suffolk 0.4%. Therefore, ONS predicts an overall population increase for ESNEFT's catchment area of 14.1% by 2041 (20% in Essex and 10% in Suffolk or an increase of 112,657 people) with the over 65s (i.e. the arthroplasty population) increasing by 50% (or approximately 2% per annum with an even split between Essex and Suffolk). At the other extreme, the National Indicative Hospital Activity Model (IHAM) estimates an average annual elective activity growth rate to 2041 of 2.1% across both NE Essex and Ipswich & East Suffolk and average annual non-elective activity growth to 2041 of 2.3% in NE Essex and 3.5% in Ipswich & East Suffolk. Within these IHAM averages the annual growth rate can vary anywhere between 2.1% and 4.6%. The STP/ICS is in the process of updating and refreshing system plans (financial, activity and workforce) as part of the NHS Long Term Implementation Framework with first draft submissions due at the end of September 2019. As part of this process, the respective informatics leads of each organisation

have been discussing the most appropriate basis to model activity growth to use. Because of the ‘volatility’ in historical trends, and the fact that ONS growth rates do not seem high enough in terms of the trends in healthcare demand that have been experienced, it has been agreed that IHAM growth rates will primarily be used for financial plans over the next five years.

3.4.9 For the purposes of modelling the theatres and bed numbers required for a centre for elective orthopaedic surgery it has been decided to use a post QIPP/demand management scenario applied to raw IHAM growth rates. Capacity modelling has taken into account multiple scenarios to include consideration of productivity assumptions in the new patient pathway and national benchmark comparators. The following projections of patient numbers are based on the most recent 12 months of actual patient activity for each site, by age and local authority with the addition of waiting list growth in the last year (246 inpatients and 336 daycase patients reflecting additional patients not being treated) and any NHS patients treated at The Oaks. This has provided a true baseline for the most recent 12 months which has then been projected forward at patient level by year up to 2041, using the growth rates projected by ONS statistics at age (0-89 individual year and 90+). These projections of patient numbers have then been used with theatre times and patient lengths of overnight stay to calculate the theatre and bed numbers required by year. In other words, applying age-band growth rates for elective orthopaedic patients would indicate growth of 21% for Essex and a 16% for Suffolk or a most likely total of around 3,343 elective arthroplasties within a total of 4,348 orthopaedic cases in ESNEFT’s catchment area by 2041. The capacity forecasts that follow model the worst-case scenario to support the 20-year predicted growth in line with the projections above.

Elective Inpatients	2019	2025	2030	2035	2041
Ipswich Hospital	1,323	1,426	1,494	1,548	1,603
Colchester Hospital	1,569	1,730	1,848	1,948	2,056
The Oaks (Private)	526	580	619	653	689
Total	3,418	3,736	3,961	4,149	4,348

Table 5: Elective Orthopaedic Inpatient Activity Projections

Elective Daycase	2019	2025	2030	2035	2041
Ipswich Hospital	1,688	1,775	1,817	1,846	1,887
Colchester Hospital	1,950	2,050	2,135	2,222	2,303
The Oaks (Private)	641	674	702	730	757
Total	4,279	4,499	4,654	4,798	4,947

Table 6: Elective Orthopaedic Daycase Activity Projections

Theatre Numbers

3.4.10 **Working patterns.** Combining the options for use of physical theatres (days a week, hours a day, etc.) and the scenarios for demand for elective procedures identifies a wide range of potential future requirements for orthopaedic theatres depending upon the scenario and utilisation pattern options as shown in the following tables. Interestingly, these figures would appear to show that the current annual utilisation of the elective orthopaedic theatres across both sites is low. For example, with approximately 350 patients currently receiving an

arthroplasty operation per theatre per annum this equates to about 1.5 arthroplasty patients per day per theatre (assuming a 45-week, 5-day a week year) or less than one joint per list! This is historical data and there will be a number of reasons for the low number of arthroplasties per theatre per day most of which will be unrelated to the number of joints actually completed on each list. For example, operating theatres carry out more than just arthroplasty procedures and if all elective orthopaedic procedures are included, then the number of cases per day rises would rise to 2.6. Working practises are also sometimes driven by pressure from non-elective activity and staff shortages to include dropping lists and leaving theatres idle when Consultants are unavailable due to leave, etc. The number of weeks per annum that a theatre is actually used is a key determinant of productivity. If theatres are used for 42-weeks a year then just scheduling activity to utilise each theatre for a full 50-week year would provide an additional 400 operating lists per year across five elective theatres.

Theatre requirements	Option 1	Option 2	Option 3	Option 4	Option 5
2025 (Adult T&O exc. Spinal)	8 hours a day, Monday to Friday only	10 hours a day, Monday to Friday only	12 hours a day, Monday to Friday only	8 hours a day weekdays, and 8 hours total at weekend	10 hours a day weekdays, and 4 hours total at weekend
Elective inpatients (exc. Oaks)	3.9	3.1	2.6	3.2	2.9
Elective inpatients (Oaks)	0.7	0.6	0.5	0.6	0.5
Elective inpatients total	4.6	3.7	3.1	3.8	3.4
Elective daycase (exc. Oaks)	2.7	2.1	1.8	2.2	2.0
Elective daycase (Oaks)	0.2	0.2	0.1	0.2	0.2
Elective daycase total	2.9	2.3	1.9	2.4	2.2
Elective total (exc. Oaks)	6.5	5.2	4.4	5.5	4.9
Elective total (Oaks)	0.9	0.8	0.6	0.8	0.7
Elective total	7.4	6.0	5.0	6.3	5.6

Table 7: T&O theatres required in 2025 (when an Orthopaedic Centre would be newly opened)

Theatre requirements	Option 1	Option 2	Option 3	Option 4	Option 5
2041 (Adult T&O exc. Spinal)	8 hours a day, Monday to Friday only	10 hours a day, Monday to Friday only	12 hours a day, Monday to Friday only	8 hours a day weekdays, and 8 hours total at weekend	10 hours a day weekdays, and 4 hours total at weekend
Elective inpatients (exc. Oaks)	4.5	3.6	3.0	3.8	3.3
Elective inpatients (Oaks)	0.9	0.7	0.6	0.7	0.6
Elective inpatients total	5.4	4.3	3.6	4.5	4.0
Elective daycase (exc. Oaks)	3.0	2.4	2.0	2.5	2.2
Elective daycase (Oaks)	0.4	0.3	0.2	0.3	0.3
Elective daycase total	3.4	2.7	2.2	2.8	2.5
Elective total (exc. Oaks)	7.5	6.0	5.0	6.2	5.6
Elective total (Oaks)	1.3	1.0	0.8	1.0	0.9
Elective total	8.8	7.0	5.8	7.2	6.5

Table 8: T&O theatres required by 2041

3.4.11 The inpatient theatre model takes the projected patient numbers and then assumes two elective patients (at average case mix (or not just arthroplasty patients)) per 4-hour list to establish the number of theatre minutes required. Assuming a 45-week year this provides 129,600 minutes per theatre and, at 90% theatre occupancy, this leads to 116,640 minutes per theatre that would be expected to be utilised. The daycase theatre model uses the current average time in theatre per patient by site. This is calculated at 72 minutes at Ipswich and 54 minutes at Colchester. The difference is explained by the different case mix between sites. The following tables show the total number of theatres that would be required when the new ECC would be open in 2025 and then again in 2041 for a range of working patterns.

3.4.12 **Increase in theatre capacity.** The building of dedicated elective orthopaedic theatres will release existing theatre capacity to support the resilience of non-elective patient care, including making available laminar flow theatres for trauma total hip replacements, driving up the Trust’s compliance with National Hip Fracture Database metrics. Once the new ECC and DSU are open there will be a net increase of two laminar flow theatres at Ipswich (to be re-allocated), with space for a potential third additional theatre in the new ECC that could be fitted out for use in the future depending upon demand. There will also be an increase in the quality of theatres available (i.e. an additional 5 new laminar flow theatre suites (with space for a 6th) in the ECC and one non-laminar flow day theatre to be built in the new DSU for the move of 2-3 theatres worth of activity to the ECC and the loss of 4 old day theatres at Colchester). It should be remembered that there is also a private laminar flow theatre at the Oaks Hospital, Colchester fully occupied with outsourced NHS activity to supplement ESNEFT’s capacity and it is intended that sufficient NHS capacity should be available with the creation of the ECC so that this activity may be repatriated subject to choice. Due to the wider programme of work, the overall impact on theatre capacity across both sites is best explained in the following diagrams:

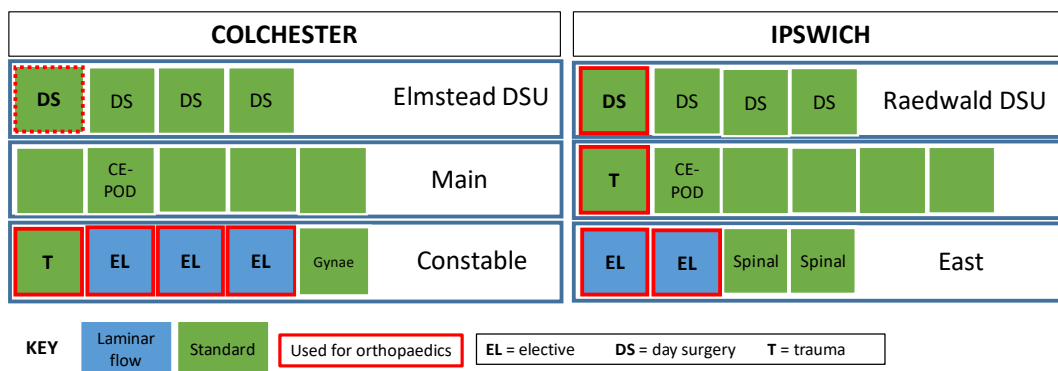


Figure 10: Current theatre allocation for Trauma and Orthopaedics

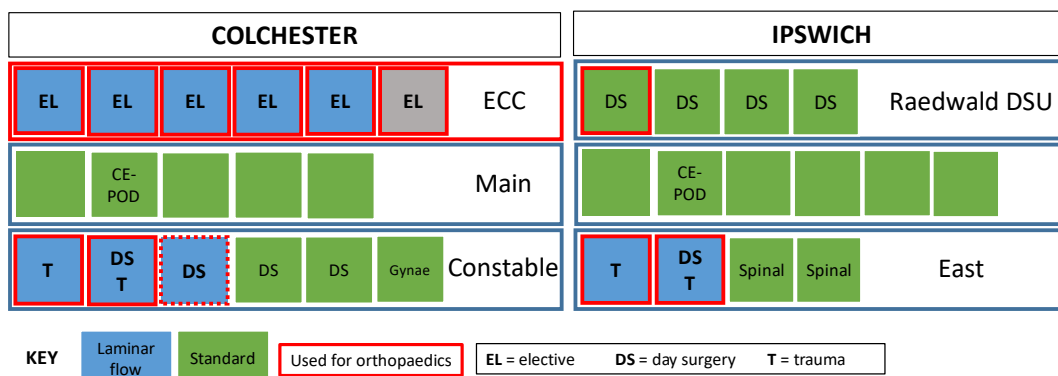


Figure 11: Post-ECC theatre allocation for Trauma and Orthopaedics

- 3.4.13 **Day surgery theatres.** Day surgery at Colchester is currently split between one day theatre in the Colchester DSU (6 sessions/week) and some use of the elective theatres in Constable. It is important to note that the day theatre used by orthopaedics could be replaced in the new DSU (in Constable) in addition to the theatre provision in the new ECC. At Ipswich there is currently one daycase theatre in Raedwald DSU for orthopaedics and this allocation would remain. References to the move of Colchester day surgery into the ECC only concern the day surgery currently carried out in the elective orthopaedic theatres in Constable that would be re-provided in the ECC and is not intended to be an alternative to replacing the day surgery theatre used for orthopaedics. The element of Colchester daycase orthopaedic activity that currently goes through Constable theatres is already included as part of the baseline activity of the 3 laminar flow elective theatres being replaced in the ECC rather than as part of the daycase activity that goes through the Colchester DSU. This element of Colchester's orthopaedic day case activity could transfer into a new DSU in Constable which would provide even more capacity for elective inpatient activity in the ECC. However, demand for day surgery is growing and creation of the ECC will free up much needed additional day surgery capacity for orthopaedics at both sites to be allocated as required.
- 3.4.14 **Elective inpatient theatres.** Assuming no change to current operating days/hours (5-days per week, 9-5) but an increase to 90% theatre utilisation, it is calculated that between 3.9 and 4.6 (depending on the Oaks activity repatriated) would be required in 2025 rising to between 4.5 and 5.4 by 2041. Oaks activity is most unlikely to come to the ECC from day one (and there will always be some people who will want to use a 'private' hospital) so it would be fair to assume that the full 0.7 of a theatre for Oaks activity will not be needed in 2025. In other words, with this improved utilisation, we could continue working 5-days/week and still deliver the projected activity in 2025 (which also assumes we treat the backlog of patients on the waiting list) and have a theatre to spare in the ECC to pick up any Oaks activity. Alternatively, if current utilisation rates are maintained, current activity could be covered with the five new theatres and any move to 6-day working would provide additional capacity to treat the backlog of patients and to absorb the activity from the Oaks. However, if both a move to 6-day operating (9-5) and an increase in theatre utilisation to 90% are assumed, then the ECC would only need between 3.2 and 3.8 theatres in 2025 rising to between 3.8 and 4.5 by 2041. Therefore, the 5 laminar flow theatres planned to open in the ECC should in theory be more than adequate for all projected activity in 2025 with space for an additional laminar flow theatre suite to be opened in due course as activity grows. In effect, this means we could replace the 5 laminar flow theatres currently used with 5 new laminar flow theatre suites in the new ECC and have room for expansion up to 6 laminar flow theatre suites as demand increases. However, there may be operational flexibility and construction cost advantages in equipping all 6 theatres in the ECC from the start and this would be explored in more detail during preparation of an OBC.
- 3.4.15 **Trauma theatres.** There is one trauma theatre on each site (currently non-laminar flow) and there will be scope to both upgrade and increase the trauma theatre provision with laminar flow on each site. At Ipswich, it is recommended that the two spinal theatres should be left as they are but that the trauma theatre (Lavender) should be moved from South Theatres to one of the two vacated theatres (with laminar flow) in East Theatres directly adjacent to the trauma ward and ITU. Assuming that the Emergency Theatre remains in South Theatres the second vacated theatre in East Theatres could be used flexibly to provide additional capacity for trauma, spinal and daycase orthopaedics. Whatever way it is eventually decided to allocate

these two vacated laminar flow theatres, creation of the ECC will allow for an increase in trauma theatre provision at Ipswich. At Colchester, it is recommended that one of the three vacated laminar flow theatres should become the trauma theatre and the reconfiguration of Constable Theatres as the DSU (with the building of an additional theatre to take the total number of theatres in Constable up to six) will allow the gynae/breast theatre to remain and also provide four theatres for the replacement DSU in addition to the trauma theatre. The four theatres in the current DSU, that would be replaced by the DSU in Constable, are currently poorly utilised so it would be possible to make at least 0.5 theatre available as additional trauma theatre capacity (along with additional day surgery capacity) from this provision which would mean that it would be possible for the trauma theatre could stay as it is (without laminar flow) with the laminar flow capability required offered from this additional capacity. Whichever choice is made, creation of the ECC will allow for an increase in trauma theatre provision at Colchester. In summary, it is not planned for any trauma patient care to take place in the new ECC, but to be managed within existing, and capacity released by the new ECC, on both main hospital sites.

- 3.4.16 The high impact of potential changes in working patterns on the number of theatres required both in 2025 and, more importantly, by 2041 is clear and the detailed analysis that has been carried out will now be combined with practical comparisons including visits to existing elective orthopaedic facilities to establish the actual number of theatres and beds to be provided for adult elective inpatient activity and the room needed for future growth. Looking only at the number of laminar flow theatres that would be required for adult elective inpatient activity whilst maintaining a two-session (8-hour) working day over a 45-week year at 90% theatre utilisation it can be seen that the number of theatres is significantly affected by the number of days worked as follows:
- Assuming the current 5-days a week would require 3.9 - 4.6 theatres in 2025 (depending on Oaks activity) rising to between 4.5 and 5.4 by 2041; or,
 - Assuming a change to 6-days a week would require 3.2 - 3.8 theatres in 2025 (depending on Oaks activity) rising to between 3.8 and 4.5 by 2041.

Bed Numbers

- 3.4.17 There will be a positive impact on both the orthopaedic and overall Trust capacity in terms of beds available. Currently, elective orthopaedics has 54 beds across the two sites, with 28 beds at Ipswich and 26 at Colchester. Whilst the final specification of the number of elective beds is to be determined, the provision of the ECC will release 48 existing beds (54 less 6 beds current used for spinal patients) across the sites with good clinical adjacencies for use as much needed additional acute bed capacity (subject to staffing) supporting the overall requirement of the Trust to deliver emergency standards. For the purposes of modelling and costing the bed capacity that would be required for the ECC, a different process was used. The starting point again was modelling provided by the orthopaedic consultants based on the current use of 48-54 NHS beds, and small number of beds in the private Oaks hospital, which was then refined to adjust for the projected growth in activity and clearance of waiting list over the 18-week standard and suggested that around 50-60 beds would be required by 2041. This estimate was then compared to a simulation of the expected bed occupancy for a 48-bed unit. First it was established from NHB 04-01 (Adult Inpatient Facilities) that it would be possible to build two standard 24-bed inpatient wards, with at least 50% single, en-suite patient rooms,

within the floor area defined by an ECC with up to 6 theatres. Then with the overnight bed capacity set at 48 ring-fenced elective beds, the calculation takes the projected patient numbers and identifies the operating days (assuming Monday to Saturday). It then uses the patient length of stay to establish the day of discharge and hence the beds occupied by day of week. Overnight average length of stay for orthopaedics patients was calculated as 3.01 days based on actual performance (which means if length of stay is improved in the ECC the occupancy rate will reduce). The following figure sets out the theoretical overnight occupancy for a ring-fenced, 48-bed unit in 2041. This identifies that, assuming the Oaks work all transfers to the ECC, it will require, on average an average of 36 beds compared to the 48 available giving an average occupancy of 75%. The utilisation of these beds differs between the days of the week based upon the operating days and with growth would peak at around 87% by 2041 over the period Wednesday to Saturday.

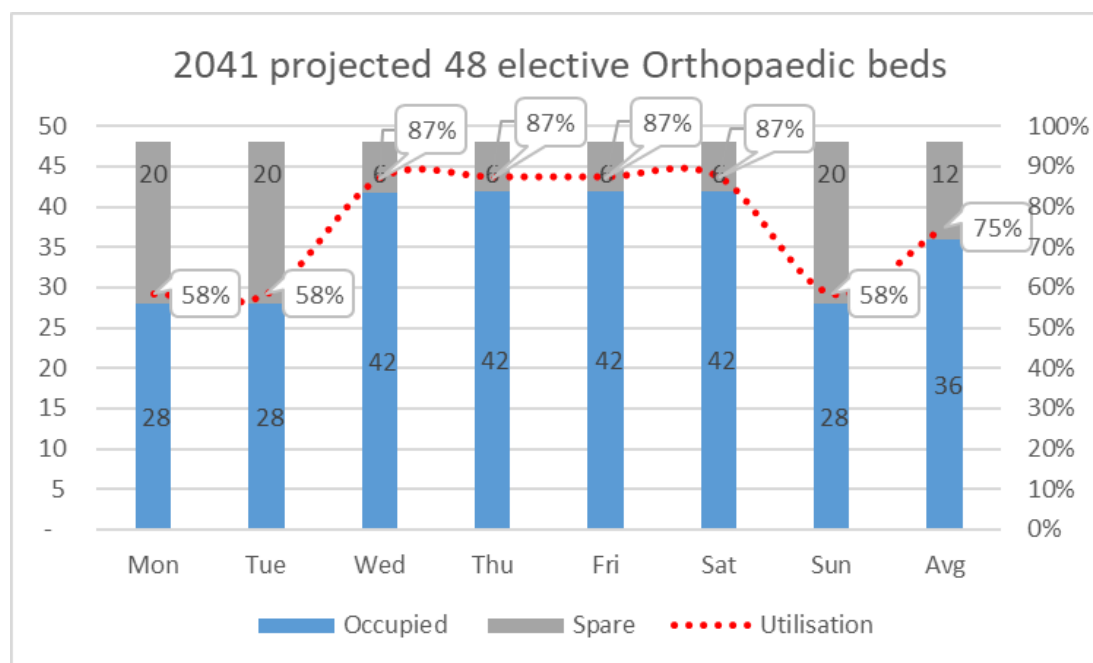


Figure 12: Projected bed occupancy for a 48-bed Orthopaedic Centre in 2041

3.4.18 This calculation was reassuring because it assumed the worst case in terms of capacity modelling of no reduction in length of stay, but it was not sufficient because it also assumed that all patients had the same, albeit ‘average’, length of stay when, in practice, patients have a variable length of stay. Moreover, an ‘overnight’ average length of stay of 3.01 days would not allow for the fact that the patient stay would take place over a four-day period. Therefore, a model was created to simulate bed usage much more accurately by introducing actual patient arrival and discharge times according to randomised lengths of stay based on historical activity. This simulation also assumed the theoretical ‘most demanding case’ where there was not only no overall reduction of length of stay but also all backlog activity, and 100% of the Oaks ‘patient choice’ activity, would be included in the ECC activity. The output of each simulated period of activity, shown in the figures which follow, is a projection of the number of beds required, by hour, by day, in the ECC which includes the theoretical maximum number of beds that would be required if a patient were never to be cancelled for lack of a bed. For example, the figures below show that in 2024/25 when the ECC opens it would need a mean of 40 beds and a theoretical maximum of 56 beds in order to never have to cancel a patient rising to a mean of 50 beds and a maximum of 65 beds respectively by 2041/42.

