



# Strategic Case for the merger of Norfolk Community Health and Care NHS Trust and Cambridgeshire Community Services NHS Trust

Draft March 2025

**Please note this version is subject to final format review  
(including table/paragraph pagination etc)**

## Contents

1. **Executive Summary**
2. **Strategic Rationale**
  - 2.1 Background to the Trusts
  - 2.2 ICS and provider challenges that the transaction will address
  - 2.3 How the merger will support ICS strategies and their five-year joint forward plan
  - 2.4 Anticipated benefits of the transaction
  - 2.5 How system partners have been engaged in developing the proposals, and how feedback has been considered and incorporated into plans
  - 2.6 Options appraisal
3. **Underlying transaction risk**
  - 3.1 Current and emerging risks and mitigations
4. **FBC Readiness**
  - 4.1 Our planning timeline
  - 4.2 Due diligence
  - 4.3 Transaction execution risk
  - 4.4 How the FBC and PTIP will be developed
  - 4.5 Our Governance Structure to ensure adequate oversight of transaction development
  - 4.6 Programme management structure and resourcing
  - 4.7 Development of detailed benefit proposals and implementation plans
    - 4.7.1 Clinical strategy
    - 4.7.2 Operating model
    - 4.7.3 Our people strategy and cultural development
    - 4.7.4 Digital
    - 4.7.5 Estates and facilities
    - 4.7.6 Governance
    - 4.7.7 Improvement and transformation
  - 4.8 Stakeholder communications and engagement
  - 4.9 Relevant Legal Advice

## Version Control – Material Changes

Date	Version	Reason for Change	Author
22.1.25	0.1	Issued to Programme Board	Andrew Butcher
27.1.25	0.2	Deleted duplicated tables Issued to SME Execs	Andrew Butcher / Bruce Luter
27.1.25	0.3	Minor format changes – not issued	Andrew Butcher / Bruce Luter
30.1.25	0.4	Introduction deleted and text moved to Strategic Rationale review comments Incorporated	Andrew Butcher / Bruce Luter
31.1.25	0.5	Clean copy issued to NHSE	Andrew Butcher / Bruce Luter
14.2.25	0.6	Amendments following NHSE comments	Andrew Butcher / Bruce Luter
18.2.25	0.7	Formatting updates	Andrew Butcher / Bruce Luter
	0.8 – 0.14	Internal not issued	Andrew Butcher / Bruce Luter
4.3.25	0.15	Issued to programme Board for review	Andrew Butcher / Bruce Luter
	0.16	Internal not issued	Andrew Butcher / Bruce Luter
7.3.25	0.17	Internal not issued	Andrew Butcher / Bruce Luter
7.3.25	0.18	Issued for comment – Group Board Development	Andrew Butcher / Bruce Luter
12.3.25	0.19	To MW for review Included revisions following board development, CK/KH, VB	Andrew Butcher
13.03.25	0.20	Changes made by MW Draft issued to NCHC and CCS Board	Mathew Winn Bruce Luter Andrew Butcher

<b>Abbreviation</b>	<b>Meaning</b>
<b>BAF</b>	Board Assurance Framework
<b>BLMK</b>	Bedfordshire, Luton, and Milton Keynes
<b>CCS</b>	Cambridgeshire Community Services NHS Trust
<b>C&amp;P</b>	Cambridge and Peterborough
<b>CEO</b>	Chief Executive Officer
<b>CQC</b>	Care Quality Commission
<b>CYP</b>	Children and Young People
<b>DHSC</b>	Department of Health and Social Care
<b>ICP</b>	Integrated Care Provider
<b>ICS</b>	Integrated Care System
<b>ICB</b>	Integrated Care Board
<b>KPI</b>	Key Performance Indicator
<b>MDT</b>	Multi-disciplinary team
<b>MoU</b>	Memorandum of Understanding
<b>MSK</b>	Musculoskeletal
<b>NCC</b>	Norfolk County Council
<b>NCHC</b>	Norfolk Community Health and Care NHS Trust
<b>NED</b>	Non-Executive Director
<b>NHSEI</b>	NHS England/ NHS Improvement
<b>PCN</b>	Primary Care Network
<b>PIFU</b>	Patient Initiated Follow Up
<b>PMO</b>	Programme Management Office
<b>PTIP</b>	Post Transaction Integration Plan
<b>RTT</b>	Referral to Treatment
<b>SLA</b>	Service Level Agreement
<b>S75</b>	Arrangements under section 75 of the NHS Act 2006
<b>SWOT</b>	Strengths, weaknesses, opportunities, threats
<b>VCSE</b>	Voluntary, Community and Social Enterprises
<b>WTE</b>	Whole time equivalent