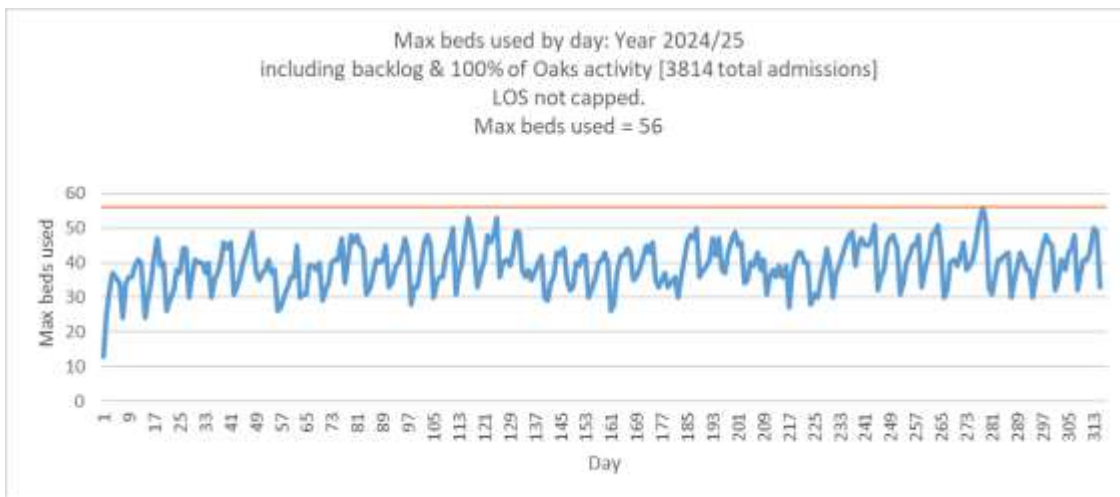


Figure 13: Projected bed numbers required for the Orthopaedic Centre in 2024/25

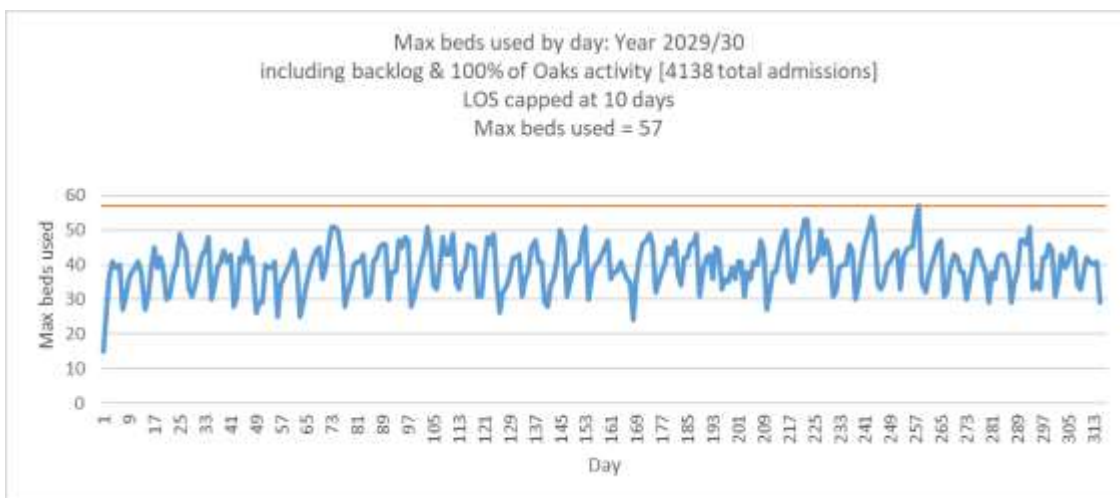


Figure 14: Projected bed numbers required for the Orthopaedic Centre in 2029/30 (mean 40 beds)

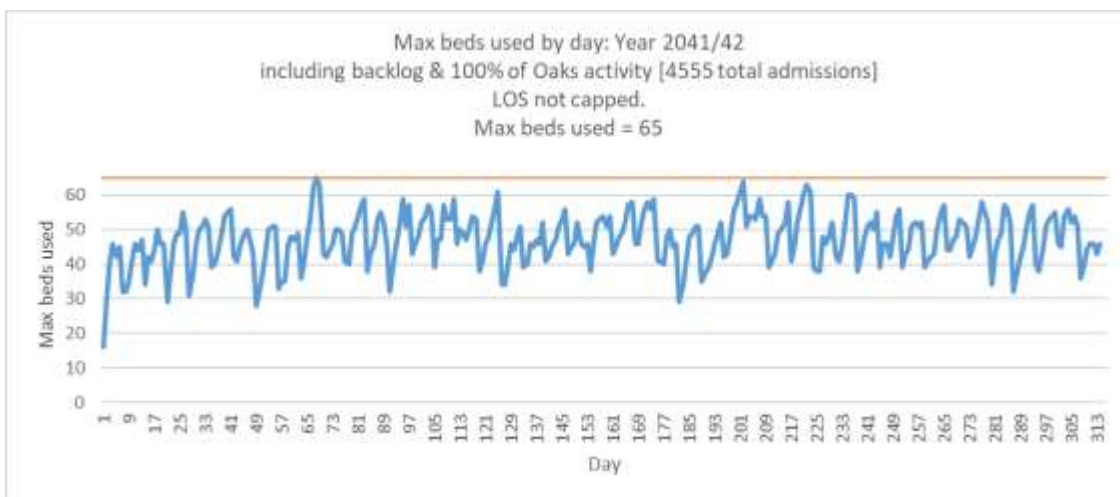


Figure 15: Projected bed numbers required for the Orthopaedic Centre in 2041/42 (mean 50 beds)

3.4.19 Whilst the exact number of theatres and beds to be provided on day one (and the expansion space required to 2041) will be established during preparation of the OBC, the working assumption is that the ECC will provide space for up to 6 laminar flow theatres with a suitable post-operative recovery area and 48-56 patient beds. It is predicted that in 2024/5 a dedicated

ECC with 5 theatres would be able to take all adult elective inpatient activity from both sites and have sufficient spare capacity to absorb the orthopaedic inpatient activity from the Oaks whatever working pattern is adopted. Moreover, an increase to 6 theatres would allow the ECC to maintain the capacity required for the elective inpatient activity projected out to 2041.

- 3.4.20 The orthopaedic transformation programme has been working on the whole pathway and the therapy-led, community element of the pathway has already been improved to ensure that at least 65% of those patients referred in to see an orthopaedic consultant go on to receive elective orthopaedic surgery; moreover, the enhanced recovery programme that has been introduced ensures that the patients length of stay in hospital is kept to a minimum with early mobilisation and rehabilitation in the community. The migration of inpatient activity to daycase has been anticipated with plans to increase capacity for daycase orthopaedics using some of the space vacated by the creation of an ECC; however, this can have the perverse effect of increasing length of stay for those procedures that remain inpatient only. Moreover, training lists and developments such as the use of new technologies (eg robotics which is already under consideration for an early trial) have the effect of increasing the theatre time required per joint. For example, a recent clinical visit to SWLEOC (South West London Elective Orthopaedic Centre) noted that it would appear to achieve the activity level predicted for the ECC in 2041 with only 5 theatres and 54 inpatient beds; however, 40% of SWLEOC's activity is daycase (with no requirement for an inpatient bed) and the theatre efficiency is delivered by the use of a very high proportion of consultant delivered surgery with no juniors, robots or use of training lists.

3.5 Orthopaedic Trauma Services

- 3.5.1 There are good examples of multi-site hospitals that have implemented elective/trauma splits of activity by site (such as Cheltenham and Gloucester) which have resulted in reductions in cancellations, waiting times and length of stay among other patient benefits. Therefore, the argument that if elective activity is centralised on one site then emergency activity should be centralised on the other site must be addressed. This argument is strongest where one site is 'hot' with a 24/7 ED accepting acute admissions and the other site is 'cold' and the hospitals are relatively close to one another. In our case, with both sites retaining 24/7 EDs and some of the highest users of this service located in Tendring (South of Colchester) and on the Suffolk Coast (North of Ipswich), it would be unlikely that public support could be gained during consultation for the transfer of patients (especially frail, older people) between sites for trauma surgery. Therefore, a full trauma service including fracture clinics and adequate theatre and ward capacity must be maintained on both sites for trauma patients. The current models of care for trauma services are slightly different across sites due to the fact they were in two different trusts until 2018 and they still have different patient administration systems (PAS). As part of work towards the ECC, the sites are aligning their processes. Introduction of the e-Trauma system, which has proved successful at Colchester, is already planned for Ipswich. This will give visibility of all trauma patients waiting for surgery across the organisation and allow decisions to be made by the wider clinical team on order of priority throughout the week.
- 3.5.2 **Trauma rotas.** Both hospitals currently operate a 12 consultant on-call rota for trauma. Consultants work in groups of three Monday-Thursday, so each consultant does a 1:3 during the week on a set day. Both hospitals deliver consultant review of every admission within 14 hours and regular senior review of all patients across the trauma wards. At Colchester, the on-

call consultant has a normal day of activity following their weekday on-call. This is often a trauma list but can also be an elective theatre or outpatients. Each consultant has a set trauma list. The consultants at Colchester also take part in a 'hot consultant' week 1:12. This involves coming out of all normal working week activities Friday to Thursday. The start of this 'hot week' coincides with the beginning of the Friday on-call (i.e. includes the weekend on-call). This gives continuity of care to all those patients admitted by that consultant at the weekend. The hot consultant carries out a ward round of all trauma patients in the hospital (including any outliers) on the Friday, Monday and Wednesday to the 'hot week'. Every working day of that week is allocated to run the virtual fracture clinic (at weekends this is fitted in wherever possible to reduce the numbers going to the Monday virtual fracture clinic when the actions from the weekend reviews are put into place). The hot consultant is the first point of contact for a senior opinion for the orthopaedic team on-call, theatre staff and ward issues. They also take phone calls from other specialties requiring senior-to-senior opinion. The remainder of the time is used problem chasing, reorganising the trauma list as things develop through the day and maintaining e-Trauma details to reflect the live state of play. The consultants are supported by six registrars and three staff grades on the on-call rota. There is also one Associate Specialist who does not take part in on-call provision and there are three specialist nurses in training. Registrars/staff grades have a rota working 24-hour non-resident on-call. No compensatory rest is allocated post on-call (non-resident pattern). The weekend is split with Friday being a separate on-call day from the Saturday and Sunday (48-hour on-call, non-resident). They work single nights (except at weekend when they work two nights) with the following day off.

3.5.3 There is some legacy disparity concerning the provision of junior medical support to the consultant teams. At Colchester there are no FY1s, eight 'SHO' level doctors (five trust grades, one FY2 and two core trainees). The team is currently recruiting to bolster the overall numbers on the junior rota to achieve parity with Ipswich and the Trust is in discussion with the deanery to even out the numbers of training posts across the two sites (which will result in one of the staff grade posts swapping sites to reduce impact of training on service provision). When the ECC opens, the registrar rotations would allow trainees access to specialist training in outpatients, trauma and daycase surgery across both sites, spinal surgery at Ipswich and elective inpatient surgery at Colchester.

3.5.4 **Trauma wards.** The trauma inpatient ward provision at the two sites is broadly similar. At Ipswich, the two trauma wards are currently some distance apart and are split by sub-specialty, with the fragility fractures based on one ward and general trauma on the other. In Colchester they are directly adjacent and split by sex with both wards admitting fragility fractures. To develop closer working and learning across sites, the wards have been 'twinned' with regular meetings between the respective ward sisters to share best practice and discuss their current operational issues and solutions. There is no significant evidence to suggest that either of these options delivers a better outcome or experience for patients; however, the fragility fracture ward in Ipswich has a relatively high turnover of staff, with anecdotal evidence suggesting this could be due to the high physical demands of the patient cohort. That said, there are practical considerations that would limit any immediate change in ward configuration because the current ward is dementia-friendly, but the general trauma ward is not. When the ECC opens and the current orthopaedic elective care ward is vacated (directly adjacent to the general trauma ward), it may be possible to relocate both wards to be collocated and dementia-friendly at which point it would be logical to make the single sex ward approach consistent across sites.

At times of high bed pressure on both sites, capacity is often lost from the current elective orthopaedic bed base in the main acute hospital to trauma or, more often, to medical outliers. At Colchester, the 20-bay elective admission/recovery area can be used for emergency admissions for other specialties (usually medicine) and this has a knock-on effect for the elective programme by reducing elective bed capacity. Paediatric trauma cases are bedded on the children's wards and, apart from the ward, their pathway is exactly the same as for the adults.

- 3.5.5 **Trauma admissions.** Admissions come through the ED or from fracture clinic. At Ipswich all admissions are on a white board in the trauma room and at Colchester are added to e-Trauma (an electronic virtual fracture clinic (VFC) platform). Discussions are ongoing with a programme to roll out e-trauma from Colchester to Ipswich. All admissions discussed at the 8am trauma meeting attended by the on call registrar/staff grade, trauma co-ordinator, virtual fracture clinic admin clerk, trainee nurse specialists, any other training grade doctors who do not have other commitments and the outgoing and incoming on-call consultant. The trauma meeting is a combined business and educational meeting also attended by the ortho-geriatric team. Ward round of admissions is conducted either before or after the trauma meeting. All admissions are reviewed by a consultant and, at Colchester, re-reviewed by the hot consultant as previously described on Monday, Wednesday and Friday. Outstanding cases are tracked via e-Trauma and the 'hot consultant' runs the trauma meeting and ensures continuity of care across the working week. The handover of outstanding cases takes place at the end of the trauma list.
- 3.5.6 **Trauma lists.** At Ipswich these take place in Lavender Theatre, South Theatres, away from main orthopaedic theatres (East Theatres) some distance from the trauma wards. At Colchester, trauma lists take place in Theatre 9, Constable Wing directly adjacent to the trauma wards. Neither trauma theatre has laminar flow. Trauma lists are 8:30am to 5pm every day at Colchester but weekend and Bank Holiday trauma lists at Ipswich are currently only 8:30-12:30. It is hoped to extend weekend trauma lists at Ipswich to full days because treatment of trauma patients delayed from weekends can result in cancellation of electives at the start of the week. Out-of-hours and at weekends – emergency trauma is picked up with other trauma (i.e. general surgical emergencies) on the CEPOD list, either in Lavender or in Emerald Theatres (for spinal) at Ipswich or Main Theatres at Colchester. Out-of-hours operating is rare for orthopaedics.
- 3.5.7 **Trauma activity.** Trauma activity is expected to grow at a faster rate than elective orthopaedics as will be seen from the table that follows. The additional capacity that will be created by the ECC will be essential to release space in the main acute hospitals, particularly at Ipswich, to allow for a reconfiguration of services for non-elective patients both to create the additional capacity required and to deliver more appropriate clinical adjacencies to improve efficiency. For example, the current non-laminar flow trauma theatre at Ipswich could be re-located to one of the vacated laminar flow theatres directly adjacent to the general trauma ward that will be vacated when the ECC is opened which would offer the opportunity to carry out total hip replacement for hip fractures in a laminar flow theatre. Both sites have provision to run an all-day trauma list, which hasn't changed for a large number of years, except now elective lists are regularly being used for trauma patients (particularly at Ipswich) and, as a result, elective patients are being cancelled at the last minute as elective capacity is lost to trauma. In addition, trauma activity can be very variable and at times one site could be inundated with trauma whilst the other could be quiet. Moving inpatient elective activity onto one site away from emergency patients would mean these lists would be protected from short notice cancellations for trauma.

Trauma Inpatients	2019	2025	2030	2035	2041
Ipswich Hospital	1,801	1,991	2,164	2,356	2,565
Colchester Hospital	2,238	2,460	2,695	2,940	3,179
Total	4,039	4,451	4,859	5,296	5,744

Table 9: Non-elective Trauma Inpatient Activity Projections

3.5.8 **Trauma performance.** ESNEFT treats over one thousand hip fractures per annum of which over half are intra-capsular; however, only 7% and 12% of National Hip Fracture Database (NHFD) defined eligible intra-capsular hip fractures receive a total hip replacement (THR) compared to a national average of over 34%. Only 53% and 63% of hip fractures have surgery on the day of, or day after, admission compared to a national average of 71% and there would appear to be a good correlation between surgery on the day of admission and shorter lengths of stay. On one site only 54% of the surgery is supervised by a consultant surgeon and anaesthetist compared to 94% on the other site which is an undesirable variation in practice between sites. These figures suggest there is potential to improve on practice for hip fractures as well as the estate.

Trauma Arthroplasty 2018	National	Colchester	Ipswich
% of patients meeting best practice criteria*	63% ²³	63%	46%
Number of Hip Fractures		530	501
Number of intra-capsular fractures		TBC	262 (52%)
Eligible displaced intra-capsular fracture with THR	34%	12%	7%
Admitted to orthopaedic ward within 4 hours	38%	73%	76%
Surgery on day or day after admission	71%	63%	53%
Surgery with consultant surgeon and anaesthetist	63%	54%	94%
Acute length of stay (days)	14.9	14.1	14.7

Table 10: Trauma Arthroplasty Performance 2018

Trauma and Arthroplasty: Percentage of eligible patients receiving THR for hip fracture.

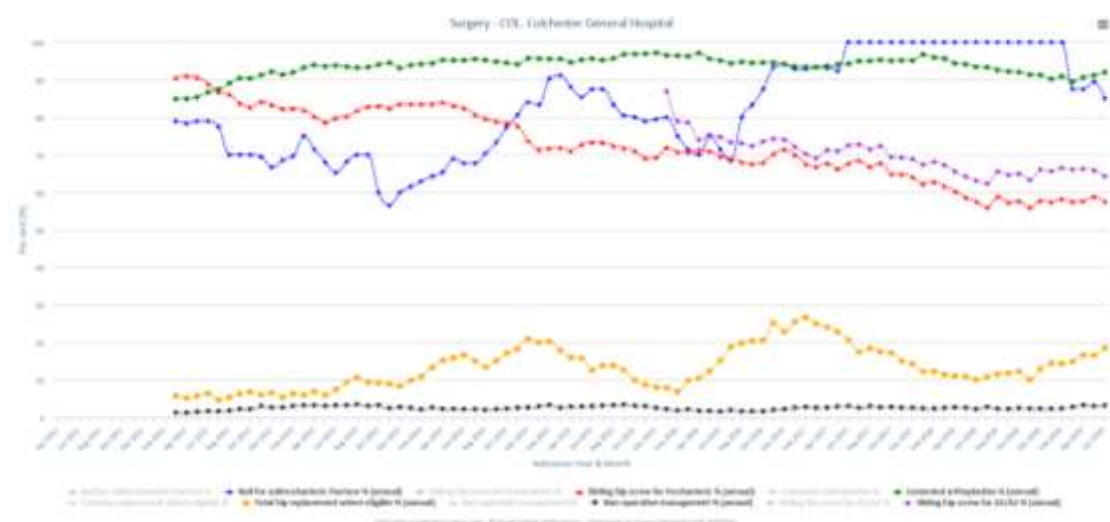


Figure 16: Trauma Arthroplasty - % THR at Colchester Hospital

²³ West Suffolk NHS Foundation Trust achieved 94% compliance with best practice criteria in 2018.

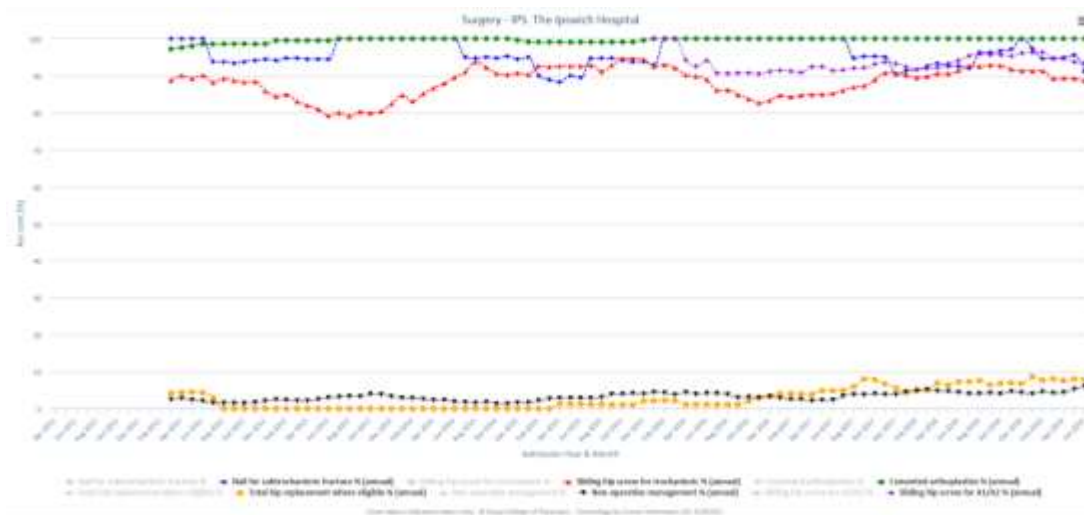


Figure 17: Trauma Arthroplasty - % THR at Ipswich Hospital

3.6 Proposed model of care

- 3.6.1 The proposed clinical service model would deliver orthopaedic outpatients, diagnostics, day surgery and follow-up outpatients along with a comprehensive trauma service including fracture clinics on both the Ipswich and Colchester Hospital sites. Only adult inpatient elective surgical activity would be centralised on one site. This is aligned to the successful bid for transformation capital funding, the FBC for the merger, and the principles underpinning the creation of Suffolk & North East Essex ICS. The proposed model will deliver specialised trauma and elective care that meets national standards and delivers reconfiguration to facilitate delivery of sub-specialisation, removal of unwarranted variation, critical mass and minimal volumes to ensure both quality and financial sustainability and protection of specialist services.
- 3.6.2 The proposed clinical model is aligned to and meets the principles of the ESNEFT Future Care Model with a single service providing local care where practicable and centralised were necessary. There is a financial case for change that requires the delivery of flexible, efficient and sustainable clinical services with enhanced capacity to absorb any NHS activity currently delivered in the private healthcare sector. Implementation of this model will deliver this through a focus on productivity and efficiency. Importantly, this is not a move towards a hot/cold split of trauma and elective orthopaedic services, which would be in contravention of the merger commitment to maintain fully functioning emergency departments on both sites.
- 3.6.3 The draft vision for arthroplasty is compatible with the wider ambition and strategic objectives of the Trust:

“To develop a unit that will be recognised as the “go to” orthopaedic centre in the East of England. The unit will provide timely, accessible, expert opinions with state-of-the-art diagnostic and treatment modalities including rehabilitation in new facilities purpose-built to the latest standards. The service will deliver high quality care with excellent outcomes, appropriately shortened length of stays, very low complication rates and high patient satisfaction.

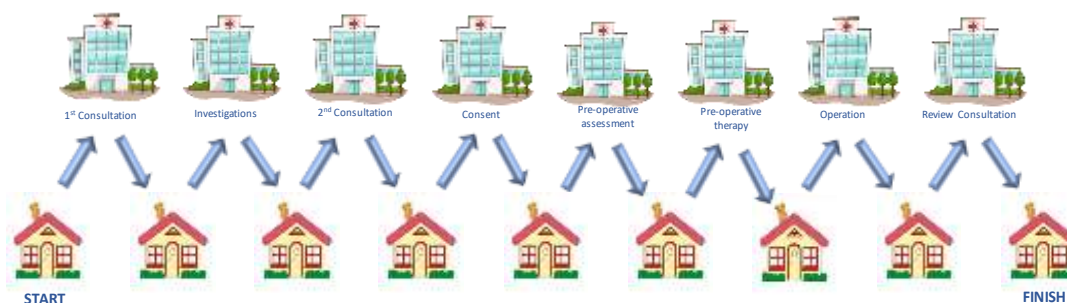
To create a unit with close ties to national training programmes and local universities to deliver an evolving and sustainable leading role in orthopaedic care using innovation, research and

education to provide the highest quality experience for all patients. Collaborative working with higher education institutes, national and international associations resulting in an environment that attracts the highest quality staff and creates a setting for the advancement of the delivery of medical training for doctors, nurses, physiotherapists, occupational therapists and all other staff working within the unit.”

3.6.4 Consultants from both hospitals have been working together develop a model of care that will deliver benefits for both patients and staff and have agreed that the best option would be to create an ECC for adult elective inpatients. The project is clinically driven and has wide-ranging benefits including adoption of best practice, minimising unnecessary duplication, providing equity for all patients, and compliance with national standards. Listed below are some of the problems the service faces and the benefits of the ECC which serve to mitigate these issues.

Issues with Model of Care

• **Current Patient Pathway**



The current patient pathway can involve up to 6 separate visits to hospital before surgery with the inconvenience associated with travel. This hospital-based process, which is slightly different at each site, follows a community-based process which will have involved visits to the local GP and referral to the Community MSK Assessment Service for up to 4 therapy-led sessions. The community assessment is slightly different according to location and is provided by physiotherapists from AHPS (Allied Health Professionals Suffolk) in East Suffolk and ACE (Anglia Community Enterprise) in NE Essex which are both community interest companies. Following surgery at the local hospital, Ipswich patients would typically receive 4-6 therapy sessions for a total knee replacement from hospital staff followed by referral to the community team whilst Colchester patients would be referred to ACE for community-based post-operative physiotherapy. All patients would receive up to 2 routine follow-up appointments at the hospital and, depending on individual practice, may then receive nurse-led or therapist-led follow-up at the hospital for up to 10 years.

• **Future Patient Pathway**



In the future, it is intended that the introduction of routine ‘one-stop’ clinics at the local

hospital will significantly reduce the inconvenience for patients associated travel to and from the hospital. The patient pathways will be standardised across sites and as much of the process conducted in the community as possible via hospital staff. In other words, the proposed changes to the service are not dependent on out of hospital changes by other community providers. Special outpatient clinics will be provided for older people and/or complex patients so that the risks and benefits of surgery may be carefully considered. Elective surgery will take place at the new ECC, under the care of the same consultant, which for up to 1,400 patients will involve a longer journey to this new facility built to the latest standards. All post-operative rehabilitation would be expected to take place in a community setting with follow-up only by exception at the local hospital.

- **Elective inpatient capacity.** Demand for elective services has already outgrown current capacity resulting in significant outsourcing of activity to the private healthcare sector. Colchester Hospital has provision to run three instrumented lists concurrently but Ipswich Hospital only has provision for two lists with instrumented cases to run concurrently. Elective capacity has not changed for either site since Constable Wing was built at Colchester in the late 1990s in spite of the inexorable growth in demand for orthopaedics from an increasing and ageing population. The theatres on both sites currently used for elective orthopaedics are tired and the main theatres at Ipswich are in need of refurbishment. There are also limitations on the productive use of theatre time due to the lack of laying-up rooms and, at Ipswich Hospital, use of elective inpatient beds and theatre lists for trauma patients.
- **Elective inpatient waiting times.** The impact of the growing demand and lack of capacity is seen in high and lengthening waiting times for surgery. The proportion of patients waiting to start elective orthopaedic treatment within the 18-week referral-to-treatment (RTT) NHS operational standard should be 92%+. In September 2019 (the most recent month for which figures are available), the incomplete pathway performance nationally was 82.7% across all providers but only 75.5% at ESNEFT. Of the patients admitted, 50% were treated within 15 weeks nationally across all providers but at ESNEFT this figure stretches out to 20 weeks.
- **Elective daycase capacity.** Colchester Hospital does not have an appropriate day surgery facility to run effective orthopaedic day case lists, resulting in nearly all of the elective activity (elective inpatient and some daycase) being run through the 3 theatres in Constable Wing. The orthopaedic daycase theatre in DSU at Colchester Hospital is in need of replacement and is now only used for minor procedures (only 6 of the 10 available sessions are utilised). At Ipswich, a 'Vanguard' ultra clean theatre unit is rented at Walker Close in Ipswich for foot and ankle surgery because there is insufficient ultra clean daycase capacity in Ipswich Hospital. The Raedwald DSU currently provides 10 sessions a week for orthopaedics but demand is growing and paediatric orthopaedic day surgery would like to move to Raedwald from the spinal theatre where this activity is currently undertaken.
- **Non-admitted patient waiting times.** Again the impact of growing demand and lack of capacity is seen in long waiting times. In September 2019, of the patients starting orthopaedic treatment not involving an admission (eg. outpatient appointments), 50% were treated within 6 weeks nationally across all providers but at ESNEFT this figure was 13 weeks.
- **Trauma capacity.** Trauma activity is expected to grow at a faster rate than elective orthopaedic activity and the current capacity is already under pressure. This is a particular

issue at Ipswich Hospital where the lack of all-day trauma lists at weekends means the ring-fencing of elective beds is breached regularly by trauma patients with the use of elective theatre lists for trauma patients leading to the short notice cancellation of elective activity.

- **ITU/HDU capacity.** Use of critical care for elective orthopaedic patients is fortunately rare. For example, in 2018/19, on the Ipswich site, all elective orthopaedic patients used a total of 56 days in critical care which would equate to 0.153 critical care beds used per day. The current occupancy of the 13 critical care beds at Colchester is 84.9% and were these extra 56 bed days to be required it would increase to 86.1% which is only slightly higher than level recommended for safe and efficient patient care²⁴; however, options to provide limited periods of Level 2 (HDU) support for patients recovering in the post-anaesthetic care unit (PACU) are under consideration and the creation of an ITU step-down facility/central HDU to increase effective ITU capacity at Colchester in due course for a range of users is the subject of a separate business case. The adjacency and ease of access to ITU/HDU facilities varies according to the scenario chosen; however, adjacencies are broadly equivalent to those already in use. There is often a trade-off to be made in terms of the ease of access to ITU/HDU, which is usually located at the centre of an acute hospital site, and the risk of the use of elective beds for emergency admissions. All scenarios would include a PACU as an integral part of the ECC with interior access to the hospital's main ITU facilities for the post-operative care of complex and revision cases.
- **Impact of capacity constraints.** Both sites are experiencing increases in elective demand. This is in addition to the number of patients who are outsourced to the Oaks private hospital from Colchester due to lack of capacity. This is exacerbated by 'winter pressures' that can lead to further activity being cancelled due to lack of beds. During 2018/19 the overall ESNEFT cancellation rate for trauma & orthopaedics (including spinal surgery) was 26% with:
 - 441 patients cancelled on the day of surgery;
 - 606 patients cancelled within 1-2 days of surgery; and,
 - 2,088 patients cancelled more than 2 days before surgery.

The main reasons for cancellation were the use of elective theatre lists for trauma patients and the use of elective beds for emergency admissions. The provision of a dedicated elective care unit, separate from the acute wards, will mitigate this and allow the delivery of elective activity on plan as well as reducing patient waiting times and disruptive cancellations.

Benefits of Proposed Model of Care

- 3.6.5 As has been stated, a strong patient benefit case is required to support a significant investment of public capital in a Centre for Elective Orthopaedic Surgery. The benefit case has to both justify release of the allocated capital funding as part of the regulatory scrutiny of high value business cases and convince the public that the proposed changes deserve their support during public consultation. Demonstrating patient benefit is always a challenge and usually involves a significant element of clinical judgement supported by best practice examples of the benefits delivered in similar cases. Proposals for change in clinical services often generate resistance for a variety of reasons from staff and members of the public and there are many examples of hospitals losing pre-allocated funding due to regulatory delays following negative feedback

²⁴ 'Critical Capacity: a short research survey on critical care bed capacity', Faculty of Intensive Care Medicine, March 2018.

from public consultation. In many cases the key point to demonstrate is that any perceived inconvenience (eg travel distance) is more than justified by improvements in outcomes or sustainability. The most important factor in gaining public support for any significant change in the NHS is usually the support of clinicians for the proposed change.

3.6.6 **Getting it right first time (GIRFT).** GIRFT has clearly demonstrated that there is an opportunity to improve medical care within the NHS by reducing unwarranted variations. The national review of adult elective orthopaedic services in England in March 2015²⁵ identified areas of unjustifiable variation in practice and made recommendations as to how to deliver cost-effective, clinically-driven change. At the heart of reducing variation is the extensive evidence base that higher volume activity leads to better outcomes^{26,27,28,29,30} when combined with local recognition of the skills needed to drive up general standards and achieve volume related improvements. The same literature obviously offers substantial evidence that surgeons undertaking low volumes of specific activities may well result in less favourable outcomes as well as increased costs. This has resulted in a call for professional bodies (led by speciality societies through the BOA) to make recommendations on minimum numbers of high cost routine and complex cases. It has also led to the recommendation that robust regional networks should be established with regional centres to ensure appropriate critical mass for complex and low volume cases to achieve excellent outcomes for patients with low complication rates along with an urgent requirement to rationalise the number of providers who undertake revision activity to no more than 30-40 networks nationally³¹.

3.6.7 The domains used for the consideration of patient benefit below are consistent both with the criteria used in the business case for the merger and the Trust's Quality Impact Assessment.

- **Patient outcomes.** *Plans support the patient's clinical needs and deliver improved quality and patient outcomes wherever possible.*
 - There is good evidence that consolidation of clinical services delivers improvements in clinical effectiveness through the well-documented link between increased volume of activity and improved outcomes in terms of mortality and morbidity³² (cf. IOG).
 - One of the key drivers of the new clinical model is to minimise variation between the two sites by adopting existing clinical best practice to improve the reliability of outcomes. A clinically-led group is to be established to harmonise the model of care between sites and across primary care, community pre-assessment and rehabilitation.
 - There is good evidence of the clinical advantages of having dedicated (ring-fenced)

²⁵ Briggs T. (2015) National review of adult elective orthopaedic services in England – Getting it right first time (GIRFT). BOA.

²⁶ Pamiilo, K., Peltola, M., Paloneva, J., Makela, K., Hakkinen, U., Remes, V. Hospital volume affects outcome after total knee arthroplasty. A nationwide registry analysis of 80 hospitals and 59,696 replacements. *Acta Orthopaedica* 2015; 86 (1): x-x 1

²⁷ Chowdhury, M.M., Dagash, H. & Pierro, A. (2007) A systematic review of the impact of volume of surgery and specialization on patient outcomes. *British Journal of Surgery*, 94 (2), 145-161.

²⁴ Com-Ruelle, L. et al. (2008) Volume d'activité et qualité des soins dans les établissements de santé. Paris, IRDES

²⁹ Davoli, M., Amato, L., Minozzi, S. et al. (2005) Volume and health outcomes: an overview of systematic reviews. *Preventive Epidemiology*, 29 (3-4 Supplement), 3-63. Helm, E.A., Lee, C. & Chassin, M.R. (2002) Is volume related to outcome in health care? - A systematic review and methodological critique of the literature. *Annals of Internal Medicine*, 137 (6), 511-520.

³⁰ Jain, N., Pietrobon, R., Guller, U., Ahluwalia, A. & Higgins, L. (2005) Influence of provider volume on length of stay, operating times and discharge status for rotator cuff repair. *Journal of Shoulder and Elbow Surgery*, 14 (4), 407-413.

³¹ Briggs T. (2015) National review of adult elective orthopaedic services in England – Getting it right first time. BOA. Page 54.

³² Ravi, B, et al. (2014) Relation between surgeon volume and risk of complications after total hip arthroplasty: propensity score matched cohort study. *British Medical Journal* 2014; 348:g3284 doi:10.1136/bmj.g3284.

beds and elective orthopaedic units built to the latest HBN standards in terms of reduced delays to theatre, reduced infection rates^{33,34}, shorter lengths of stay³⁵ and fewer cancellations³⁶ particularly on the day of surgery (due to medical outliers).

- **Patient experience.** *Plans improve the experience of patients, their families and carers matching capacity to demand at their preferred location(s) for care where practicable.*
 - There is good evidence that standardisation of clinical operations is linked to improved reliability of outcomes³⁷ with resultant improvements length of stay, waiting times and cancellation rates that would improve the experience of patients, their families and carers (eg. GIRFT). That said, a recent analysis of NJR data from 430 hospitals across the UK revealed that Ipswich Hospital was one of only 6 NHS hospitals and one private hospital with better than expected rates of hip revision surgery³⁸.
 - If GIRFT recommendations were to be fully implemented, with 30-40 regional centres nationally conducting all complex and specialist work (including revisions), the creation of a single Centre for Orthopaedic Surgery would give ESNEFT the best chance of designation as a regional hub thereby maintaining convenient local access for patients to the full range of elective orthopaedic procedures.
 - Creation of the ECC would aim to improve overall patient experience in terms of the quality of care through the provision of an improved physical environment, reduced waiting times³⁹, length of stay, cancellations at short notice, complications, re-admissions and the total number of visits (to compensate for any longer journey).
- **Clinical sustainability.** *Plans improve clinical and workforce sustainability and support the delivery of acute and emergency services across 7-days. Plans should contribute to the development of staff and specialist services through innovation, research, education and training and provide regional competition for the delivery of the best care thereby helping the Trust to retain and attract the best healthcare professionals.*
 - ESNEFT is already one of the biggest T&O units in the country by activity and increased elective inpatient activity offers improved opportunities for sub-specialisation.
 - Greater scale has been shown to increase patient recruitment into clinical trials, provide earlier access to novel treatments (such as robotic surgery) and increase patient confidence that care is being delivered by a high quality provider.
 - The new elective orthopaedic centre would be likely to offer additional research and commercial opportunities due to the critical mass of clinical activity and staff that would be achieved.
 - ESNEFT is committed to delivering on-site clinical and educational supervision for all

³³ <http://www.bjj.boneandjoint.org.uk/content/88-B/7/943.long>

³⁴ <https://www.lenus.ie/hse/handle/10147/303576>

³⁵ Barlow D, Masud S, Rhee SJ, Ganapathi M, Andrews G. Ring fenced beds - The effect of a 'ring-fenced' orthopaedic arthroplasty ward on length of stay and surgical site infection - <http://www.ncbi.nlm.nih.gov/pubmed/22717284>

³⁶ M.R. Whitehouse, N.S. Atwal, J.A. Livingstone. Does Ring-Fencing Improve Efficiency in an Orthopaedic Day Case Unit? - <http://www.iaasmed.com/files/Journal/14/14.4/WHITEHOUSE.pdf>

³⁷ Badawy, M, et al. Higher revision risk for unicompartmental knee arthroplasty in low-volume hospitals. Data from 5,791 cases in the Norwegian Arthroplasty Register. *Acta Orthopaedica* 2014; 85 (4): 342–347.

³⁸ 'Revealed: The best and worst places to have your hip operation', *The Telegraph*, 12 October 2019

³⁹ 'Patients waiting for hip operations suffering 'pain worse than death'', *The Telegraph*, 15 August 2019

medical grades and 24/7 consultant support fully compliant with all NHSE 7-day working quality standards.

- Health Education England is supportive of the intention for T&O specialist trainees to rotate into the Elective Care Centre and benefit from enhanced training opportunities in joint replacement surgery.
- In 2019, trainees voted Colchester as their Orthopaedic Training Hospital of the Year. ESNEFT will be able to offer excellent training opportunities and attract the best trainees for CST/STR posts and internationally for fellowships. This will be good for trainees and for staffing but will also help to provide the highest quality staff for care.
- **Financial sustainability.** *Plans improve efficiency through the reduction of waste from duplication and contribute to the development of a financially sustainable care system.*
 - There is good evidence that dedicated units deliver significant improvements in both clinical and financial efficiency. These benefits include increased theatre utilisation, decreased lengths of stay, shorter waiting times and decreased infection, complication and re-admission rates (eg. SWELEOC and Guy’s and St Thomas’).
 - There are best practice models (eg three-session days and six-day operating) currently not in place as standard at either site that could form part of new ways of working.
 - Creation of a new-build elective care centre on the Colchester site would permit re-use of the vacated theatres in Constable wing as the replacement day surgery unit offering capital savings that would not be available if the centre were to be built on the Ipswich site (when a new build day surgery unit would be required at Colchester).
 - It has been assumed that the Trust will compete for the repatriation of NHS ‘Choice’ activity by delivering low waiting times and offering the highest quality care.
- **Alignment/Strategic fit.** *Plans align with the STP’s clinical vision for the Integrated Care System and have the support of commissioners. Plans are compatible with national policy, particularly the NHS Long Term Plan 2019.*
 - The allocation of new capital for the creation of a single elective care centre through clinical reconfiguration was awarded the highest priority for funding by our STP/ICS.
 - Creation of a new-build elective care centre on the Colchester site would free up clinical space on the Ipswich site that would allow much needed improvements to be made in terms of clinical adjacencies and quality of estate for a number of other clinical services.
- **Deliverability and execution risk.** *Plans must be assessed for likelihood of service being able to maintain effective performance management and meet all regulatory and statutory requirements.*
 - The creation of a new, dedicated elective care centre would increase the physical capacity and quality of estate available within ESNEFT for orthopaedic care. This would offer the Trust the greatest likelihood of being able to meet performance and regulatory standards as demand for these services grows over the next 20+ years.

- Consultant cover will be operated on a team-based approach with agreed standard operating procedures for all peri-operative care. ESNEFT has an active programme of competency-based team modelling incorporating the medical, advanced care practitioner, nursing and physician associate workforce to ensure maintenance of safe ward staffing and skill-mix.

3.6.8 Consideration of benefits will also include potential improvements in quality that could be available with this option in terms of % best practice criteria, etc. along with any potential impact on access in terms of waiting times for related services (trauma, daycase and spinal) if additional capacity were to be made available in the form of an elective care centre on one site.

3.7 Workforce Issues

3.7.1 This section looks to identify the key workforce issues that need to be addressed to ensure a sustainable workforce to deliver services at both the ECC and on both acute sites. Both sites will continue to deliver trauma services and so have trauma beds and DSUs. The specialist spinal service will continue to be delivered from Ipswich Hospital.

3.7.2 A key enabler for planning the workforce for the ECC and remaining T&O services on both sites, is how the Trauma service will operate. This model will have to be consistent across both sites and will be worked up over the next 2-3 years to ensure 24/7 cover on both sites. The T&O teams across both sites currently operate differently, for example, there are only FY1 doctors at Ipswich and Advanced Nurse Practitioners (ANP) support the Ipswich FY1 rota. The Implementation Team will work with the Medical Director, Clinical Education Leads and Deanery to develop a staffing model for doctors in training that delivers the best possible training experience to these staff combined with use of Physician's Associates and ANPs. The ECC and the spinal service at Ipswich provide enhanced opportunities for doctors in training to rotate between sub-specialties and this will, of course, include a placement in the ECC. Health Education England is supportive of the intention for T&O specialist trainees to rotate into the ECC and benefit from enhanced training opportunities in joint replacement surgery.

3.7.3 In terms of the T&O nursing workforce, Acuity Reviews are undertaken on a 6-monthly basis across all six wards that support delivery of a sustainable workforce adjusted to patient demand / acuity. It is envisaged that the ECC may operate for 3 sessions per day during the week and this would necessitate an extended recovery service until midnight on those days. Complex patients and revision joints would stay as inpatients. The anaesthetic trainee doctor at the ECC site will cover this extended recovery as part of their on-call. At Ipswich, the current burden for this cover is not onerous.

Workforce Issues, associated risks and plans for mitigation

3.7.4 A number of potential workforce issues have been identified and have been included in the table below along with their associated risks and initial plans for mitigation. In consequence of the significant number of retirements anticipated before the ECC would open, the number of staff directly affected and likely to be offered the opportunity to work on a different site is expected to be relatively small. Natural staff turnover in other areas could be expected to provide sufficient opportunities for any staff unwilling to move to work in the ECC by 2024/5.

Issue	Risk	Mitigation
<p>Cross-site working – there will be a cost in financial and time terms of staff based at the non-ECC site travelling to the ECC site.</p>	<p>Travel is unproductive use of staff time.</p> <p>Staff safety (increased time on the road – increased risk of accidents?)</p> <p>Increased cost to run the service.</p>	<ul style="list-style-type: none"> • There will not be travelling between sites for nursing or AHP staff for service delivery (travel likely for developmental purposes but this will be during core day-time periods and supported by normal travel training expense arrangements). • Some T&O ward-based staff and non-medical theatre staff will be re-deployed to the ECC. A consultation to support this process will be undertaken including details on travel expenses. • Medical doctor in training on-call will be incorporated into the site on-call arrangements. Doctors in training will rotate to the ECC for a 6-month period during their placement. During this period they would deliver on-site on-call, so travel will not be an issue. The junior medical on-call may / may-not include the ECC ANP staff – this will be dependent on the service model agreed. • It has been identified that Consultant / Senior Registrar / Registrar / Specialty Doctor staff based on the ECC site will provide senior medical on-call activity so this will not require additional travel for these individuals. • The staff affected with additional travel will be consultants, other career grade medical staff and senior registrars / registrars who are based on the non-ECC site as for up to 4 out of 6 weeks they will work at the ECC. They will be entitled to work-based travel expenses in accordance with the Trust’s travel expenses policy and procedure (as staff who currently work across sites). • It is felt that the productivity and morale gains from having ‘protected beds’, for elective care so that winter pressures do not impact on elective activity will outweigh the inconvenience and cost associated with staff travelling to the ECC.
Issue	Risk	Mitigation
<p>What if staff from the non-ECC site do not wish to travel to work in the ECC?</p>	<p>Failure to have a sustainable workforce model to deliver the transformed service.</p>	<ul style="list-style-type: none"> • It is envisaged that with a ‘state of the art’ ECC, the opportunity to be part of a regional centre, and the additional opportunities this will give for research and innovation, many staff from both sites will be keen to work in the ECC. • Nevertheless, a communication and engagement strategy will be developed prior to public consultation and sustained throughout the period until implementation to ensure that messaging around this service transformation re-assures and supports staff wherever they are on their career journey.

		<ul style="list-style-type: none"> • Some medical staff will routinely be required to travel from the non-ECC site to the ECC in blocks of time in accordance with their rotas. These will be consultants, other career grade medical staff and senior registrars / registrars based on the non-ECC site. <ul style="list-style-type: none"> ▪ For doctors in training this will be detailed in schedules issued pre-commencement as part of their contract. It is anticipated that working at the ECC will provide doctors in training with enhanced training opportunities in the most modern facilities. ▪ For consultants and other career grade medical staff a consultation around 7-day working including working in the ECC will be undertaken. Following consultation job plans will be amended accordingly. It is likely there will be at least a 9-month lead-in period (6 months for consultation and 3 months for notice of a change in job plan) although it is anticipated that the vast majority of staff will welcome this as a positive development. • Some non-medical ward-based staff and theatre-based staff will also be re-allocated to the ECC site from the non-ECC site. This will be supported by a consultation process and clear travel expenses / support.
Issue	Risk	Mitigation
<p>This service transformation will require additional staff in T&O and also in hard-to-fill roles – particularly anaesthetic & theatre staff – how, in the increasingly challenging national context will this be delivered?</p>	<p>Failure to have a sustainable workforce model to deliver the transformed service.</p>	<ul style="list-style-type: none"> • ESNEFT has recently enjoyed success in recruiting a T&O consultant and two consultant anaesthetists, and the vacancy factor is relatively low with actions in place to lower it further. The number of training grade vacancies across ESNEFT has also decreased and feedback from trainees cited that one of the main reasons for choosing ESNEFT was the breadth of training opportunities that are available. • Nevertheless, this service transformation would offer significant kudos to future recruiting including: <ul style="list-style-type: none"> ▪ The brand new ‘state of the art’ ECC ▪ The opportunity to be part of a regional centre ▪ Opportunity for enhanced training in and obtaining substantive roles in sub-specialties including spinal surgery and rehabilitation ▪ Additional opportunities for research and innovation. <p>These will all be unique selling points in a targeted recruitment strategy to attract the highest quality and motivated staff.</p>

		<ul style="list-style-type: none"> The combination of the demonstrated post-merger ability to appoint to hard-to-fill consultant roles and future enhancements to services that will attract staff, is expected to support successful recruitment to all required roles. It is also hoped that the enhanced training opportunities will enable ESNEFT to “grow its own” consultant workforce in the future.
Issue	Risk	Mitigation
How will the Trust ensure that in clinical teams working / training at the non-ECC site are not considered as ‘second best’ to the ECC site?	Failure to retain and recruit quality staff to sustain services at the non-ECC site.	<ul style="list-style-type: none"> Both sites will continue to deliver trauma and day case activity. Doctors in training will rotate between the non-ECC and ECC sites during their placements. This will also support discussions with the Deanery on training numbers as the Trust will be able to offer higher quality training opportunities. This in turn influences the Trust’s ability to attract trainees into substantive Consultant and other career grade roles Nursing and AHP staff will be supported to rotate between the trauma and elective services on both sites to enhance skills.

Table 11: Workforce Issues, associated risks and plans for mitigation

Detailed Workforce planning

- 3.7.5 The new Director of Workforce has joined the newly formed Building for Better Care Programme Board and with the very recent appointment of a workforce integrated care system (ICS) lead a comprehensive workforce plan is now in development for the future of the service, supported by the clinically-led Elective Care Working Group. This will be based on a more detailed understanding of the staffing needs of the ECC when it opens in 2024 and any associated issues identified following public consultation. The work of this group is also examining potential changes to working patterns within orthopaedics (such as use of all-day lists, extended days and 6-day working) and the development of definitive rotas for consultants.
- 3.7.6 The workforce plan will cover the recruitment, retention, training and development across all staff groups, including but not limited to Medical, Nursing and AHP. The workforce plan will be developed and implemented to enable the right establishment and skills mix to be available for the opening of the ECC with no adverse impact upon the quality of services remaining as both Ipswich and Colchester hospitals. A key part of this detailed workforce plan will be the identification of all potential risks and the development of clear mitigations.
- 3.7.7 Detailed workforce planning will also allow for inclusion of all elements of the NHS Employers Workforce Supply Strategy. ESNEFT intends to ensure that it continues to attract and retain the best staff by improving access to employment for new staff and retaining existing staff by improving staff experience.

4. Estates options to support clinical service reconfiguration

This section describes the wide range of estates options considered following extensive engagement with clinical stakeholders, patient representatives and partner organisations along with an assessment of the risks and benefits of each option.

4.1 Facilities for elective (planned) orthopaedic surgery

4.1.1 The Building for Better Care capital funding has been awarded to improve access to emergency care, including a new emergency department at Ipswich, and to improve access to elective care through the re-provision of facilities for day case surgery at Colchester and the creation of a single elective surgery centre. The following additional considerations have been identified:

- Facilities for any services displaced by or required for the creation of a new centre for elective surgery must be re-provided from within the available capital funding;
- Any centre for elective surgery should be adjacent to but separate from the main acute and emergency facilities to reduce the possible use of elective beds for medical outliers;
- Any elective orthopaedic surgical facility must have access to a minimum of 5 laminar flow theatres (with room for expansion to 6) and at least 48 elective inpatient beds which would require a minimum total floor area to HBN Standards of 5,120sqm;
- Access to any new facility should be good with convenient public and staff parking.

4.1.2 **Option 1: Business as usual.** This is the ‘do minimum’ option with no significant change to existing arrangements. This option would not deliver the capacity required and, although not considered a viable option, it was used as a benchmark to show the ‘business as usual’ position.

4.1.3 **Option 2: Redesign existing space at Colchester.** Colchester has existing facilities that could be modified for use as an orthopaedic centre. The modern facility offers good clinical space and adjacencies to essential clinical support services in the main buildings connected by a covered link corridor. The 3-storey building currently has 5 operating theatres on the top floor (3 with laminar flow) and 2 wards used for elective orthopaedic surgery (day case and inpatient).

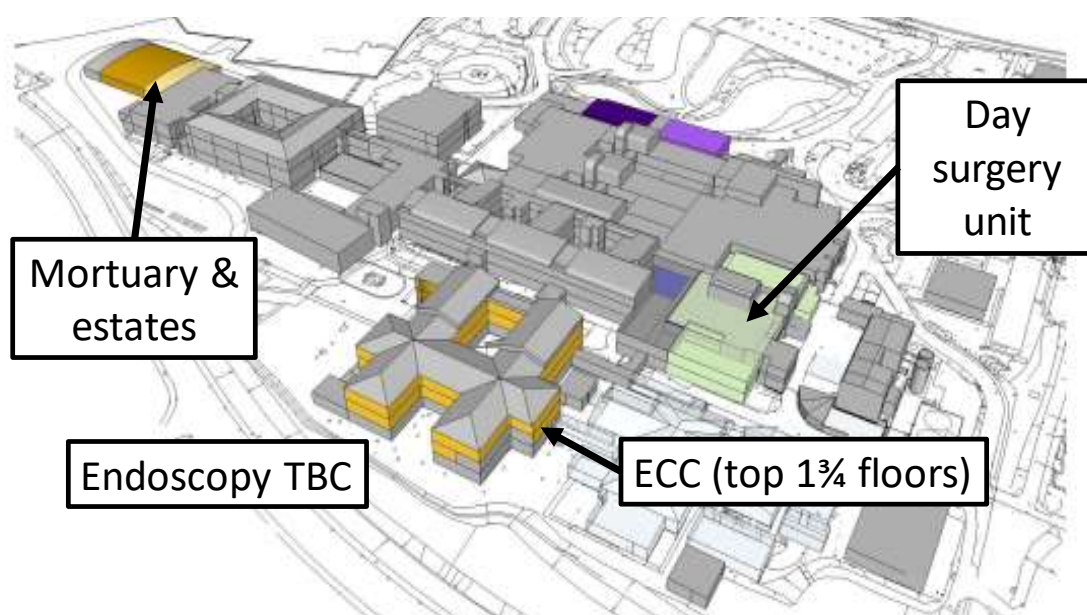


Figure 18: Redesign existing space at Colchester: Option 2

- 4.1.4 If this existing facility were to be used a number of clinical services would be displaced and, in simple terms, in addition to the replacement for the day surgery unit, another new inpatient ward and three new theatres would have to be built from within the allocated capital budget. A potential location for a replacement day surgery unit would be in the main hospital building adjacent to the surgical admissions ward in the space currently occupied by the restaurant and offices on the first floor (which would need to be re-located). Patient reception and recovery areas could be provided on the ground floor in the space which could be vacated by a move of the mortuary and bereavement suite, estates workshops and the goods delivery yard to the current medical records facility. This option would involve a large number of inter-dependent phases of building work in or directly adjacent to clinical areas that would be likely to be highly disruptive to other clinical services. Moreover, the extensive nature of the work and sequential clinical service relocations would require a temporary decant facility. This option was not considered to be practically buildable or affordable and was not shortlisted for further analysis.
- 4.1.5 **Option 2A: Redesign existing space at Ipswich.** Ipswich Hospital was considered but no suitable building could be found with the required clinical adjacencies for redesigning existing space as a centre for orthopaedic surgery. Much of the clinical space at Ipswich now needs updating which cannot be completed without suitable vacant space to take the existing clinical services while the work is completed. The pressure of demand on the existing clinical space means that decant space is not currently available but it would become available if the centre for orthopaedic surgery were to be located at Colchester.
- 4.1.6 **Option 3: New build at Ipswich and new build day surgery unit at Colchester.** A variety of locations were considered with the existing Education Centre at the heart of Ipswich Hospital (**Option 3A**) an obvious place to be re-developed for clinical use. Whilst this location is constrained on three and a half sides by existing buildings, it is well located beside the main hospital corridor with good adjacencies to essential clinical support services. It should be noted that a new build orthopaedic centre on this site would require more than two storeys to provide the necessary floor area. In view of the adjacency to residential housing, outline planning permission would have to be established at the earliest opportunity. Before the site could be cleared for building, a replacement Education Centre would have to be provided which would be likely to involve use of existing car parking space to be re-provided by a multi-storey car park.



Figure 19: New build at Ipswich and new build day surgery unit at Colchester: Option 3A

4.1.7 Alternative locations were considered for the orthopaedic centre at Ipswich Hospital site on car parks adjacent to existing clinical buildings and, whilst not requiring a replacement Education Centre, all would require replacement of lost parking in the form of a multi-storey car park, re-routing of roads and provision of a covered connection to the existing hospital buildings for patients. However, these less constrained car park sites should permit the necessary floor area to be provided across two floors rather than three. If the site next to the Garrett Anderson Centre (**Option 3B**) were to be used the cost and complexity of linking the new building to a private finance initiative funded building would have to be factored in. The major decant and building work that will be in progress to create the new expanded Emergency Department and Urgent Treatment Centre at Ipswich Hospital may further complicate delivery of this option. Most importantly, with Option 3, the space vacated at Colchester by the centralisation of elective orthopaedics at Ipswich (one inpatient ward and two theatres) would not be sufficient to be re-used as a replacement day surgery unit. Therefore, any Ipswich site option for the orthopaedic centre would result in the requirement for a new build replacement of the day surgery unit at Colchester. This adds significantly to the cost (compared with the cost of refurbishing existing clinical space) because the floor area required to meet mandatory NHS Health Building Note (HBN) standards for new buildings is considerably more than the space currently used for the equivalent facilities. The estimated cost of Option 3 (A or B) is £77.5M.



Figure 20: New build at Ipswich and new build day surgery unit at Colchester: Option 3B

4.1.8 **Option 4: New build at Colchester and day surgery unit at Colchester.** The old site of the Chemotherapy Suite would be the obvious location for a new build at Colchester Hospital. This site would allow the necessary space for a new orthopaedic centre to be provided over a number of storeys that would be most unlikely to be constrained by planning permission. As previously stated, the site is connected to the main hospital buildings by a corridor and, when completed, the provision of the new day surgery unit may allow parts of the existing facility to be re-used/demolished (along with the soon to be replaced cardiac catheterisation unit) to provide convenient patient parking directly adjacent to the new facilities, the maternity unit and ante-natal clinics. Specifically, re-use of the vacated day surgery unit as the endoscopy unit would provide a much needed JAG compliant endoscopy unit at minimal cost. In spite of the

additional decked car parking planned for construction in 2020 at Colchester there is severe pressure on the current parking provision for staff and patients on both sites as activity continues to grow. As previously stated, an entrance off the main Northern Approach Road (subject to appropriate permissions and funding) ideally combined with a new link road behind Constable Wing would both improve hospital site access for patients and staff and reduce traffic congestion for local residents.

- 4.1.9 There are two alternative options for the replacement of the existing day surgery unit. The simplest option (**Option 4A**) would be to incorporate the replacement into the ground floor of a new 3-storey orthopaedic centre leaving orthopaedic day surgery in the existing facilities and orthopaedic outpatients and fracture clinics in main outpatients at Colchester. The design of the centre would obviously have to ensure that the elective orthopaedic beds and theatres were completely separated from the day surgery unit. A clear advantage of this option would be the removal of requirement for sequential, inter-dependent phases of building work and clinical service relocations because all building work could be completed in a single phase without disruption to existing clinical services. The vacated elective ward and the two laminar flow theatres (along with most of the capacity of the admission and recovery ward) would offer a number of alternatives for reconfiguration of other clinical services and the vacated day surgery unit would be suitable for use as a compliant endoscopy unit with minimal adaptation. However, this option would exceed the available budget because not only would a new build day surgery unit be required as part of a 3-storey orthopaedic centre (rather than a re-use of an existing facility) but this new day surgery facility would have to be built in accordance with NHS Estates Health Building Note (HBN) standards which requires considerably more space than currently used for the equivalent facilities (and clinical floor area is the primary driver of building costs). The estimated cost of Option 4A is £77.5M.



Figure 21: New build and day surgery at Colchester: Option 4B

- 4.1.10 The most cost efficient option (**Option 4B**) would be to use the space vacated by a move of elective orthopaedics as a replacement day surgery unit. This could be achieved with minimal

re-work and there would be likely to be a significant cost saving from the re-use of existing clinical space rather than a new build to the latest HBN standards. As described previously, this existing facility has five operating theatres (3 with laminar flow used for elective orthopaedic surgery) and two wards currently used for elective orthopaedic surgery (day case and inpatient). Four theatres and a treatment room would be required for the replacement day surgery unit so, assuming the current trauma theatre is kept for that use (with good adjacency to the trauma wards) and the current breast and gynae surgery theatre is kept for that use (with good adjacency to the women's ward on the floor below), an additional theatre would have to be built (probably replacing the current recovery area which would then need to be re-provided in the adjacent ward area) along with the provision of a suitable treatment room. Again the vacated day surgery unit would be suitable for use as a regulatory compliant endoscopy unit with minimal adaptation along with connection of the new endoscopy unit to the adjacent scope decontamination facility (or relocation of that facility). The activity from the laminar flow theatre currently used for orthopaedic day case activity would also have to be re-located (probably to the new orthopaedic centre at first). However, the reduced requirement for a 2-storey new-build facility combined with re-use of existing clinical space offers significant capital cost savings. The estimated cost of Option 4B is £43.6M

4.1.11 **Option 5: New build ECC off-site and DSU at Colchester.** This option was included for consideration following early pre-consultation engagement during which the possibility of building on a site between the two hospitals was raised. The alternative sites most often mentioned were the retail parks at the new Colchester Stadium or the Copdock roundabout (where the A12 and the A14 roads intersect) between Ipswich and Colchester (known for severe traffic delays at peak times). Consideration was also given to introducing a discrete option of an off-site location for the orthopaedic centre but on an existing community hospital site but this was not separately identified because the issues of an off-site location would be broadly similar regardless of the site selected. The main differences between using an existing acute hospital site and an off-site location would be the additional cost of land purchase and the cost of re-provision of essential clinical and non-clinical support services. In brief, a centre for orthopaedic surgery built away from an acute site would also require provision or easy access to an ITU, blood bank, radiology service, decontamination service and a number of other clinical and non-clinical support services which would have to be available 24/7 (but would be most unlikely to have the critical mass of activity needed for efficient delivery of services). Regardless of whether the cost of providing facilities for these services at an off-site location could be met, it may be assumed that it would not be possible to recruit the extra clinical staff necessary to provide sustainable operational cover. This option was not considered to be clinically acceptable or affordable and was not shortlisted for further analysis

4.1.12 Both qualitative and quantitative options appraisals clearly demonstrated that the highest ranked, and therefore the preferred option, would be a new centre for elective orthopaedic surgery and refurbished day surgery unit at Colchester: Option 4B. Importantly, whilst this was the preferred option, it was also significantly less expensive in terms of capital costs than the other options and would, in fact, be the only affordable option. Therefore, it was recommended that the public consultation should be conducted on the single preferred and only affordable and, therefore, deliverable option: Option 4B.

4.2 Non-financial options appraisal

Evaluation criteria (Critical Success Factors)

4.2.1 The following criteria were developed and tested with governors, patients and our HOSCs to evaluate clinical reconfiguration options during extensive public engagement as part of the recent merger process. These evaluation criteria are now used by ESNEFT to assess the quality impact of any proposed change to a clinical service and have been used as the framework to develop a detailed assessment of options. The benefits criteria have been revisited during pre-consultation engagement to test the criteria and assumptions made before using them to determine a preferred option for the development. The evaluation criteria used were:

- **Patient outcomes.** Options must support the patient’s clinical needs and deliver improved outcomes where possible. The factors used as indicators of patient outcomes included: mortality; morbidity; length of stay; and standards of care. The specific factors used were:
 - Potential to become a national exemplar in provision of elective care and to be seen as a centre of excellence;
 - Offers the potential for overall reductions in morbidity and length of stay through standardisation of care; and,
 - Reduces risk of cross infection with more single rooms and separation of elective and emergency patient flows.
- **Patient experience.** Options should improve the experience of patients, their families and carers matching capacity to demand at their preferred location for care where practicable. The factors used as indicators of patient experience included: waiting times; equity of access; average length of stay; and availability of the service. Specific factors used were:
 - Supports implementation of new model of care which simplifies access for patients;
 - State of the art facilities built to the latest standards with convenient road/rail access and public parking;
 - Improved reliability and reduction in cancellations; and,
 - Significantly reduced waiting times for surgery.
- **Clinical sustainability.** Options must improve clinical sustainability and support the delivery of acute and emergency services across 7-days. The factors used as indicators of clinical sustainability included: delivery of clinical standards for 7-day services; clinical vacancies; contribution to training; and contribution to research. Specific factors used:
 - Promotes principle of delivering right care, right time, right place, by the most appropriately skilled clinician;
 - Improves capacity coupled with long term flexibility to grow and change service in line with population needs; and,
 - Supports maintenance of access to specialist services within the ICS.
- **Workforce sustainability.** Options must improve workforce sustainability and support the delivery of clinical services across 7-days where appropriate. The factors used as indicators

of workforce sustainability included: rates of recruitment & retention; intensity of consultant on-call rotas; and succession planning. Specific factors considered were:

- Improves staff recruitment, development and retention;
 - Improves the physical environment for staff with improved facilities; and,
 - Offers improved opportunities for education, training and research.
- **Value for money.** Options must contribute to the development of a financially sustainable health economy for the integrated care system. The factors used as indicators of value for money (or financial sustainability) included: reduction of duplication or waste; availability of cross-cover; standardisation of the care pathway; and the potential for estate rationalisation. Specific factors considered in the financial options appraisal were:
 - Improves efficiency of staff utilisation by supporting appropriate clinical adjacencies;
 - Offers potential for more patients to choose NHS care.
- **Alignment/Strategic Fit.** Any option should align with health economy objectives and have the full support of commissioners. It should also take account of compatibility with National policy (such as the integration of health and social care and delivery of care that is convenient to access) and anticipated developments in healthcare. The factors used as indicators of alignment/strategic fit included: alignment with STP plan; potential to improve integration with primary care; facilitation of research; facilitation of innovation; and potential to improve integration of secondary care. Specific factors considered were:
 - Contributes to sustained delivery of national standards of care and GIRFT principles;
 - Supports integration by adopting comparable models of care across both Ipswich and Colchester sites; and,
 - Enables innovative technology developments such as integration of IT systems, self-check in and streaming.
- **Deliverability.** Options must be assessed for practicality of implementation based on affordability and local experience of delivering comparable changes to clinical and support services. The factors used as indicators of deliverability included: managerial feasibility; commissioner support; and adequacy of resources. Specific factors considered were:
 - Buildability; and,
 - Affordability (only used in financial options appraisal).
- **Execution Risk.** Options must be assessed for likelihood of the organisation being able to maintain effective performance and meet all regulatory and statutory requirements. The factors used as indicators of execution risk included: likely impact on delivery of statutory requirements; likely impact on delivery of regulatory requirements; and likely impact on delivery of operational performance standards. Specific factors considered were:
 - Avoids significant modification to existing assets;
 - Simple plan with no requirement for significant decant; and,
 - Disrupts current service provision as little as possible.

Long-listed options

4.2.2 The five long-listed options described in Section 4.1 above were developed, assessed and scored in accordance with best practice contained in the Capital Investment Manual and using the options framework to produce a shortlist for formal appraisal against three key criteria: Clinical Benefits; Buildability; and, Affordability.

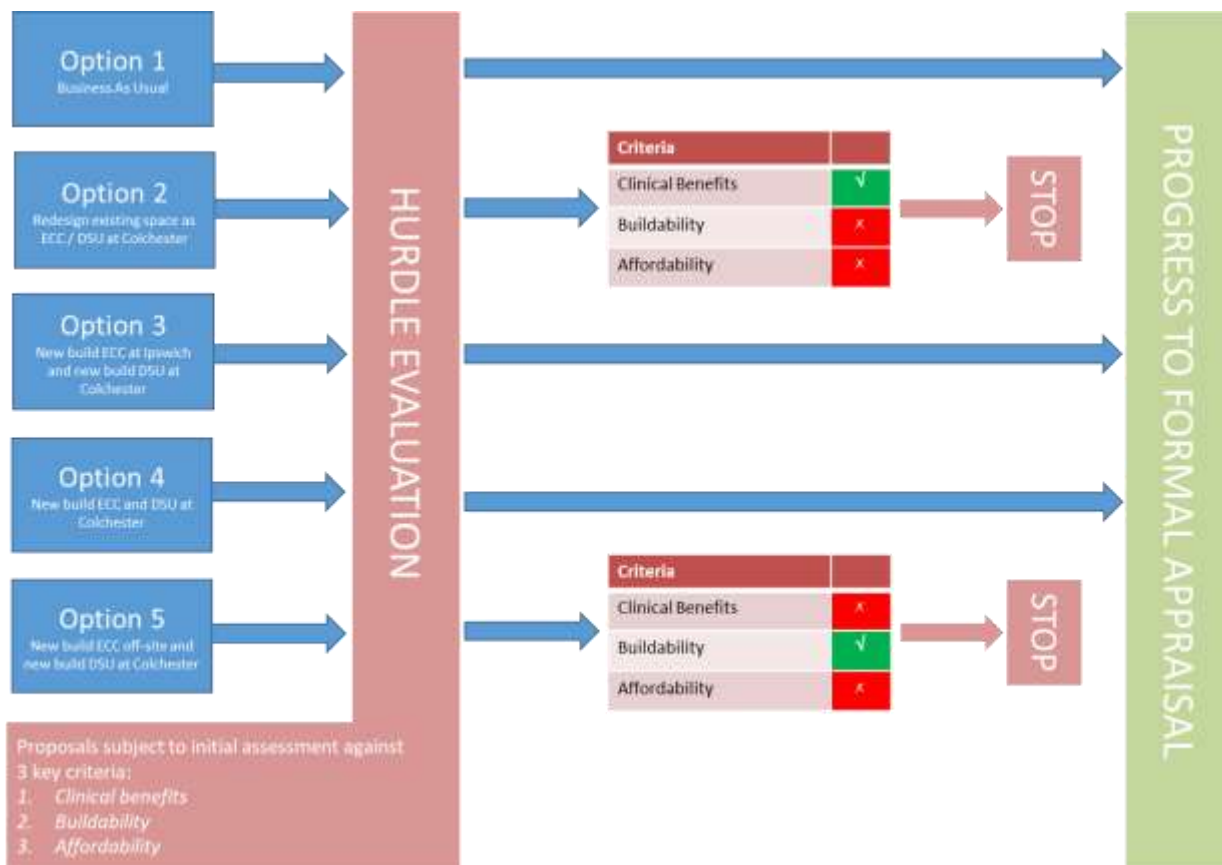


Figure 22: Longlist sifted to shortlist using Hurdle Evaluation Criteria

4.2.3 The options and status following option sifting are included in the following table:

Options	Description	Status
Option 1	Business as Usual (except backlog maintenance)	Carried forward (Benchmark)
Option 2	Redesign existing as ECC and DSU at Colchester <ul style="list-style-type: none"> Clinical benefits Buildability Affordability 	Discounted
		Good
		Complex interdependencies
Option 3	New build ECC at Ipswich and new DSU at Colchester	Carried forward (Preferred Way Forward)
		Carried forward (Preferred Way Forward)
Option 4	New build ECC and DSU at Colchester	Carried forward (Preferred Way Forward)
Option 5	New build ECC off-site and new DSU at Colchester <ul style="list-style-type: none"> Clinical benefits Buildability Affordability 	Discounted
		Lacks key clinical adjacencies
		Good
		New land and support services

Table 12: Summary of longlist to shortlist option sifting

Shortlisted options

4.2.4 A summary of the shortlisted options with their advantages and disadvantages is as follows:

Option 1: Do Nothing - no change to existing arrangements with the exception of backlog maintenance on the existing facilities	
Advantages	<ul style="list-style-type: none"> • No disruption to existing services due to major capital building works. • No requirement for capital funding.
Disadvantages	<ul style="list-style-type: none"> • Does not deliver national, ICS and ESNEFT strategy. • Limits implementation of new model of care and improvements in clinical effectiveness resulting in continued high and growing demand for limited capacity. • Limits achievement of access targets and improvements to patient and staff experience. • Sub-optimal space that presents cross infection issues and privacy and dignity challenges.
Option 3: New build at Ipswich and new build day surgery unit at Colchester	
Advantages	<ul style="list-style-type: none"> • Delivers national, ICS and ESNEFT strategy (eg. clinical, financial, workforce sustainability). • Facilitates implementation of new model of care and improvements in clinical effectiveness, achievement of access targets and improving patient, relative and staff experience. • All new accommodation built to the latest HBN design standards. • Improved staff and patient environment.
Disadvantages	<ul style="list-style-type: none"> • No possibility of funding for 3 new laparoscopic theatres over UTC at Ipswich Hospital. • Potential planning restrictions on location/height of centre and therefore space available. • Will require funding for multi-storey car park and link to main hospital buildings. • May require funding for re-provision of Education Centre facilities or re-routing a road. • May require decant facilities for day surgery at Colchester to permit re-use of existing site.
Option 4 (A or B): New build and day surgery unit at Colchester	
Advantages	<ul style="list-style-type: none"> • Delivers national, ICS and ESNEFT strategy (eg. clinical, financial, workforce sustainability). • Facilitates implementation of new model of care and improvements in clinical effectiveness, achievement of access targets and improving patient, relative and staff experience. • All new accommodation built to the latest HBN design standards. • Improved staff and patient environment. • Provides future expansion potential. • Avoids need for decant facilities during construction phases. • Vacated DSU provides suitable JAG-compliant endoscopy unit with minimal adaptation. • May be able to provide improved hospital site access with new junction off Northern Approach Road with reduced traffic congestion on Turner Road for local residents (TBC). • May permit funding for new laparoscopic theatres over UTC at Ipswich Hospital (TBC).
Disadvantages	<ul style="list-style-type: none"> • New patient car park could not be constructed until all works complete.

Table 13: Summary of shortlisted options

5. Communications and Engagement

This section details the process undertaken to engage the public, staff and other stakeholders during the pre-consultation phase and demonstrates how their feedback shaped the development of options.

5.1 Pre-consultation engagement

5.1.1 Stakeholder engagement has been in process since the merger that formed ESNEFT in July 2018 as part of the iterative process of developing the proposal into a mature business case. Extensive internal and external engagement was also a major feature of the development of the Trust's Strategy for 2019/24 between July 2018 and April 2019. The strategy was publicly signed off by the ESNEFT Board at its meeting on 2 August 2019. Creating the ECC is one of the main contributions to meeting the strategic objective – Developing Centres of Excellence.

5.1.2 In April 2019, the project team engaged Dr Steven Wilkinson of 'Consulting the Community' to provide independent expertise on the consultation process. Dr Wilkinson is a social scientist and expert in developing and running public consultations. His support has been central to our engagement planning and he has provided us with much of the analysis and reporting.

5.1.3 Adequate pre-consultation engagement activity was a requirement to involve the public in the development of proposals for service change. To ensure the engagement was fair and proportionate the Trust ensured that it complied with the Gunning/Sedley criteria as follows:

- It was completed whilst proposals were at a formative stage;
- Sufficient information was provided to enable reasoned responses;
- Sufficient time was provided for responses; and,
- The feedback was meaningfully taken into account when finalising proposals.

5.1.4 Pre-consultation engagement activity relating to the proposals outlined here formally started on 17 May 2019 and continued until the end of October. The nine events held across Suffolk and north east Essex were key to gathering wider feedback on our initial proposals to which over 150 representatives were invited from local patient organisations, Healthwatch, local charities and associated voluntary organisations in the community including patient transport groups. This feedback was most useful when finalising our proposals. For example, the importance to patients and their families of a proposal that avoided extended waiting times and cancellations became very clear. One Ipswich musculo-skeletal (MSK) user group member told us "No-one wants to lose facilities at their nearest hospital, but if travelling to Colchester improves cancellations then so be it". The frequent suggestion by members of the public of an 'off site location for the ECC somewhere between the two existing hospitals' resulted in its inclusion in the formal options appraisal. The importance of ease of access by public transport and from public car parks were also factored into the options and taken into account when developing the proposal. Naturally, development of the initial proposals and securing the required capital has involved ongoing discussions, particularly with clinical teams, commissioners and NHS system partners prior to this period.

5.1.5 Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, local authorities are no longer required to have Health Overview and Scrutiny

Committees (HOSCs) as the means by which they discharge their scrutiny function, although in practice most have retained them. Under Regulation 23, NHS England, CCGs, public and independent sector providers of NHS services must consult with relevant local authorities about any proposals for a substantial development or variation of the health service in the authority's area. Commissioners and the Trust have ensured that they have good channels of communication with their local authorities, and that members have been kept informed of proposed changes.

- 5.1.6 Following approval of the PCBC, a full public consultation is expected during the 6 weeks from 18 February 2020 to 1 April 2020. This phase will build the dialogue between Commissioners, the Trust and its internal and external stakeholders in order to gather further insight and data on the impacts of the proposals on those affected. An independent consultation advisor will help to shape the consultation questions and the responses will be the subject of an independent analysis the results of which will be presented to the Board and governing bodies.

5.2 Stakeholder engagement

Public sector equality duty

- 5.2.1 The NHS Act 2006 (as amended by the Health and Social Care Act 2012) creates a legal duty on the Secretary of State for Health, NHS England and CCGs to have regard to the need to reduce health inequalities. This duty sits alongside the existing Public Sector Equality Duty (PSED) to which all public bodies are subject when exercising their functions. It particularly applies where an NHS body is proposing policy changes that will have an effect on a large number of patients who are in groups which have a "protected characteristic". The PSED requires us to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people who share a protected characteristic and people who do not share it
- foster good relations between people who share a protected characteristic and people who do not share it

- 5.2.2 Obviously, reducing health inequalities means giving everyone the same opportunities to lead a healthy life, no matter where they live or who they are. All matters of public engagement for the proposed ECC are overseen and steered by an Engagement Group that meets fortnightly. During the pre-consultation engagement phase a series of nine stakeholder meetings were held to gather impressions, opinions and issues relating to the proposals. This set of meetings included an independent formal feedback collecting exercise which was analysed and reported in an internal document 'Stakeholder Feedback' summarised below and provided in full at Appendix 1. This report was then used to inform the development of the consultation document and associated survey response.

- 5.2.3 In practice we need to understand the likely impact of the proposed changes on everyone but specifically on people with the protected characteristics as defined in the Equality Act, namely: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation; and, Carers 'by association' with some

protected characteristics (eg. disability and age). This is to ensure that there is a good understanding of how the proposals will impact on disabled people so that those factors may be taken into account in the final decision.

5.2.4 To consider the potential impact of the proposal on patients and staff (and potential patients and staff), an Equality Analysis (EA) (formerly referred to as an Equality Impact Assessment) has been completed by an independent academic consultant, at Appendix 2, along with a Travel Impact Assessment (TIA) at Appendix 3. The EA was completed before the detail of the proposed ECC for orthopaedics had been established on the presumption that a single centre would be proposed at either Ipswich or Colchester, and that there may be implications for NHS Staff and service uses. The findings of EA were then included in the development and evaluation of potential options for the proposed ECC. In summary, the EA identified the following challenges and opportunities:

Staff and potential staff

- Reasonable adjustments will be made concerning existing and newly appointed staff in the workplace with disabilities.
- Some staff with disabilities may be asked to consider relocating from their current workplace. This will raise issues concerning travel and parking which will be considered in the final design of the ECC.
- Work/life balance matters relating to additional travel and/or transport concerns and/or family/personal commitments will need to be considered on an individual basis.
- Matters concerning staff or potential staff who are themselves carers will be considered on an individual basis and reasonable adjustments will be considered.

Patients and potential patients

- The matter of disability access will be integral in the design of the ECC – and will meet the necessary standards.
- Matters concerning travel will be identified in the public consultation and will need to be considered in the final decision making process. There is evidence that concerns relating to travel, transport and parking will be raised during the consultation period, as these matters arise in consultations in this region.
- Considerations should also include family and carers, who are integral to the overall healthcare process. Previous and similar consultation feedback highlights this issue as highly significant.

5.2.5 To ensure disabled people can access the information they need, support will be offered to people who need help in accessing and understanding information, so that no part of society is unfairly disadvantaged. Healthwatch will have a signposting function and should connect to and involve local groups and organisations that work with and are part of communities of interest, geography, demographic and characteristic. This will mean that, locally, people can have access in different ways to the information they need. This will include by definition, 'hard to reach' and 'seldom heard' groups. Matters concerning gender specific in-hospital facilities will be part of the design process and any matters concerning equality will continue to be revised and considered and the EA will be reviewed and updated prior to the decision making

process. To gain a deeper understanding of health inequalities a series of questions are being put to the public in the Consultation. These include:

- What forms of transportation would you use if you were to travel to this new Centre?
- Should you need to have planned (non–emergency) hip or knee surgery, how will this proposal affect you?
- Should you need to have planned (non–emergency) hip or knee surgery, how will this proposal affect others (including your family, relatives, friends, carers)?
- What could we do to make this centre for planned hip and knee surgery in Colchester easier for you to access?

Equality data will be collected from all respondents and participants in the consultation elements of this project.

Travel Impact Assessment

5.2.6 This section summarises the current conclusions of the Travel Impact Assessment (TIA) which may be found at Appendix 3. The key points to note from the TIA are as follows:

- ESNEFT has a catchment area for patients running to the south of Chelmsford, to the north of Bury and to the border of Lowestoft.
- There are areas of the highest deprivation in Tendring, Pier Ward of Colchester and Ipswich central. There are areas of moderate deprivation in parts of north east Suffolk.
- In 2018/19, 2,358 major joint procedures were completed increasing to 3,336 by 2041.
- The split of patients by site is currently 52% Colchester, 48% Ipswich; therefore, locating the ECC at either site will increase travel for around half of the patients.
- However, most elective pathways involve at least five visits and the ECC will affect only one of these. The increase in total travel is therefore small. An ECC at Colchester would increase travel by 9% for the average patient (12 miles), vs 14% (18 miles) if at Ipswich.
- All current patients would be able to access both hospitals by car within 60 minutes, according to the Public Health England SHAPE Tool.
- Public transport has issues currently. Travel times (if the journey is even possible) are over 2 hours from the north of Suffolk to Ipswich hospital and from the south of Tendring to Colchester hospital. There is virtually no public transport in south Tendring.
- Putting the ECC at Ipswich has the greatest impact on reducing ease of access by public transport. It particularly reduces access from Tendring.
- Parking is limited on both sites but additional parking is planned at Colchester.

5.2.7 Therefore, the site which would appear to minimise travel impact would be Colchester. This is favoured by:

- A small majority of current orthopaedic patients served by Colchester Hospital;
- Higher growth predicted for orthopaedic patient numbers in the Colchester catchment;
- Better public transport access to Colchester Hospital from all areas;

- Lower impact on the most deprived populations if ECC located at Colchester Hospital.

Public and patient engagement

- 5.2.8 Commissioners and ESNEFT have a number of established forums for gathering patient views and feedback from communities. Since merger ESNEFT has kept in contact with the main hospital user groups to develop the new strategy and to start delivering change. The Trust has continued to brief these groups on plans through pre-consultation, and will continue to do so focusing on the musculo-skeletal (MSK) user group for Ipswich Hospital with whom it plans to have regular contact, as a group of key service users, throughout the development and delivery of proposals. An equivalent group at Colchester does not exist at this point. The project team will continue to build relationships with colleagues and stakeholders in the wider health and social care system, and with public and patient representative groups.
- 5.2.9 ESNEFT's Public and Stakeholder Governors play a key part in representing the views of the people in the area. A sub-group of Governors is involved in a strategy and engagement forum that has been a vital component in developing external engagement activities and providing input into the direction and development of our briefing materials. Governors have also attended briefings/meetings with members of the community and continue to deliver both parts of their role, scrutinising plans and acting as key participants in engagement activity.
- 5.2.10 Key to the activity gathering feedback on proposals has been nine events held across Suffolk and north east Essex. Engagement at these events was of a high quality and we received a high number of considered responses to the information we presented at the event. During the events, following a presentation stakeholders were asked to give their views on the proposals to build the ECC on either the Colchester or Ipswich site. This feedback took the form of a group SWOT (strengths, weaknesses, opportunities, threats) analysis. The detailed results of the data-gathering exercise that took place during these events may be found at Appendix 1. Stakeholders who took part in our events have also had an opportunity to review and comment on the PCBC before it was submitted for approval.

Common themes

- 5.2.11 In order of weighting, the themes that emerged that were common to either location included:
- **Getting there.** This theme included travel, journey-time, transport, and to some extent parking. Issues raised included difficulties with the road systems (including bridges and traffic congestion) and a lack of suitable public transport (bus and train). Community transport schemes were identified as existing and in need of funding support and development. The potential to open road access into the Colchester site from the Northern Approach Road was viewed positively as was its proximity to the railway station.
 - **Improvements to patient care.** The opportunity for improvements that an ECC could bring were regarded positively for both sites. These improvements included the potential to better manage waiting lists with shorter waiting times and whatever benefits may be achievable in a Centre of Excellence (such as shorter bed stays, lower infection rates and improvements in patient outcomes). It also included a positive view on the potential improvements to other services subsequent to the building of the ECC at either site.

- **Preferred Option.** As could be predicted, both sites were considered the preferred option; however, creation of a Centre of Excellence was considered a positive development and the potential to develop research and teaching was recognised as important.
- **Staff.** The potential to attract, retain and develop staff was considered positively for both sites. There was some concern regarding staff willingness to travel between sites.
- **Growing demand.** Both sites were considered to have a growing demand for the services to be provided at the ECC in terms of local housing growth, general population growth and the increasingly older demographic profile more likely to need elective joint replacements.
- **Accessibility.** Including distance from the car park and or front entrance of the hospital, to the ECC and disabled parking spaces – which were regarded as in need of improvement on both sites. That said, Colchester was felt to have more favourable access than Ipswich.
- **Potential local objections.** There was concern that people local to either hospital may object to the building of an ECC. There was also concern that people from Ipswich may object or ‘feel devalued’ if the centre were to be built in Colchester – and vice versa.
- **Links to universities.** Links with local universities were considered as an important opportunity for both potential sites in terms of education and research.

Colchester-specific themes

- **Reputation.** Perceptions formed from historic media reporting, past poor CQC ratings and sometimes from personal experience were cited as a weakness; however, the potential to improve the reputation of Colchester was also raised as an opportunity.
- **Facilities.** The opportunity to develop current facilities in Colchester was viewed positively and, while there was some discussion about limitations, the overall impression was that Colchester provided the better ‘space’ and ‘building options’ of the two sites and therefore would be more cost effective. Services were also felt to be better co-located at Colchester.
- **Proximity to London.** Colchester’s proximity to London was seen as an advantage in terms of staff recruitment and the ability to attract private patients and to generate new income.
- **Other.** The three other ‘themes’ particular to Colchester included:
 - Concerns about the degree of collaboration between the two sites;
 - Concerns about poor IT access; and,
 - The ‘proximity of the MOD being a potential threat’ (*sic*).

Ipswich-specific themes

- **Suitable site.** The lack of availability of suitable space and related project issues (such as the potential rebuilding of car parks and an education centre) were seen as weaknesses. Ipswich was also considered to be a less cost effective option compared with Colchester. Potential issues with gaining planning permission for the Ipswich site were also raised.
- **Reputation.** The reputation of Ipswich in terms of the performance of the hospital and the ‘culture’ amongst staff was considered as a positive strength.

- **Location.** The perception that Ipswich was more centrally located for the Trust was regarded as a strength but also as a threat if this central location lowered demand for services. It was felt the ECC would benefit Ipswich in terms of status and opportunities.
- **Community support.** Concerns were raised about the level of support in the community and primary care for Ipswich patients and carers. Good hospital-based networks and collaboration with community care were viewed as strengths.

Internal stakeholder engagement

- 5.2.12 Development of the proposals with the operational and clinical teams has been ongoing since before the 2019 merger (see section 4.1.1). On 17 May 2019, engagement on the proposals began more formally with a presentation by the lead consultants to the senior clinical and operational management of the MSK division. A full list of events can be found at Appendix 3.
- 5.2.13 Since July, we have briefed staff on our plans including through the Staff Partnership Forum and widely through the Chief Executive’s monthly briefing and vlog. Sessions that are more detailed have been held to brief staff and gather their feedback and views in a similar way to the public stakeholder engagement sessions. Feedback from these sessions is at Appendix 5.

NHS and health system partners and regulators

- 5.2.14 Commissioners and primary care partners have played a significant part in helping the Trust to develop its plans, providing scrutiny and oversight. A key part of the governance structure during this period has been the creation of a Joint Reconfiguration and Oversight Group (JROG). This group is jointly chaired by the Chief Executive for the local clinical commissioning groups (who is also the ICS lead) and ESNEFT’s Chief Executive with members of the senior team from both organisations and sets the strategic direction for the work of the project. It is also a key conduit for the consideration of papers and other information by the governing bodies of North East Essex CCG and Ipswich and East Suffolk CCG. Letters of support for the proposal were received from commissioners, our ICS and the adjoining STPs.
- 5.2.15 Since the merger, ESNEFT has been in regular contact with colleagues at NHSI/E to understand how they wish the Trust to proceed and to gather information to support the development of proposals. The local Joint Health Overview and Scrutiny Committee (JHOSC) has been a focal point for strategic discussions. There had been some changes to the local Health Overview and Scrutiny Committees in both Suffolk and Essex as a result of the recent local council elections, so an informal briefing was arranged held in conjunction with both CCG and ICS leadership. This briefing sought to ensure early awareness by the JHOSC of proposals, to provide an opportunity to put them in the context of the local system and to answer questions and provide initial feedback in advance of the formal process of scrutiny.

Local politicians

- 5.2.16 In June, we wrote to 11 local MPs informing them of our plans to develop the elective care centre and to offer them an opportunity to meet us to discuss the proposals. So far, we have been in communication with Will Quince, MP for Colchester; Sandy Martin, MP for Ipswich; Dan Poulter, MP for Mid-Suffolk; and, Priti Patel, MP for Witham. ICS leaders also wrote to all councillors in Suffolk and north east Essex to advise them of the proposals and briefed Ipswich

Borough Council on 23 September and Colchester Borough Council on 30 October. As the new MP for Ipswich Tom Hunt (vice Sandy Martin) has now been briefed following the election.

Media activity

5.2.17 On 22 July, the Trust held a media briefing on the building work arising from the £69.3m capital investment. At this presentation, the Chief Executive and Director of Facilities outlined the plans to develop the elective care centre and the work in urgent and emergency care. Representatives from BBC Radio Suffolk, BBC Look East, the East Anglian Daily Times, the Colchester Gazette/Ipswich Star and the Health Service Journal covered the overarching story, with a number of stories covering the Elective Care Centre. Coverage continued in the local press following public commentary by local MPs during August concerning the ECC location.

5.3 Public consultation communications and engagement plan

5.3.1 The communications and engagement plan for the public consultation has been developed that builds on the extensive pre-consultation engagement undertaken to date and designates a single communications lead for this project with input from communications teams across east Suffolk and north east Essex.

5.3.2 Consultation document development included the stakeholders from the pre-consultation engagement work who agreed to be involved. It is deliberately written as a short and highly accessible document that is intended to be easy to read, and respond to. Experience running previous public consultations has demonstrated to the team that this is the best way to secure strong engagement and a good response rate. The consultation document is aimed at the average reading age of 8-10 years. Additional documentation will be fully accessible on line (printed versions will be produced on request). This additional supporting information will include this document (which includes the content of the Clinical Senate submission), a report of the feedback received from public engagement activity to date, the equality assessment, the travel impact assessment and the Clinical Senate Independent Review Panel Report. An easy read version of the consultation document will also be produced.

5.3.3 An independent academic and consultation expert, Dr Steve Wilkinson, will analyse every response (on line or by post) to the public consultation and produce a report highlighting key themes. The report will include all the narrative comments in full, as submitted, to ensure that every respondents voice is heard. This will be used to run a decision making workshop, externally facilitated, from which a final report will be produced. Both documents will be presented to ESNEFT's Board and the CCG Governing Bodies in public to enable a final decision on the outcome of the consultation to be made. This decision will then be presented to the JHOSC for their potential referral consideration before any further action is taken.

6. Assurance of service change

This section, combined with Section 5, provides evidence that the proposals comply with the Government's tests for service change and NHS assurance checks.

6.1 The Secretary of State's four tests

6.1.1 NHS England outlines good practice in the development of proposals for major service changes and reconfigurations by which it will assure those proposals prior to public consultation⁴⁰. These tests are designed to demonstrate that there has been a consistent approach to managing change and, therefore, to build confidence within the service, and with service users and the public. From April 2017, NHS England introduced a new (fifth) test to evaluate the impact of proposals that include a significant number of bed closures; however, as there are no plans to reduce bed numbers this test does not apply. All reconfiguration proposals should be able to demonstrate evidence to meet the following four tests before they can proceed:

- Strong public and patient involvement;
- Consistency with current and prospective need for patient choice;
- A clear clinical evidence base; and,
- Support for proposals from clinical commissioners.

6.1.2 **Test One: Strong public and patient involvement.** This test evaluates how service users and the public have been, and will continue to be, involved in the development of proposals to reconfigure clinical services. Robust stakeholder engagement has been undertaken since well before the merger in July 2018 and pre-consultation engagement activity (as described in Section 5) related to the proposals in the PCBC started on 17 May 2019.

6.1.3 **Test Two: Consistency with current and prospective need for patient choice.** This test illustrates whether the proposed clinical service reconfiguration would maintain the availability of service user choice. During preparation for the merger that formed ESNEFT, a GP referral analysis demonstrated that alternative providers were available for all clinical services provided as outpatients, elective daycases or elective inpatients. Further analysis and pre-notification consideration by the Competition and Markets Authority's (CMA) Markets Intelligence Committee led the CMA to conclude that the merger would not involve a substantial lessening of competition. The proposal to create an ECC would leave choice of provider unchanged but would result in a small reduction in choice of site for an element (adult elective inpatient care) for orthopaedics for a relatively small number of patients more than offset by the benefits offered. Therefore, there is no basis for believing that the proposed clinical reconfiguration would result in changes to the commissioning arrangements beyond the discussions already taking place via the ICS (for example, about the adaptation of pathways to provide greater support to patients). Specialised services are commissioned by NHS England and no change has been notified for these services as a result of the proposed service reconfiguration.

6.1.4 **Test Three: A clear clinical evidence base.** This test is to demonstrate sufficient clinical evidence and clarity on the case for change (see Section 3). Independent verification and support for the clinical case for change has been gained from the East of England Clinical Senate following their independent review of these proposals to improve patient pathways and develop a single ECC carried out on 18 September 2019 (including those clinicians most directly affected from both sites who are leading the development of the proposals).

⁴⁰ NHS England (2018), "Planning, assuring and delivering service change for patients"

- 6.1.5 **Test Four: Support for proposals from clinical commissioners.** This test is to provide assurance that the proposals have the approval of local Commissioners. The services involved are commissioned in the main by Ipswich & East Suffolk CCG and North East Essex CCG. Preparation for the establishment of our ICS included a coming together of these commissioning bodies which now, along with West Suffolk CCG, all share the same accountable officer who is also the ICS lead. The I&ES CCG Governing Body, the NEE CCG Governing Body and ESNEFT Board of Directors authorised the formation of a Joint Reconfiguration Oversight Group (JROG) to make recommendations and provide advice to their respective Governing Bodies and Board of Directors on any proposals for the reconfiguration of clinical services taking account of the known intentions of health and care partners across the system. This group has significant clinical representation in the form of the chairs and clinical leads of both CCGs along with the Chief Medical Officer and Medical Director from ESNEFT. It also has patient representation in the form of the chief executives from both Essex Healthwatch and Suffolk Healthwatch. Letters of support for the proposal were received from commissioners, our ICS and the adjoining STPs.
- 6.1.6 **Test Five: Impact of plans that include significant numbers of bed closures.** There are no plans for bed closures and the total number of physical bed spaces will be increased by at least 48.

6.2 East of England Clinical Senate Independent Review

- 6.2.1 ESNEFT approached the East of England Clinical Senate in May 2019 with a request to review its proposals to improve patient pathways through service reconfiguration across the hospital sites in Colchester and Ipswich with development of a single ECC. The scope of the review was limited to the proposed service changes associated with the development of a single ECC for adult elective inpatient orthopaedic care and the continued delivery of trauma services (including trauma surgery), orthopaedic day surgery and outpatients on both main hospital sites. The report of the Clinical Senate independent review panel included a number of helpful recommendations and its conclusions were as follows:
- The proposal made clinical sense and once new pathways had been implemented and the new unit was built and operational then outcomes for elective orthopaedic patients should improve.
 - The Trust needed to develop a well described Quality Improvement Framework with clear performance indicators, outcomes and targets.
 - The aim to reduce waiting times for patients both through enhanced patient pathways, with a requirement for fewer pre-operative patient visits along with the development of a high volume elective centre with protection from interruptions and loss of capacity due to emergency workload, was very much supported.
 - The larger clinical teams should mean greater resilience and the concentration of procedures should also provide enhanced training opportunities for all staff.
 - The panel agreed that it made more clinical sense, would have less impact on access and should provide a wider range of benefits for patients of other clinical services at both Colchester and Ipswich if the ECC were to be located at Colchester Hospital.
 - The panel agreed that the long-term analysis regarding anticipated growth in demand was to be commended – whilst both the ESNEFT team and the panel recognised that the

number of variables involved meant that this was unlikely to be 100% accurate. The panel tested the rationale for both the number of beds and the theatres with several questions both checking whether there might be too few or whether there might be too many. The panel was of the view that the estimates for planning were reasonable and the panel felt that at this stage the planned capacity is likely to be appropriate.

- The panel agreed that the proposed clinical model provided a robust basis for moving forward with the future development of an ECC and clinically-led reconfiguration of orthopaedic services.

ESNEFT response to the East of England Clinical Senate Review Recommendations

6.2.2 The recommendations of the Clinical Senate Review were all accepted as follows:

- **Recommendation 1 - clear clinical outcome objectives.** Membership of the clinical transformation group has been re-defined under the chairmanship of the clinical director and it is now working to develop a clear set of outcome measures and targets for orthopaedics to include ambitious, joint specific, outputs in line with GIRFT best practice. These outcome measures, expected to be agreed by summer 2020, will then be used, along with NHS standards for waiting times, to monitor clinical performance going forward with significantly better than the NHS standard as the achievable target and upper decile performance as the stretch target for access. An area where the target for improvement has already been agreed is reduction of the cancellation rate for trauma & orthopaedics (including spinal) from the current high level of 26% (or over 3,000 cancellations a year) down to zero avoidable cancellations. Avoidable has been defined as anything other than cancellation for medical reasons within 48 hours of admission. The main reasons for cancellations have been the use of elective theatre lists for trauma patients and the use of elective beds for emergency admissions. Winter bed pressure is increasing and the provision of a dedicated Elective Care Centre, separate from the acute wards, will mitigate this and allow the delivery of elective activity on plan as well as reducing patient waiting times and disruptive cancellations.
- **Recommendation 2 – workforce plan.** The Director of Workforce has joined the newly formed Building for Better Care Programme Board and with the very recent appointment of a workforce integrated care system (ICS) lead a comprehensive workforce plan is now in development, supported by the clinically-led Elective Care Working Group, to encompass the recruitment, retention, training and development of workforce for the future of the service. The work of this group is also examining potential changes to working patterns within orthopaedics (such as use of all-day lists, extended days and 6-day working) and the development of definitive rotas for consultant on-call. Health Education England is supportive of the intention for T&O specialist trainees to rotate into the Elective Care Centre and benefit from enhanced training opportunities in joint replacement surgery.
- **Recommendation 3 – clinical pathway redesign.** Further clinically-led transformation work is underway through the re-defined, clinical transformation group, chaired by the clinical director, to develop and agree high quality, efficient patient pathways for elective orthopaedic surgery with seamless links to the community MSK teams in East Suffolk and NE Essex. Work is already underway to minimise the number of pre- and post-operative

outpatient visits and to offer AHP support closer to home. The Elective Care programme board and Alliance partnership group are working with commissioners to deliver care closer to home together with telephone and virtual clinic review where clinically appropriate. This work is expected to be complete by the summer of 2020 to inform production of any Outline Business Case (OBC).

- **Recommendation 4 – engagement.** Pre-consultation engagement has continued with staff, patient and carer groups and other stakeholders to validate impact assessments and to develop mitigations. The clinical strategy underpinning the Elective Care Centre has been developed in collaboration with our cross divisional, multidisciplinary clinical strategy reference group which includes community, primary care and commissioners.
- **Recommendation 5 – patient access support services.** Further work is planned for the public consultation to assess and improve the access of patients to services including the development of community transport schemes.
- **Recommendation 6 – support services.** Further work is underway to ensure that all support services and systems essential to patient safety are fully developed (including ICT) to support implementation of the plans. There is strong engagement from the integrated pathways division to address the need for elective ortho-geriatric assessment and peri-operative care both in hospital and in the community. ESNEFT is committed to an integrated trust-wide paperless investigation requesting and reporting system being fully implemented by 2021 to support our elective patient care pathways.

6.3 Building for Better Care programme governance

6.3.1 **Programme scope.** The Building for Better Care programme encompasses the clinical service transformation required to deliver the ESNEFT strategy and the integrated care system (ICS) plan. This includes managing ESNEFT’s use of the £69.3m STP capital investment secured in March 2018, elements of Trust capital investment, programme funding and other resources secured to support the project. The programme will facilitate improvements in services and facilities at Colchester General Hospital and Ipswich Hospital. The programme of works must be completed in line with the timescales agreed with NHSE/I. The projects included in this programme are in two streams as stated earlier and the scope includes:

- Co-development of new clinical service models with local Alliance partners in the ICS. These service models must allow ESNEFT and the local system to offer the best care and experience in a sustainable way.
- The development and approval of the business case documentation in line with the HM Treasury (HMT) model. This includes the preparation of this PCBC for Stream 2 only, outline business case (OBC) and full business case (FBC).
- The design and procurement of new and modified buildings and equipment.
- The construction and commissioning of new assets.
- Benefits realisation and post-project evaluation.

6.3.2 **Programme governance.** The lead organisation for conducting the public consultation for the ECC will be the combined CCGs of Ipswich & east Suffolk and north east Essex, supported by

ESNEFT. The broad planning and programme implementation governance structure for the delivery of these investments is outlined in the organisational charts below. These structures are designed to provide for inclusive stakeholder involvement in the development of the detailed clinical service models, business cases and in the estates design development and operational service commissioning for each work stream. Each of the project teams will have terms of reference (TORs) and will report to the Building for Better Care programme board. The strategy programme management office (PMO) will provide co-ordination and administrative support to the programme.

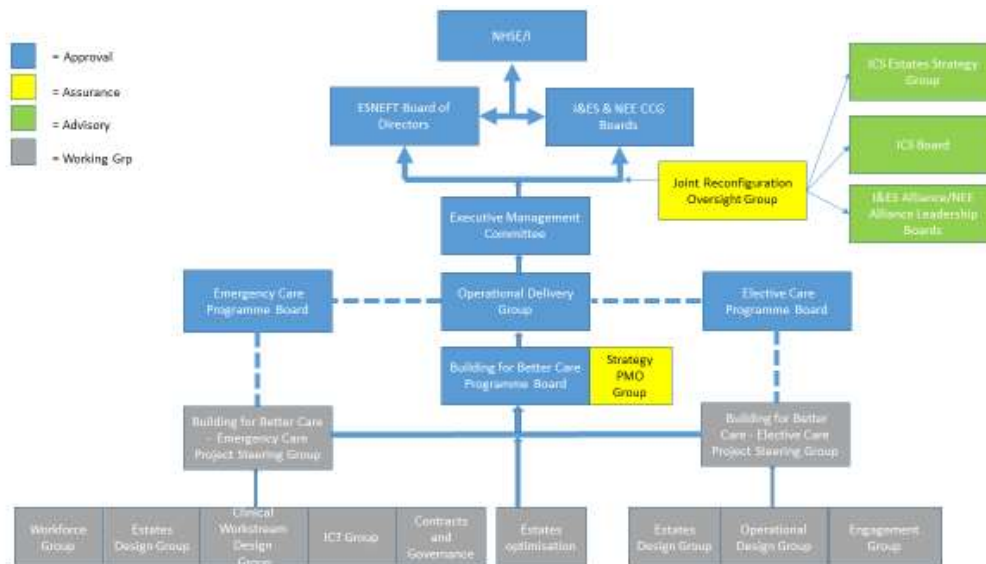


Figure 23: Project Governance Structure for Business Case development

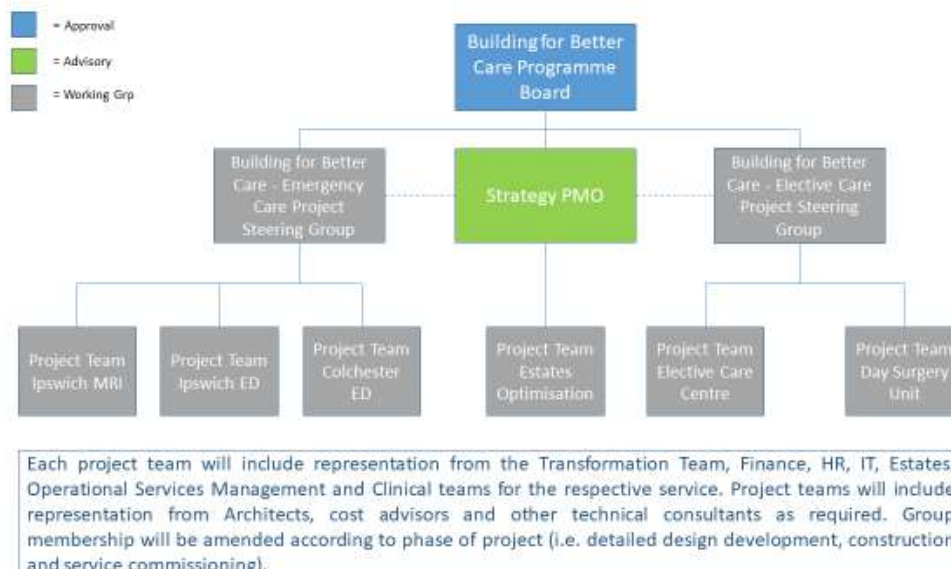


Figure 24: Governance Structure for Estates Design Development and Operational Commissioning.

6.3.3 The programme board’s role will be to give oversight and maintain a strategic overview of the project, to ensure compliance with the agreed scope, including delivery of the benefits identified in the strategies and funding applications. The programme board will have delegated powers from the executive team and board of directors to make approval decisions within

defined parameters (e.g. variations to programme scope, milestones and costs). The programme board will report to the executive management committee (EMC), and then to the ESNEFT board of directors. Core members of the Programme Board are: Director of Strategy, Innovation & Research – Chair; Director of Estates & Facilities - Deputy Chair; Chief Medical Officer/Medical Director – Deputy Chair; Director of Finance; Director of Clinical Strategy Implementation; STP Programme Director; Director of Operations (Group 1); Director of Operations (Group 2); Director of Information, Communication & Technology; Director of Communications & Engagement; Deputy Director of People and Organisational Development; Director of Nursing (or nominated Deputy); Director of Logistics; Head of Transformation; and, CCG Representatives. (Directors may nominate a deputy to attend the programme board and programme team members will normally attend in an advisory capacity).

6.3.4 **Responsibility, accountability and duties of the programme board.** The programme board is to ensure that the objectives of the projects within the programme are achieved. The programme board is accountable to the ESNEFT board of directors. The programme board will meet monthly. The quorum is five members, which must contain, the Chair or Deputy Chair, Director of Finance (or nominated Deputy), one Clinical Representative (CMO, AMD) and at least two other core members. The programme board will:

- Ensure the programme is managed in line with Trust, NHSE/I and HMT requirements.
- Ensure that programme control documentation is established and kept up to date. This includes regular highlight reports and risk management documentation.
- Co-ordinate the development of the clinical service models, ensuring that other elements of the programme support these.
- Support and co-ordinate clinical engagement with the programme.
- Ensure good communication with internal and external stakeholders.
- Oversee design development for buildings, ensuring alignment with the clinical strategy priorities, the Trust's strategic objectives and the affordability envelope.
- Oversee the development of the PCBC, SOC, OBC and FBC documentation associated with the programme, ensuring that milestones are met, and arbitrating and resolving issues if required.
- Oversee regulatory and statutory compliance of service models and construction.
- Oversee the capital procurement process for the building solutions and associated equipment.
- Maintain capital financial control and budget review.
- (In construction phase) monitoring and authorisation/management of variations, within an agreed scheme of delegation, etc.
- Ensure that expenditure planned in the Trust's wider capital programme aligns where appropriate with the use of STP / ICS investment
- Support service implementation and operational commissioning and oversee the benefits realisation as specified in the business case.

- Report at agreed intervals to the EMC, Trust board of directors, external stakeholders, regulators and commissioners on the progress of the programme. This includes keeping the board apprised of significant risks and issues.

(The programme management office (PMO) will act as the ‘engine room’ of the programme, undertaking and co-ordinating the activities required to deliver the programme).

6.3.5 **Objectives of the programme board.**

- Identify the inter-relationships and interdependencies between the projects within the programme. Take steps to limit the impact of these on individual projects and take advantage of synergies across the programme.
- Identify the resources required in terms of staff time and financial cost in managing projects within the programme and a funding route for these costs.
- Ensure that the projects within the programme form part of a cohesive strategic vision across the Trust.
- Report on progress to the Trust Board.
- Decision-making for programme management issues as required.
- Performance management of projects.

6.3.6 **Project steering groups.** Project steering groups will be established for each of the programme work streams. These groups will meet monthly (or more frequently if required) and be titled the emergency care project steering group and elective care project steering group. The role of these groups will change over time from co-ordination of business case development, estates design, operational service commissioning and post project evaluation. Consequently, group membership may also be amended according to the phase of the project. The project steering groups will:

- Ensure the project is managed in line with Trust requirements.
- Lead on the development of documentation associated with the programme, in accordance with HM Treasury Green Book and project business case guidance.
- Work closely with medical and clinical teams to design service models and built environment solutions.
- Steer design development for buildings ensuring alignment with the clinical strategy priorities, the Trust’s strategic objectives and the affordability envelope.
- Lead on the capital procurement process for the building solutions and associated equipment.
- Maintain capital financial control and budget review seeking variation approval from the Programme board as required.
- Be responsible for robust project planning for service implementation and operational commissioning.

- Provide a formal monthly highlight report to the programme board, which clearly sets out project progress against key milestones, risks and issues, proposed variations and decisions required by the programme board.
- Provide regular communications to Trust staff, service users and other key stakeholders on project progress.

6.3.7 **Project Working Groups and Project Teams.** In the business case development phase of the programme, project working groups for each of the projects will be established and a project execution plan prepared for each. At different stages in the programme, the membership of each group will change. For example:

- At the OBC/FBC phase, membership will include the Director of Clinical Strategy Implementation, the Associate Director of Capacity & Analytics, health planner expertise, cost advisors, and consulting architects.
- In the detailed design and procurement phase, membership will include capital projects managers, health planner expertise, cost advisors, consulting architects and specialist consultants (e.g. M&E, BREEAM, planning). This phase will need significant clinical user engagement and involvement.
- In the construction phase, membership will include capital projects managers, cost advisors, consulting architects and specialist consultants as required.

6.3.8 Over time the project groups will merge into project teams, as indicated in the governance chart above, these teams will be the focus for engagement with clinical and other users in ensuring plans and designs align to clinical models, pathway design and specialist design requirements. The project teams will meet fortnightly and report to the relevant project steering group. The STP Programme director, supported by the teams, will maintain the overall programme and individual project plans, the programme risk register and maintain the programme documentation records. Project control will be provided by the use of a standard format of highlight reports, risk registers and where required exception reports. Project working groups/teams will include key members of staff to lead on the following: clinical services design; communications & engagement; ICT; workforce planning; financial planning; service transfer & mobilisation planning; estates design; and, estates & facilities operations.

6.3.9 **User groups.** The future care model group chaired by the Medical Director is the clinical reference group for the programme. Clinical user groups (CUGs) will act as the focus for wider engagement with a cross-section of staff and others (including patient representatives) affected by the development. The role of the CUGs will include co-designing the operational requirement of the service. As the programme progresses CUGs will be involved in design, room data sheets, aesthetics, service continuity/migration plans, etc. User groups will need to include change management and transformation expertise to help optimise pathways.

6.4 Programme timeline

6.4.1 A high-level process timeline for the Building for Better Care programme including Business Case Two (Elective Care) approvals is shown in the tables below. NHSE/I confirmed in its letter dated 1 October 2019 approving the SOC for Business Case One (Emergency Care) that an SOC for Business Case Two would not be required as part of the work of NHSE/I to streamline the allocations and approvals process. The resulting programme timeline should allow Contract Let by the end of Q3 2021/22 with the new facilities open to the public by Q2 2024/25.

6.4.2 If the CCGs and ESNEFT Board decide to proceed, the expected next steps would be:

- **Regulatory approvals** – appoint the design team and development of the OBC and FBC.
- **Clinical reconfiguration** – developing the new clinical models of care, and the detailed plans and processes of operational delivery and management, as well as the change management programme – delivering the cultural change and leadership development programme that will ensure successful delivery of benefits.
- **Communication and engagement** – developing detailed plans to support further external stakeholder engagement following public consultation along with and the internal change management programme.
- **Programme management** – creation of a programme board with the appropriate professional support and governance structures to deliver both the engagement and clinical reconfiguration work-streams.

Business Case Two (Elective Care)

Activity	Target Date
PCBC completion and approval by GBs and Trust	Q3 2019/20
PCBC submission to NHSI/E	Q3 2019/20
PCBC approved	Q4 2019/20
Public Consultation started	Q4 2019/20
Public Consultation completed	Q4 2019/20
Decision	Q1 2020/21
Procurement decision	Q1 2020/21
Planning approval	Q3 2020/21
Detailed design process	Q2-Q4 2020/21
OBC completion and approval by Trust	Q3 2020/21
OBC submission to NHSI/E	Q3 2020/21
OBC approved	Q4 2020/21
Construction Tender	Q4 2020/21
FBC completion and approval by Trust	Q1 2021/22
FBC submission to NHSI/E	Q1 2021/22
FBC approved	Q2 2021/22
Contract let	Q3 2021/22
Construction starts	Q4 2021/22
Operational facility open	Q2 2024/25

Table 14: Programme Milestones – Business Case Two

Glossary

Abbreviation	Definition
A&E	Accident and Emergency (usually called ED)
ACP	Advanced Clinical Practitioner
AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner
BAME	Black and Minority Ethnic
BREEAM	Building Research Establishment Environmental Assessment Method
CCG	Clinical Commissioning Group
CH	Colchester Hospital
CHUFT	Colchester Hospital University NHS Foundation Trust
CIP	Cost Improvement Programme
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CSF	Critical Success Factors
CSS	Clinical Support Services
CT	Computerised Tomography
DID	Diagnostic Imaging Dataset
DHSC	Department of Health and Social Care
DQI	Design Quality Indicator
DSU	Day Surgery Unit
EAU	Emergency Assessment Unit
EBITDA	Earnings before interest, tax, depreciation and amortisation
ECC	Elective Care Centre
ED	Emergency Department
EIA	Equalities Impact Assessment
EMC	Executive Management Committee
ERP	Enhanced Recovery Programme
ESD	Early Supported Discharge
ESNEFT	East Suffolk and North Essex NHS Foundation Trust ('the Trust')
FAB	Frailty Assessment Base
FBC	Full Business Case
FRF	Financial Recovery Fund
GAC	Garrett Anderson Centre
GIRFT	Getting It Right First Time
GP	General Practitioner
HBN	Health Building Note
HDU	High Dependency Unit
HEE	Health Education England
HES	Hospital Episode Statistics
HTM	Health Technical Memorandum
ICS	Integrated Care System
ICU	Intensive Care Unit

Abbreviation	Definition
IH	Ipswich Hospital
IHT	Ipswich Hospital NHS Trust
IR	Interventional Radiology
ITU	Intensive Therapy Unit
JAG	Joint Advisory Group on Gastrointestinal Endoscopy
(J)HOSC	(Joint) Health Oversight and Scrutiny Committee
LTFM	Longer Term Financial Model
MRET	Marginal Rate Efficiency Tariff
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
NEESPS	North East Essex & Suffolk Pathology Service
NHFD	National Hip Fracture Database
NHS	National Health Service
NHSI/E	NHS Improvement/NHS England
NICE	National Institute for Health and Care Excellence
NJR	National Joint Registry
OBC	Outline Business Case
ONS	Office for National Statistics
OPE	One Public Estate
PFI	Private Finance Initiative
PHE	Public Health England
PIR	Post Implementation Review
PMO	Project Management Office
PPE	Post Project Evaluation
PROMS	Patient Reported Outcome Measures
PSED	Public Sector Equality Duty
PSF	Provider Sustainability Fund
RCR	Royal College of Radiologists
RPA	Risk Potential Assessment
RTT	Referral to Treatment
SCBU	Special Care Baby Unit
SOC	Strategic Outline Case
STF	Sustainability and Transformation Funding
STP	Sustainability and Transformation Partnership
SWLEOC	South West London Elective Orthopaedic Centre
TAU	Trauma Assessment Unit
THR	Total Hip Replacement
TKR	Total Knee Replacement
UCC	Urgent Care Centre
UTC	Urgent Treatment Centre
VFC	Virtual Fracture Clinic
VFM	Value for Money
WTE	Whole Time Equivalent

Pre-Consultation Engagement - Stakeholder Feedback

Introduction

The proposed Elective Orthopaedic Centre project public engagement is overseen by an Engagement Group, which meets fortnightly and steers matters of public engagement at each stage of the Consultation. During the pre-consultation period, it was decided to hold a series of 'Stakeholder' events to collect the views and early impressions of a selected and representative group of 'Stakeholders' across the ESNEFT region. This report provides the outcome and findings from these meetings.

Methodology

The format used in these events was designed to provide an outline of the proposal and options as far as they had been developed at that time and then to collect feedback on these proposals. The 'Objective' of these events was to gain an indication of the thoughts, ideas and perceptions of the Stakeholders to inform the further development of the project proposal.

The 'Sample' of Stakeholders can be described as 'Purposive' (or Selective) as they were chosen to join each event <https://research-methodology.net/sampling-in-primary-data-collection/purposive-sampling/> Accessed August 2019.

This Methodology can be described as Grounded Theory (https://en.wikipedia.org/wiki/Grounded_theory Accessed August 2019). The Methods used included a 'SWOT Analysis' and the 'Nominal Group Technique'.

The two options presented to these groups included either building an Orthopaedic Centre on the existing hospital site in Ipswich or the existing hospital site in Colchester. These options reflected the limitations placed on this project and therefore no alternative options were available for consideration.

Analysis

Analysis of this feedback consists of a table of the Meeting Feedback which has been consolidated, conflated and grouped into 'Themes' as they emerged, in order of weighting along with a summary of each individual meeting.

This Analysis required elements of interpretation and surmising – and does not represent a detailed transcript of all conversations or fully developed ideas within the feedback. It does, however, provide an indication of the emergent 'Themes' and points of similarity and points of difference between the two options posed. (i.e. either building a Centre at the hospitals in Ipswich or Colchester). It also provides a 'weighting' which tells us which of the 'Themes' are considered by this Sample to be of greatest significance or more important. Note – The 'weighting' is not intended as a Quantitative method for presenting a hierarchy within the response themes. Each contribution to this exercise can be viewed and valued on its own merits.

Discussion – common themes

In order of weighting, the themes that emerged that were common to either location included:

- **Getting there.** This theme includes Travel (Journey) Transport, and to some extent Parking. It was recognised that this proposed Orthopaedic Centre would require additional movement and costs for potentially unwell patients and their carers – and this impacted mostly on those at greater distance and in more remote locations to either site. This was considered the greatest

'Weakness & Threat' on both proposed sites. Although it was also considered a 'Strength' at the Colchester site and an 'Opportunity' (for development) at the Ipswich site. Issues raised included difficulties with the road systems (including bridges and traffic congestion) and a lack of suitable public transport (bus and train). Community transport schemes were identified as existing and in need of support and development (funding). The potential to open road access into the Colchester site was viewed positively.

- **Improvements to patient care.** The potential improvements that an Orthopaedic Centre could bring were regarded positively for both sites. These included the potential to better manage waiting lists and whatever benefits may be achievable in a Centre of Excellence (such as shorter bed stays, lower infection rates and improvements in patient outcomes). It also included a positive view on the potential improvements to other services subsequent to the building of the Orthopaedic Centre at either site.
- **Preferred Option.** As could be predicted, both sites were considered the preferred option. A Centre of Excellence was considered a positive development for this Trust and the potential to develop research and teaching was recognised as important.
- **Staff.** The potential to attract, retain and develop staff was considered positively for either site. There was some concern regarding staff being prepared to travel from one site to the other.
- **Growing Demand.** Both sites were considered to have a growing demand for the services provided at the Orthopaedic Centre in terms of the current and predicted age demographics of the population. Although a potential increase in demand on the proposed services was considered a 'Threat'. Particularly if patients from other regions opt, or are referred in, to this centre and supply is overwhelmed by demand.
- **Accessibility.** Including distance from the car park and or front entrance of the hospital, to the Orthopaedic Centre, disabled parking spaces – were regarded as being in need of improvement on both sites. Although Colchester did have more favourable access than did Ipswich.
- **Potential local objections.** There was concern that people local to either hospital may object to the building of an Orthopaedic Centre. There was also concern that people from Ipswich may object or 'feel devalued' if the centre were built in Colchester – and vice versa.
- **Links to universities.** These were considered an important 'Opportunity' for both potential sites.

Discussion – themes relating to Colchester

- **Reputation.** Reputation was considered to be a 'Weakness & Threat' in Colchester. This was in part based on perceptions formed in experiences, media reporting and CQC results. The potential to improve the reputation of Colchester was also raised as an 'Opportunity'.
- **Facilities.** The opportunity to develop current facilities in Colchester was viewed positively and while there was some discussion about limitations, the overall impression was that Colchester provided the better 'space' and 'building options' of the two sites and therefore would be more cost effective. Services were also better co-located at Colchester.
- **Proximity to London.** Colchester being closer in proximity to London was seen as an advantage. It was thought that this may impact on attracting staff and patients into the centre as being closer to London provided a greater population base and travel into and out of London would be easier from Colchester. This may also have an impact on the Orthopaedic Centre's ability to

attract private patients and therefore generate income.

- **Other.** The three other 'themes' particular to Colchester included:
 - Concerns about the collaboration between the two sites;
 - Poor IT access;
 - The proximity of the MOD being a potential 'Threat'.

Discussion – themes relating to Ipswich

- **Suitable site.** The availability of space and related project issues (such as the potential rebuilding of car parks and an Education Suite) were seen as 'Weaknesses & Threats' relating to the Ipswich site. It was also considered to be less cost effective compared with Colchester. Potential issues with planning permission were also raised as 'Threats'; however, the potential to develop facilities at Ipswich was regarded as an 'Opportunity'.
- **Reputation.** The reputation of Ipswich in terms of the performance of the hospital and the 'culture' amongst staff was considered as a positive 'Strength'.
- **Location.** Ipswich being more centrally located for the Trust was regarded as a 'Strength'. However, if being more central lowered demand for services, this may pose a 'Threat'. It was also considered that a Centre of Excellence in Ipswich would benefit the wider area of Ipswich in terms of status and opportunities.
- **Community support.** Concerns about support in the community for patients and carers. Good hospital-based networks and collaboration with community care were viewed as 'Strengths'.

Findings

While it is not the intention of this report to draw conclusions from this feedback, it would seem important to consider the following issues that arise from this discussion (in no particular order).

- Travel and Transport are matters that currently exist in terms of patients use of either site. The point of difference here is that certain patients will be required to travel further for one part of their care. It will be important to clearly articulate what this will mean for those patients and what measures may be in place to mitigate this issue. Also a case should be made that provides people with an understanding of the benefits of the centre which on balance may weigh against the problems of travel.
- The arguments for either Ipswich or Colchester, (as indicated in this feedback) should be considered in the development of the Project Plan and associated documents. There should be transparency in the decision making process that informs the wider public why one site was preferred over the other so that the full Public Consultation can benefit from this pre-consultation stage.
- This feedback should be triangulated with other feedback (e.g. Staff, Public Representatives, Other Stakeholders) to validate the 'themes' identified and to demonstrate public involvement.

Conclusions

This report was compiled by an independent consultant on Public Consultations – Dr Steven Wilkinson (steven.wilkinson@talktalk.net). The views expressed are not necessarily those of any ESNEFT staff.

Supporting Information

Consultation Planning Meetings

Pre-Reading

A 2-page proposal outlining the two options: (a) New Build at Colchester; and, (b) New Build at Ipswich.

Meeting Format

- 10 mins Introductions & Outline of the Pre-Consultation process
- 20 mins The Proposal – (presentation)
- 30 mins Collecting views (SWOT and NGT – see over)
- 20 mins Plenary
- 10 mins Close and next steps

Timings are indicative and the meeting may take between 1 ½ - 2 hours.

Collecting Views - Methods

SWOT Analysis

SWOT Analysis is a useful technique for understanding your Strengths and Weaknesses, and for identifying both the Opportunities open to you and the Threats you face. Two flip charts will be drawn up, one for each of the proposals.

Participants will be briefed in how to interpret each of the squares on the first of the flip charts. Each participant will then be given a pack of 'post it' notes and a pencil, and given 10 minutes to write their ideas onto separate note pages and stick them onto the chart. The exercise will then be repeated for the second of the flip charts and then the results will be discussed.

Strengths	Weaknesses
•	•
Opportunities	Threats
•	•

Nominal Focus Group Technique

A Nominal Focus Group Technique is a useful technique for prioritising a set of ideas.

Given the completed SWOT analysis, which, in your view, are the most significant issues raised?

In turn each member of the group is asked to write a number 5 onto the Post-it note on the flip chart that they believe to be the most significant issue, a number 4 beside the next, then 3, 2 and 1 beside the next three in descending priority order. This exercise will be explained in detail and will be repeated for each of the two flip charts after which we will then add up the scores for each answer on each sheet.

Consolidated SWOT Analysis and Nominal Group Feedback from all events

Colchester Option

Strengths	Weaknesses
Preferred Option - 137 Improved Services - 39 Closer to London - 32 Age Demographics - 31 Travel, Transport & Parking - 31 Access - 30 Staff - 6 Reputation - 3	Travel/Transport & Parking - 144 Reputation - 36 Impact on Suffolk - 12 Access - 7 Age Demographics - 6 Site limitations - 2 IT Access
Opportunities	Threats
Improved Services & Patient Outcomes - 136 Staff - 68 Facilities - 55 Age Demographics - 12 Private patients - 6 Road Link - 8 Links to University - 1	Performance - 46 Objections - 49 Staff - 21 Travel/Transport & Parking - 21 Lack of Community Transport - 11 Project Issues - 9 Collaboration between sites - 7 Access - 7 Age Demographics - 3 MOD presence - 1

Ipswich Option

Strengths	Weaknesses
Preferred Option - 76 Improved Services - 47 Staff - 26 Transport, Travel and Parking - 23 Carers - 16 Age Demographics - 20 Reputation - 13 Access - 8 Community support - 5 Links to University - 4	Travel/Transport & Parking - 115 Space - 52 Access - 37 Staff - 24 Performance - 16 Location - 16 Planning Consent - 8 Cultural - 6 Cost - 2
Opportunities	Threats
Improved Services - 114 Staff - 97 Facilities - 23 Local Impact - 10 Transport, travel & parking - 8 Links to University - 6 Age Demographics - 5 Funding - 3 Private patients - 1 Carers - 2	Transport, Travel & parking - 40 Objections - 42 Project issues - 30 Demand - 17 Access - 17 Staff - 37 Collaboration - 13

Governors Meeting Ipswich Hospital – 11 July 2019

Colchester Option

Strengths	Weaknesses
Better site/estate - 16 Facilities for a growing/expanding population - 11 Local Access (Travel) - 10 Easier to Develop (less disruption) - 6 Centre of excellence - 5 Economy of scale - 2 Opportunities for staff Staff satisfaction	Travel/Transport & Parking - 31 Site limitations Devalues Suffolk IT Access
Opportunities	Threats
Staff Development/Retention/ Recruitment - 22 Centre of Excellence - 13 Enhanced Facilities Capacity for private patients	Chelmsford based Clinical Planning -7 Objections from Suffolk Residents - 5 Lack of Consultant By-in - 4 Suffolk Staff Morale - 3 Increased Demand - 2 Project Issues (slippage/costs) - 2 Performance Drift - 2 Alternative hospitals preferred Relatives needs overlooked Need becomes obsolete Lack of Public Support Transport form Suffolk

Ipswich Option

Strengths	Weaknesses
Centre of Excellence – 20 Staff Development/Retention/ Recruitment – 10 Staff Morale - 9 Good location for Suffolk - 5 Placement within existing buildings– 4 Geographically Central Economy of Scale	Travel/Transport & Parking – 21 Difficult Estate – 7 Staff Preference - 5 Less Increased Demand Consultants losing private work Protracted Planning Permission Disruption to hospital activity Further from London
Opportunities	Threats
Attracting Quality Staff - 12 Faster Hospitalisation - 5 Career/Clinical Development - 3 Local Employment Opportunities - 2 Connections (Town/Country) - 2 Room to expand/Space - 2 ECC Close to allied Facilities University links Values Suffolk Expanded parking wider benefits Opportunity to redevelop buildings	Further from Most Pts - 9 Lack of Support from Essex - 7 Lack of Public Support - 5 Disruption to existing services - 5 Rise in Demand - 4 Cost - 2 Lack of Transport Lack of staff Need becomes obsolete The Unknown/Press Colchester staff resentment

Felixstowe Meeting – 5 August 2019

Colchester Option

Strengths	Weaknesses
Access for London-based staff - 26 Better Location/Access - 16 Available land - 6 Larger/Growing population - 5 Closer to London - 3 Good public transport links - 2 Access Raise Colchester profile	Greater Distance (for some) - 14 Poor reputation - 9 Conflict between Suffolk/Essex - 6 Poor parking - 5 Lack of community transport - 5 Difficult to reach (elderly/rural) - 4 Family Travel (+ cost) - 3 Traffic congestion - 2 Weak CQC results - 2
Opportunities	Threats
Improved standards - 9 Improved Recruitment/Retention - 7 Specialised care - 7 Centre of excellence - 6 Attract more private consultation - 5 Larger population - 5 More building space available - 5 Location within hospital Better facilities Commercial uplift for town Better skills More comfortable	Difficult to access - 6 Parking - 5 Not in my backyard - 4 Bad reputation - 4 Staff quality needs improvement - 2 Younger population (lower need) Poor for Ipswich Colchester bias Staff/patient not prepared to travel Makes Ipswich less attractive Lack of fall back service Transport issues

Ipswich Option

Strengths	Weaknesses
Family Visiting - 15 Closer to older people (+ coastal) - 12 Better location - 12 Better Transport system - 11 Better community support - 5 Closer to deprived areas - 5 Better CQC & Staff morale - 3 Access Public Transport	Lack of sufficient space/Access - 22 Parking - 6 Is this the right medical priority? - 3 Access to new centre - 2 Travelling Height limitation Cost for families Staff availability New building unnecessary
Opportunities	Threats
Better Care - 20 Attracting staff /Research - 12 All in one place - 5 Improved patient outcomes - 2 A new Education Centre - 1 Reduced waiting times Care at home/Family friends support More efficient local service Local transport available Lower cost for locals Better facilities	Lack of Disabled parking - 6 Lack of space - 5 Access (Transport) - 5 Ipswich will feel downgraded - 2 Local objections - 2 Loss of specialised staff - 1 Road block Terrorists Power cuts Distance (for some)

Needham Market Meeting – 7 August 2019

Colchester Option

Strengths	Weaknesses
Day Care Upgrade - 13 4 Story build possible - 3 Elective Surgery (enhanced) - 2 Easier Access/Parking New Facility	Car Parking - 2 Distance for Suffolk people - 2 Everything Difficult access through town
Opportunities	Threats
Better patient outcomes - 15 Additional Day Surgery - 12 Attract and Retain Staff - 9 Improve Access (road) - 4 Reduce cancellations - 4 Reduce waiting times - 3	Staff (Not wanting to work there) - 5 Patients unable to travel - 4 Relationship between sites - 2 Travel from North Suffolk Suffolk people

Ipswich Option

Strengths	Weaknesses
Central to Ipswich - 7 Centre of Excellence - 6 Excellent staff - 3 Greater population Easier parking Easier access Familiar hospital to local people	Access by road - 14 Transport from villages - 2 Building regulations Loss of space on site Travel for others Car Parking
Opportunities	Threats
Attracting staff - 17 Improved outcomes/better care - 10 Reduced waiting lists - 8 Near to Ipswich University - 5 Improve staff skills/knowledge - 3 Attract funds - 2	Get less for money than Colchester - 4 People from Essex (opinion) - 4 Relationship between sites - 1 Travel from Colchester Staff/Patient parking

Clacton-on-Sea Meeting – 8 August 2019

Colchester Option

Strengths	Weaknesses
Closer to home - 11 Easy Access (Main transport links) - 7 Available space - 5 Majority (of Ops) currently at Colchester - 5 Service Upgrade - 5 Demographics - 3 Locals know the hospital - 1	Parking - 9 Population growth - 5 Transport access - 3 Travel - 2 Access from Suffolk
Opportunities	Threats
Development of a Centre of Excellence - 11 Staff enhancement - 9	Underfunding of community transport - 11 Patients from Suffolk (Uptake) - 3

Appendix 1: Feedback from Stakeholder Engagement

Day Surgery Upgrade - 4 Better road access - 3 Support for more people - 3 Expansion of facilities	Approach roads traffic - 2 South Essex consortium Available car parking Ipswich remains underdeveloped
---	---

Ipswich Option

Strengths	Weaknesses
Centre of Excellence - 8 Staff Enhancement - 4 Development/Improvement - 3 Existing Centre of Excellence - 2 Large Hospital New Build Access from Suffolk	Access/Travel from Essex - 30 Transport (Links) - 12 Parking - 3 Further from London Visitor access The Bridge Language
Opportunities	Threats
Development of older buildings - 7 Quality staff - 6 Care for more people - 5 Attract Private Patients Community Transport	Difficulty for Visiting - 7 Poor take up (from Essex) - 5 More missed appointments - 5 Travel/Transport - 5 Lack of parking Peoples Care Norfolk and Norwich

Colchester Meeting – 9 August 2019

Colchester Option

Strengths	Weaknesses
Available space on site - 10 No change - 7 Multi modal transport access - 4 Proximity to London - 1 Aging population Greater number of Orth patients	Distance from Suffolk - 10 Clinical/Cultural issues - 3 Age of population
Opportunities	Threats
Attract Staffing - 9 Enhance expertise - 4 Shorter journeys for Essex people - 3 Good use of site space Overall benefits enhanced Improved connections	Ipswich takeover - 3 Sustainable development - 2 Increased journeys - 1

Ipswich Option

Strengths	Weaknesses
Good clinical outcomes - 2 Age profile - 2 Shorter journeys for Suffolk people - 2	Accessibility - 19 Site Problems - 10 Journeys/Transport - 7

Appendix 1: Feedback from Stakeholder Engagement

Closer for visitors None	No direct rail link
Opportunities	Threats
Improved connections - 2 Attract and retain staff - 2 Enhance expertise - 1 Improved access for Suffolk patients	Delays/Timescales - 7 Public concerns - 4 Colchester challenges Lack of facilities

Ipswich Meeting – 12 August 2019

Colchester Option

Strengths	Weaknesses
Travel and transport - 13 Parking - 10 Access - 5 Larger projected population - 5 Better inpatient time - 3 Available space	Travel (Bridges) - 15 Ipswich residents - 6 Distance from North Suffolk - 2 Space - 1
Opportunities	Threats
Improved quality of Care - 15 Nearer by Train - 7 Central - 4	Ipswich residents - 14 Lack of agreement (loss of grant) - 5 MOD presence - 1 Not easy for people

Ipswich Option

Strengths	Weaknesses
Is more local - 15 Transport - 5 Railway station	Restricted Parking - 18 Specialists will not come - 8 Restricted site (space) - 5 Traffic problems - 3 Derision - 3
Opportunities	Threats
State of Art services - 7 Specialists on site - 6 Central - 2 Local help at hand - 1 Easier for residents	Surgeons will not come to Ipswich - 10 More people will object to Ipswich - 5 Town apathy - 4 Space on site - 3 Public unrest at Colchester - 2 More parking needed - 1 None

Wickham Market Meeting – 14 August 2019

Colchester Option

Strengths	Weaknesses
Space available - 12 Improved Outcomes - 10 Better Road Links - 3	Failure to attract quality staff - 10 Distance from north - 4 Too far for some in Suffolk - 4

Appendix 1: Feedback from Stakeholder Engagement

Greater opportunities for staff - 3 Better rail links - 2 Closer to London - 1 Attracts Doctors	Turner Road - 3 Unfamiliar to Suffolk People Ipswich being a centre of Excellence
Opportunities	Threats
Closer to London (also for Doctors) - 9 More available building space - 9 Centre of Excellence - 5 Greater Demand - 4 Innovative Care - 2 Recognition - 1 Job opportunities Closer relationship to Universities Site development	Loss of skills to Ipswich - 14 People from Suffolk have to travel further - 8 Diminishing Ipswich - 7 Doctors not wanting to work in Ipswich - 3 Enough funding - 2

Ipswich Option

Strengths	Weaknesses
Better Outcomes - 9 Centre of Area - 7 Better access for Suffolk people - 5 Greater development For Suffolk - 5 Closer university links - 4 Attracts Staff - 2 More opportunities Greater Surgeons	Not enough Space - 18 Location - 12 Parking - 2 Comparatively Higher costs - 2 Not as popular as Colchester - 2 Poor rail access - 1 Fewer patients - 1 Poor road access Travel distance from rural Essex Loss of skills at Colchester
Opportunities	Threats
Increase research and Innovation - 13 Develop local skills - 9 Centre of Excellence - 6 Ipswich has increasing older population - 5 Attracts Staff - 5 Better location Better Funding Job opportunities Research More operations	Access to hospital (road) - 11 Car Parking - 6 National Usage - 2 Transport - 1 Not enough money - 1 Inadequate site - 1 Staff working away from Colchester Greater Cost

Aldeburgh Meeting - 16 August 2019

Colchester Option

Strengths	Weaknesses
More cost effective - 27 Better transport links - 5 Centre of Excellence - 3 Better site - 3 Less impact on existing services - 2 Closer to London	Transport /Travel/Distance - 18 Staff travel concerns - 6 Draws staff from Ipswich - 5 Better staff at Ipswich - 3

Appendix 1: Feedback from Stakeholder Engagement

Opportunities	Threats
Centre of Excellence - 39 Better patient care - 1 Provides more support Benefits for Colchester Attracts specialist teams	Degradation of Ipswich - 5 With more patients waiting time goes up again - 5 Service amalgamation threat - 5 No London weighting for staff - 4 Timescales (other trusts beat us) - 2 Resistance by staff/patients - 2 Increasing transport Age demographic

Ipswich Option

Strengths	Weaknesses
Closer for Suffolk people - 10 Higher rated hospital - 7 Well Known Site Centre needed Public support Local transport Car parking Access for family support Further from London/less cost	Less space/Higher cost - 14 Staff retention - 8 Access by bus/Transport - 4 Dearth of Experience in Colchester - 3 Parking Further from London
Opportunities	Threats
Centre of Excellence - 20 Better patient care - 13 Improves professionalism of services - 5 Everything in one place - 4 Improve transport - 2 Attracts staff Development of associated services	Deterioration of staff - 14 Amalgamation of services fear - 10 Lack of ongoing care - 2 Lack of public support Local public complaints Other areas transport

Equality Analysis of the proposals for the future delivery of Adult Elective Orthopaedics services in Ipswich and Colchester.

What is an equality analysis?

An Equality Analysis - EA, (formerly referred to as an Equality Impact Assessment) is a way of systematically and thoroughly assessing, and consulting on, the effects that a service is likely to have on people from different characteristic groups. Their purpose is to identify and address existing or potential inequalities, resulting from practice development. Ideally, EA's should cover all the strands of diversity and will help trusts get a better understanding of its functions and the way decisions are made, by:

- considering the current situation;
- deciding the aims and intended outcomes of a function;
- considering what evidence there is to support the decision and identifying any gaps;
- ensuring it is an informed decision.

<https://www.nhsemployers.org/retention-and-staff-experience/diversity-and-inclusion/tools-and-resources/external-resources/equality-analysis-and-equality-impact-assessments>

<https://www.royalwolverhampton.nhs.uk/about-us/equality-diversity-and-inclusion/equality-analysis/>

Who contributed to this EA?

This EA was undertaken by: Dr Steven Wilkinson an independent academic consultant commissioned to work with this consultation. This EA was conducted in June and July of 2019. Additional advice was provided by: Dr Alistair Lipp, Medical Director & Responsible Officer, NHSE/I – East of England Region and Megan Haugh, Programme Officer, NHS Diversity and Inclusion

Why do we need an Equality Analysis?

This Equality Analysis will consider the potential impact on the protected characteristics as defined in the Equality Act 2010, namely:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Carers 'by association' with some protected characteristics e.g. disability and age

In some areas, equality data is unavailable so we cannot say with certainty how some groups would be affected. Where data is not available, we have considered potential impacts to the best of our ability.

The NHS Act 2006 (as amended by the Health and Social Care Act 2012) creates a legal duty on the Secretary of State for Health, NHS England and clinical commissioning groups (CCGs) to have regard to

the need to reduce health inequalities. This duty sits alongside the existing Public Sector Equality Duty (PSED) to which all public bodies are subject.

The PSED requires public bodies to have due regard to the need to: eliminate discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010; advance equality of opportunity between people who share a protected characteristic and people who do not share it; foster good relations between people who share a protected characteristic and people who do not share it.

The Department of Health’s Equality Objectives Action Plan states that: as a Department of State and the system leader of the reformed health and social care system: the new direction for health and social care requires some fundamental changes to functions right across the health and care system, the Department and its arm’s length bodies. Equality remains an integral and vital part of this transition.

As an employer: the Department has an on-going commitment to promoting and achieving equality and diversity in the workplace. We aim to attract, retain and develop people who are the best in their field, with the right skills and competencies from a diverse range of backgrounds.

At the point in time that this EA was developed, the detail of the proposed orthopaedic elective care centre had not been finalised. It was considered that this EA would contribute to this process. This EA has been developed on the presumption that a single centre will be proposed at either Ipswich or Colchester, and that there may be implications for NHS Staff and service uses.

Are we well-led?

One of the five key questions the CQC (Care Quality Commission) asks all care providers as part of an inspection is ‘Are you well-led?’ with a focus on five key lines of enquiry as part of this ‘well-led’ domain:

- Is there a clear vision and credible strategy to deliver high-quality care and support, and promote a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people?
- Does the governance framework ensure that responsibilities are clear and that quality performance, risks and regulatory requirements are understood and managed?
- How are the people who use the service, the public and staff engaged and involved?
- How does the service continuously learn, improve, innovate and ensure sustainability?
- How does the service work in partnership with other agencies?⁴¹

This EA provides evidence in support of the above mentioned criteria.

Equality Analysis

Aims and Objectives. To conduct an EA – to include patients and potential patients, staff and potential staff in relation to the proposed development of an orthopaedic elective care centre.

Evidence
This Equality Analysis (EA) relies on the document ‘Options for Adult Elective Orthopedics’ which

⁴¹ <https://healthcare.radarsoftware.co.uk/media/1288/are-you-well-led-flyer.pdf>

had been developed early in the pre-consultation stage of the project. It also drew on the advice from the NHS Employers ‘diversity and inclusion’ division and NHS England & NHS Improvement. The Care Quality Commission criteria for ‘Well Led’ organisations also provided guidance in this process. A similar consultation held by the Mid and South Essex STP – ‘Your Care in the Right Place’ 2018 <https://midessexccq.nhs.uk/about-us/the-library/consultations-1/your-care-in-the-best-place> also provided insights relevant to this EA.

In addition, the ESNEFT has established a Consultation Working Group which meets regularly to develop engagement activities with both staff and patient groups. These activities range from public meetings, specialty staff meetings and a range of interviews and proposal development meetings undertaken by members of this group. Details of this exercise and the Communication Strategy can be provided on request.

Equality and Diversity matters are embedded within the ESNEFT Values which can be located here: <https://www.esneft.nhs.uk/work-and-learn-at-esneft/learn-and-develop-at-esneft/our-values/>

Protected Characteristic – Disability

Evidence shows that the prevalence of disability increases with age. Around 6% of children are disabled, compared to 16% of working age adults and 45% of adults over state pension age.

ESNEFT are partnered with ‘Disabled Go’ http://www.changing-places.org/find_a_toilet/disabledgo_access_information.aspx to provide information to support people to use the hospitals. Currently we have accessibility information mapped for both Ipswich and Colchester Hospitals.

Patients and potential patients

Due to the specific specialist nature of the proposed service, it can be assumed that all patients, and potential patients using this service will have a degree of disability.

The impact of this disability may raise issues around physical access to the Centre and travel to and from the Centre.

There is no evidence that patients with disabilities will be medically or clinically disadvantaged by this proposed service. However, it is anticipated that patient experience will be significantly enhanced.

The matter of disability access will be integral in the design of the Centre – and will meet the necessary standards.

Matters concerning travel will be identified in the Public Consultation and will need to be considered in the final decision making process. There is evidence that concerns relating to travel, transport and parking will be raised during the consultation period, as these matters arise in similar consultations in this region.

Considerations should also include family and carers, who are integral to the overall healthcare process. Previous and similar consultation feedback highlights this issue as highly significant.

Staff and potential staff

Staff with recognised disabilities may be effected by workplace related considerations and travel.

Reasonable adjustments will be made concerning existing and newly appointed staff in the workplace.

Some staff with disabilities may be asked to consider relocating from their current workplace. This will raise issues concerning travel and parking which will be considered in the final design of the Centre.

Work/life balance matters relating to additional travel

<p>To ensure disabled people can access the information they need, the NHS will be encouraged to offer support to people who need help in accessing and understanding information, so that no part of society is unfairly disadvantaged. HealthWatch: https://www.healthwatch.co.uk/ will have a signposting function and should connect to and involve local groups and organisations who work with and are part of communities of interest, geography, demographic and characteristic. This will mean that, locally, people can have access in different ways to the information they need and will, by definition, include, ‘hard to reach’ and ‘seldom heard’ groups.</p>	<p>and/or transport concerns and/or family or personal commitments will need to be considered on an individual basis.</p>
<p>Protected Characteristic – Sex</p> <p>Men and women share many health risks. Yet there are some marked differences between them which impact upon morbidity, mortality and health outcomes. Domain One of the NHS Outcomes Framework shows that life expectancy has been steadily rising for males and females since 1990 and, although female advantage persists, the gap between males and females has narrowed.</p> <p>The new centre will present an opportunity to treat those most at need regardless of personal characteristics, such as gender. We do not anticipate any adverse impact on the grounds of gender relating to this proposed Centre.</p>	
<p>Patients and potential patients</p> <p>Matters concerning gender specific in-hospital facilities will be part of the Centre design process.</p> <p>It is not anticipated that matters of gender will have an impact on this proposed centre for patients or potential patients.</p>	<p>Staff and potential staff</p> <p>The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, introduced gender pay reporting legislation, which requires employers with 250 or more employees to publish statutory calculations every year identifying the pay gap between male and female employees.</p> <p>In 2018 a Gender Pay Gap Summary report was completed and can be accessed at: https://www.esneft.nhs.uk/about-us/equality-diversity-and-inclusion/</p> <p>It is not anticipated that matters of gender will have an impact on this proposed centre for staff or potential staff.</p>
<p>Protected Characteristic – Race</p> <p>Evidence shows that some long term conditions are more prevalent and have more severe consequences for some ethnic minority groups. The Centre will be developed using a model of anticipated demand over the forthcoming 20 years using regional demographic data.</p> <p>ESNEFT is working with NHS England to complete work on the Workforce Race Equality Standard.</p> <p>It is not anticipated that matters of race will have an impact on this proposed centre for patients or potential patients, nor staff or potential staff.</p>	

Protected Characteristic – Age

We know that the numbers of people aged 75 and over is increasing, it is predicted that the proportion of people in that age group will rise from 8% of the population in 2011 up to 11% of the population in 2026. We also know that this group access secondary healthcare more regularly – people aged 75 and over account for 29% of emergency admissions, 44% of unplanned bed days.

We believe that those aged 75 and over will see significant benefits with the creation of this proposed Centre. The Care for the Elderly department will provide hospital based services. With integration between health and social care becoming the norm, it is anticipated that out of hospital care, providing the capacity for safe discharge from the proposed centre, will be in place.

It is not anticipated that matters of Age will have an impact on this proposed centre for patients or potential patients, nor staff or potential staff.

Protected Characteristic – Gender Reassignment (including transgender)

The National Lesbian, Gay, Bisexual and Transgender partnership have highlighted the importance of data security surrounding issues of sexual orientation and gender reassignment.

Doctors are required to manage patient confidentiality in accordance with GMC guidelines 'Confidentiality: Good practice in handling Patient Information' which can be accessed here: https://www.gmc-uk.org/-/media/documents/Confidentiality_good_practice_in_handling_patient_information_English_0417.pdf_70080105.pdf

Safeguards are also in place and are part of the management practice within ESNEFT.

It is not anticipated that matters of Gender Reassignment (including transgender) will have an impact on this proposed centre for patients or potential patients, nor staff or potential staff.

Protected Characteristic – Sexual Orientation

The Government estimates that between 5% and 7% of the UK population are lesbian, gay or bisexual. This Equality Analysis found a lack of evidence about whether LGBT staff or patients currently face discrimination of any kind. However, a more intensive review of this matter further into the consultation process would be advised.

It is not anticipated that matters of Sexual Orientation will have an impact on this proposed centre for patients or potential patients, nor staff or potential staff.

Protected Characteristic – Religion or Belief

It is not anticipated that matters of Religion or Belief will have an impact on this proposed centre for patients or potential patients, nor staff or potential staff.

Protected Characteristic – Pregnancy and Maternity

For Staff and potential staff - Maternity support (paternity) leave and pay – is covered by Section 35 of the NHS Conditions of Service, which can be located here:

<https://www.nhsemployers.org/pay-pensions-and-reward/agenda-for-change/nhs-terms-and-conditions-of-service-handbook/parents-and-carers/maternity-support-paternity-leave-and-pay-section-35>

<p>It is not anticipated that matters of Pregnancy and Maternity will have an impact on this proposed centre for patients or potential patients, nor staff or potential staff.</p>	
<p>Protected Characteristic – Carers</p> <p>Carers play an important role in caring for older people who are in vulnerable circumstances and those with complex needs. The 2011 Census figures for England, Wales and Northern Ireland show an increase in the number of carers since the last Census in 2001, from 5.2m to 6.0m, an increase of 629,000 people who are providing care in only 10 years.</p> <p>Inequalities exist within the demographics of carers. Women are more likely to be carers than men, with 1 in 4 women between the ages of 50 and 64 being carers, and they are more likely to report poor health than men when caring for someone whilst working full-time. People providing high levels of care are twice as likely to be permanently sick or disabled, and some ethnic minorities are far more likely to be carers than other ethnic groups. Bangladeshi and Pakistani men and women, for example, are three times more likely to provide care compared with their white British counterparts.</p>	
<p>Patients and potential patients</p> <p>There is an ESNEFT Carers Hospital Support Service, details of which can be found here: https://www.esneft.nhs.uk/get-involved/patient-and-carer-support-groups/colchester-support-groups/carers-hospital-support-service/</p>	<p>Staff and potential staff</p> <p>Matters concerning staff or potential staff who are themselves carers will be considered on an individual basis and reasonable adjustments will be considered.</p>
<p>Engagement and involvement</p> <p>Was this work subject to the requirements of the cross-government Code of Practice on Consultation? https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/2695/code-practice-consultations.pdf Yes.</p> <p>While this project continues to evolve, matters concerning equality will continue to be revised and considered. This document will be updated prior to the decision making process.</p> <p>Equality data will be collected from all respondents and participants in the consultation elements of this project.</p>	

Summary

This initial Equality Analysis (EA) has identified the following challenges and opportunities:

Staff and potential staff

- Reasonable adjustments will be made concerning existing and newly appointed staff in the workplace with Disabilities.
- Some staff with disabilities may be asked to consider relocating from their current workplace. This will raise issues concerning travel and parking which will be considered in the final design of the Centre.
- Work/life balance matters relating to additional travel and/or transport concerns and/or family or personal commitments will need to be considered on an individual basis.
- Matters concerning staff or potential staff who are themselves carers will be considered on an individual basis and reasonable adjustments will be considered.

Patients and potential patients

- The matter of disability access will be integral in the design of the Centre – and will meet the necessary standards.
- Matters concerning travel will be identified in the Public Consultation and will need to be considered in the final decision making process. There is evidence that concerns relating to travel, transport and parking will be raised during the consultation period, as these matters arise in consultations in this region.
- Considerations should also include family and carers, who are integral to the overall healthcare process. Previous and similar consultation feedback highlights this issue as highly significant.

To ensure disabled people can access the information they need, the NHS will be encouraged to offer support to people who need help in accessing and understanding information, so that no part of society is unfairly disadvantaged. HealthWatch, <https://www.healthwatch.co.uk/> will have a signposting function and should connect to and involve local groups and organisations who work with and are part of communities of interest, geography, demographic and characteristic. This will mean that, locally, people can have access in different ways to the information they need. This will include by definition, 'hard to reach' and 'seldom heard' groups.

- Matters concerning gender specific in-hospital facilities will be part of the Centre design process.
- While this project continues to evolve at pace, matters concerning Equality will continue to be revised and considered. This document will be reviewed and updated prior to the decision making process.
- Equality data will be collected from all respondents and participants in the consultation elements of this project.

Travel Impact Assessment

Summary

This is the current data on travel analysis. The key points to note are:

1. ESNEFT has a catchment area for patients running to south of Chelmsford, north of Bury and the border of Lowestoft.
2. There are areas of the highest deprivation in Tendring, Pier Ward of Colchester and Ipswich central. There are areas of moderate deprivation in the north east part of Suffolk.
3. In 2018/19 ESNEFT completed 2,358 major joint procedures which will rise to 3,336 by 2041.
4. The split of patients is currently 52% Colchester, 48% Ipswich.
5. Putting the Centre at either site will increase travel for around half of the patients. However, most elective pathways involve at least five visits and the Centre will affect only one of these. The increase in total travel distance is therefore small. Colchester would increase travel by 9% for the average patient (12 miles), vs 14% (18 miles) if at Ipswich.
6. All of our current patients would be able to access both hospitals by car within 60 minutes, according to the Public Health England SHAPE Tool.
7. Public transport currently has serious deficiencies. Travel times (if the journey is even possible) are over 2 hours from north Suffolk to Ipswich hospital and from south Tendring to Colchester hospital. There is virtually no public transport in the south of Tendring.
8. Putting the Centre at Ipswich has the greatest impact on reducing ease of access by public transport. It particularly reduces access from Tendring.
9. Parking availability is limited on both sites but additional parking is planned at Colchester.

Therefore, the site which would appear to minimise travel impact is Colchester. This is favoured by:

- A small majority of current orthopaedic patients are served by Colchester Hospital;
- Higher growth is predicted in orthopaedic patients in the Colchester Hospital catchment;
- There is better public transport access to Colchester Hospital from all areas;
- Lower impact on deprived populations.

This is not conclusive and requires further internal and external quality assurance / validation.

Purpose of this document

This is a briefing on the emerging data for the Travel Impact Assessment (TIA). The TIA is a requirement for the public consultation on the proposal to create a Centre for Elective Orthopaedic Surgery.

Caveats

This data is generated from sources available to the Trust. It has not yet been through any Trust governance or quality assurance, nor has any external assurance although it has been submitted to both Essex and Suffolk County Councils for their advice. It should therefore be treated with caution.

Base data & modelling

The data sources used are:

1. Activity data from 2018/19 in Orthopaedics. This offers a reasonable representation of patients needing hip or knee surgery in terms of age profile and area of residence.
2. Activity predictions up to 2041, based on age-banded ONS data mapped onto existing patients from 2018/19.
3. National Joint Registry data for benchmarking.
4. Public Health England SHAPE (Strategic Health Assets Planning and Evaluation) data for deprivation and travel times. Travel time catchments assume ‘worst case’ rush hour travel for car journeys and weekday morning travel for use of public transport.

Current activity data

Relative volume of activity at ESNEFT

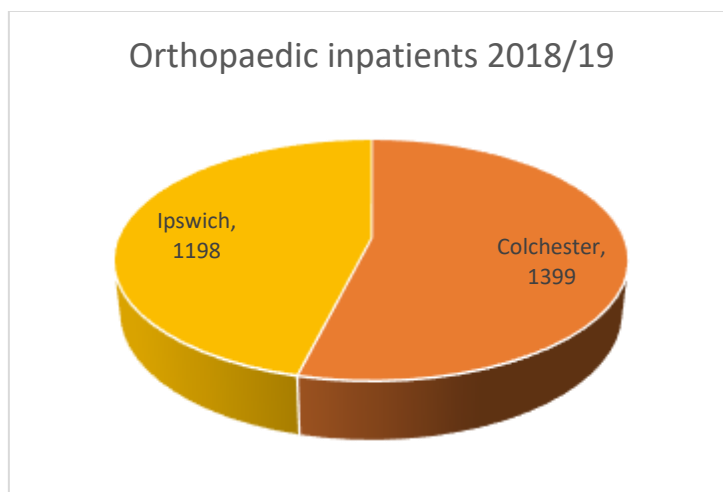
The last complete year of National Joint Registry (NJR) data is shown below:

National joint registry 2017

Hospital	Hip	Knee	Ankle	Elbow	Total
ESNEFT [CH & IH combined]	878	849	1	8	1736
Norfolk and Norwich	648	519	11	19	1197
Colchester	505	481	0	5	991
Addenbrookes	457	362	6	17	842
Southend	361	409	1	6	777
West Suffolk Hospital	441	317	1	0	759
Ipswich	373	368	1	3	745
Mid Essex Hospital	362	364	0	0	726
James Paget	368	302			670
Basildon	272	314	0	0	586

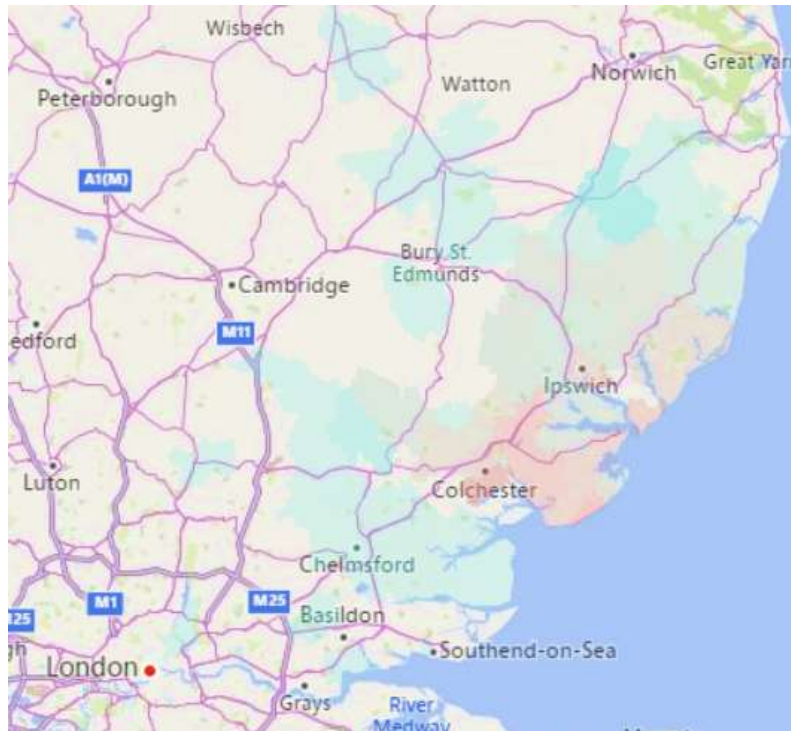
Colchester was already providing the second highest number of major joint procedures in the East of England. When combined as ESNEFT, the Trust undertakes 45% more procedures than the Norfolk & Norwich teaching hospital.

In 2018/19, the number of procedures at Colchester Hospital (CH) and Ipswich Hospital (IH) was:



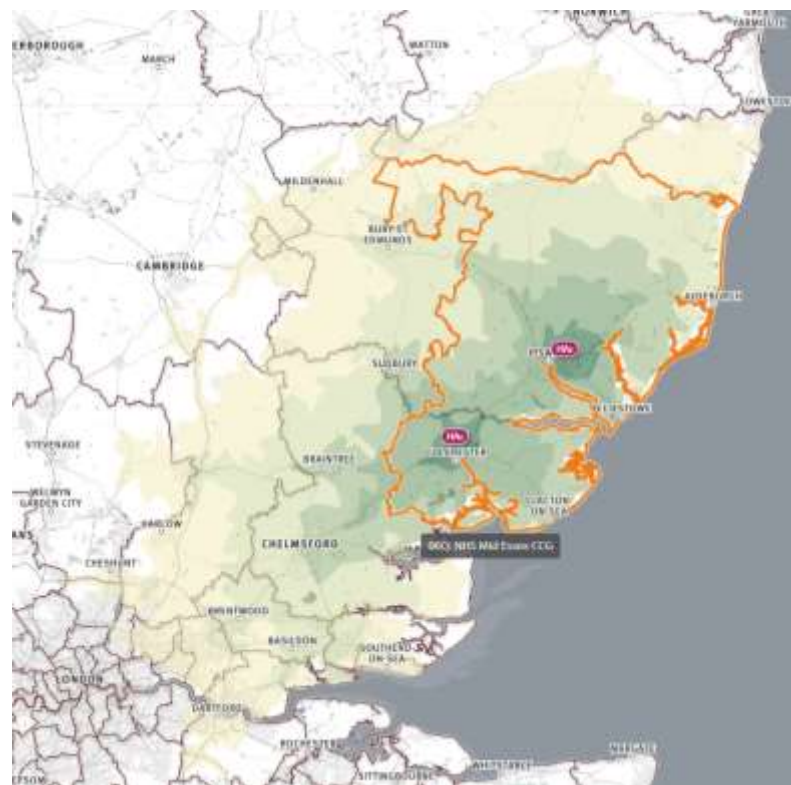
Current patients by geography

The map shows 2018/19 numbers patients by post code (red = highest number of patients)



Current travel times by car

All our current patients would be able to access both hospitals by car within 60 minutes.



10 20 30 45 60 minutes

Current travel time by public transport

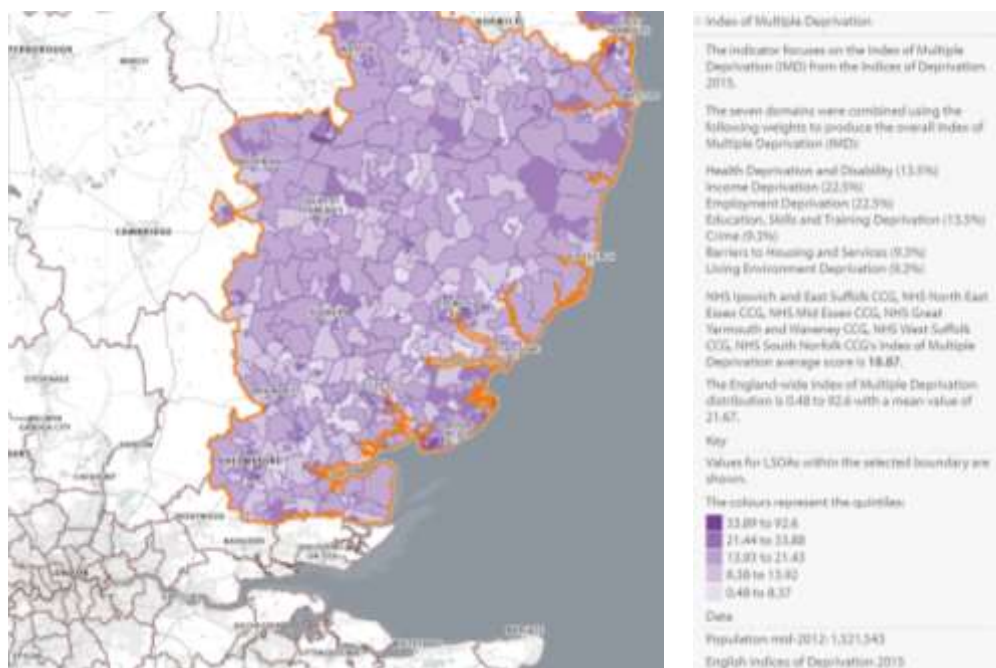
Almost all Colchester patients can access Colchester Hospital by public transport within 2 hours, with the exception of residents in the southern coastal part of Tendring. A significant proportion of the northern part of east Suffolk is not well served by public transport now.



20 40 60 90 120 minutes

Deprivation

The highest areas of deprivation⁴² in the current catchments are in south Tendring, Ipswich central and Pier ward in Colchester. There are some areas of moderate deprivation in the northern part of east Suffolk.



⁴² Index of multiple deprivation (IMD) – Public Health England 2015

Predicted growth in patients to 2041

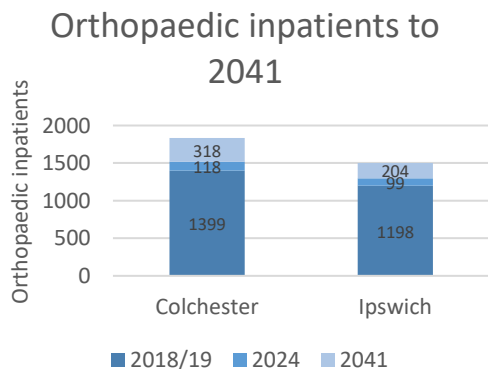
Population growth will be different with 17-18% growth in north east Essex compared to 8-9% growth in Suffolk.



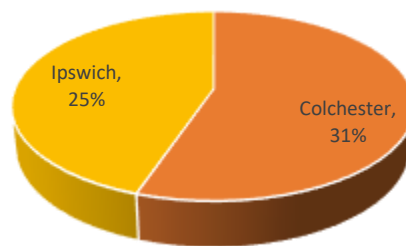
Growth in patients will also be different across our catchment area:



This will lead to 6% more growth in activity around Colchester Hospital, compared to around Ipswich Hospital, over the 20 years to 2041.



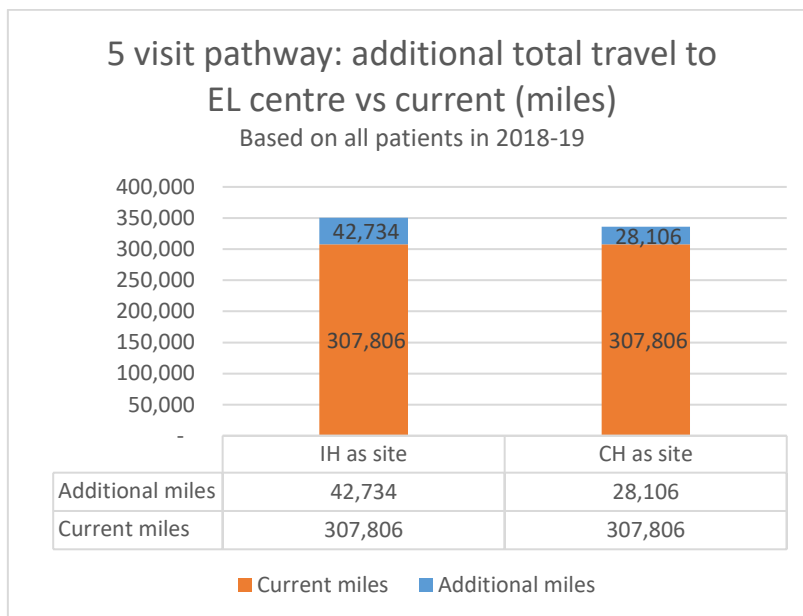
% growth in activity to 2041



Impact on travel

Orthopaedic pathways of care involve multiple visits to hospital (5 or more including the procedure). A single Centre will increase travel *only for the procedure journey*.

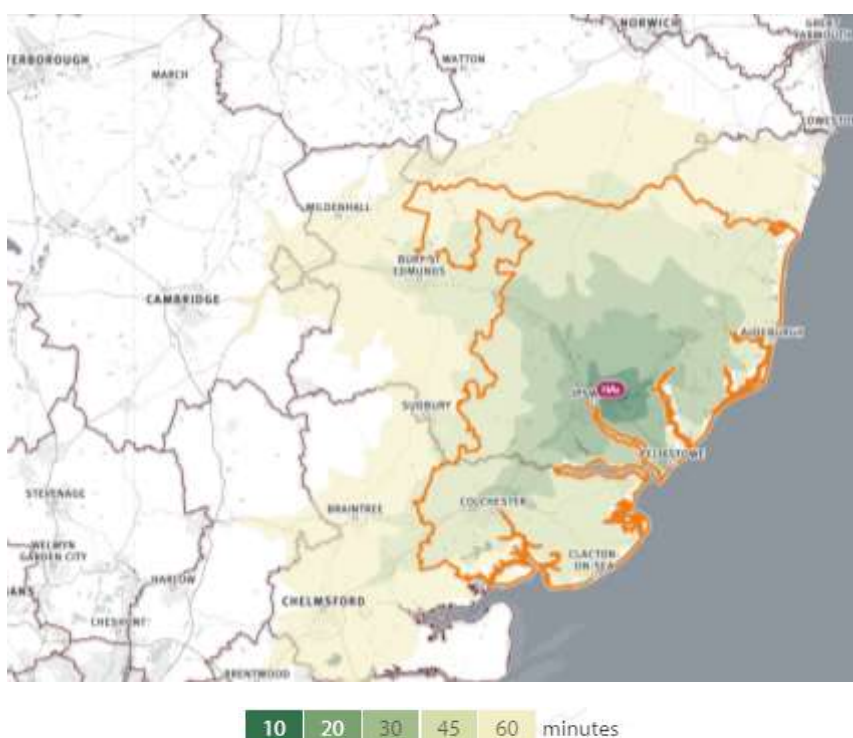
Travel distance



Basing the elective centre at Colchester leads to a 9% increase in travel over the whole pathway, while at Ipswich would lead to a 14% increase.

Travel time by car - ECC at Ipswich Hospital

Accessibility by care remains good for all Suffolk patients and the majority of patients in the Colchester hospital catchment.



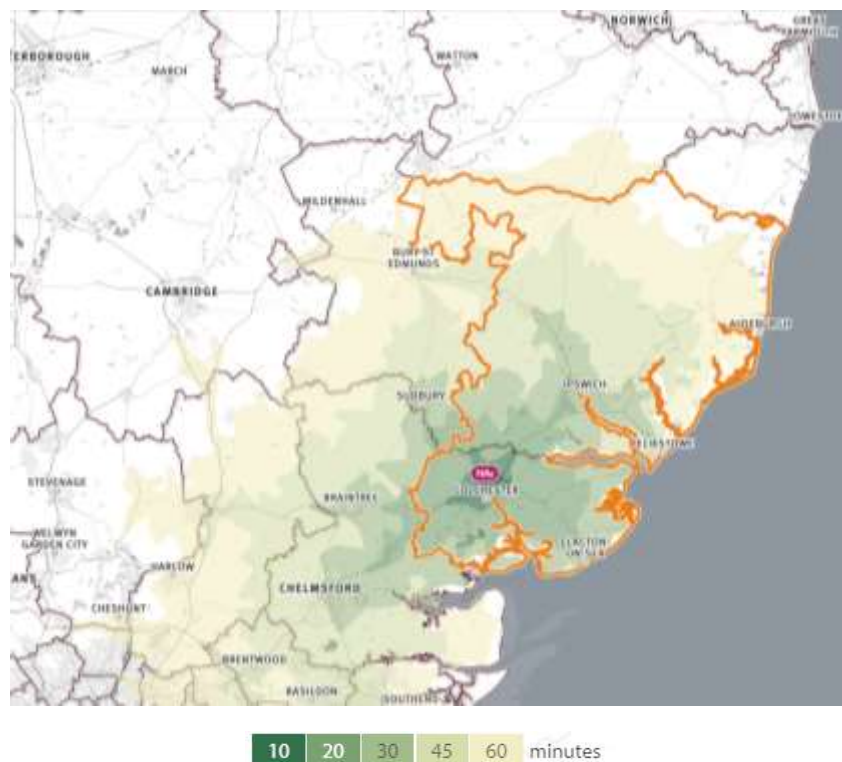
Travel time by public transport - ECC at Ipswich Hospital

In this scenario, significant areas of Tendring, the Colne Valley, south Colchester and north Chelmsford are not accessible by public transport within 2 hours. This also removes public transport access from the areas of highest deprivation in Tendring.



Travel time by car - ECC at Colchester Hospital

Accessibility to CH by car is within 60 minutes for all patients in the Colchester catchment and most patients in the Ipswich catchment.



Travel time by public transport - ECC at Colchester Hospital

Public transport accessibility from Suffolk is slightly reduced in this scenario. However, this is the area with the fewest number of patients and the lowest deprivation.