## 1. Executive Summary

### Our Vision

To create a new NHS Community health and care Trust that serves communities in Norfolk, Waveney, Suffolk, Cambridgeshire, Peterborough, Bedfordshire, Luton, Milton Keynes:

That:

- Provides outstanding care and support to the populations we serve
- Is underpinned by a population health approach with a focus on preventing disease and supporting individuals and communities to improve their health and resilience
- Builds on our existing vibrant and positive cultures

- i. Cambridgeshire Community Services NHS Trust (CCS) and Norfolk Community Health and Care NHS Trust (NCH&C) are high performing specialist community health and care providers working across half of the East of England. Both have a strong track record, with the highest ratings from the Care Quality Commission (CQC), best in class NHS staff survey outcomes, and a decade of experience in good financial and performance management.
- ii. By merging our Trusts, we will create an organisation that is truly sustainable and brings together community health and care delivery across the East of England. We will have expertise across a huge range of services from inpatient beds to dental chairs and from paediatrics to end of life care. We will be in strong position to support the health and care systems in which we work to:
  - Improve outcomes in population health and social care.
  - Tackle inequalities in outcomes, experience and access.
  - Enhance productivity and value for money.
  - Help the NHS and Local Authorities support broader social economic development.
- iii. In common with the experience across England we have seen collaboration and technological innovation develop at a pace and scale previously unimaginable; our merger will build on and formalise our collaborative working by creating a single entity that supports the adoption of new technology, the best of our cultures, and new approaches to solving long-standing problems.
- iv. Our new organisation will help our clinicians to do their jobs better and will simplify systems and processes that might impede, or even prevent them, from working in the way they would wish. It will put the power of digital and data at the centre of our decision-making, supporting us to join up and transform the care we provide to our population.
- v. Working together will allow us to strengthen our relationships with acute hospitals (especially on discharge, urgent and emergency care pathways and disease specific pathways), primary care, social care and the third sector to meet patient and service user needs more creatively. Being able to attract, train and retain a dedicated workforce will ensure patients receive an improved service. Integrated Care Boards and Local Authorities will trust us to deliver their strategies, and we will be in a better position to meet the increasing demand and complexity that our health and social care services face both now, and in the future.
- vi. Working as a single organisation will result in financial benefits through creating greater economies of scale. We will achieve savings by consolidating our non-clinical expenditure and support service infrastructure allowing us to increase the proportion of our resources that are spent on direct patient care.

- vii. Combining the Trusts into a Group model and later, a merger will support the continued improvement and sustainability of community healthcare delivered services across our geographies. Whilst the maximum benefits will be delivered through merger, we are already delivering real benefits in becoming a Group and will continue to do so on our journey to becoming a single entity.
- viii. Recognising the challenges facing the NHS and our systems we are conscious that circumstances may arise that would mean that a delay to our intended timetable to a full merger, may be appropriate. This would delay the full realisation of our expected benefits, and we would only delay if alternative benefits (to systems or the Trusts) were identified that, in the short term, would take precedence.
- ix. The key messages from our Strategic Rationale are:
- Both Trusts have CQC ratings of 'Outstanding', have performed well historically and continue to do so and have aligned purpose and visions.
  - We have a recent history of joint working and delivering both financial and quality benefits.
  - Our service portfolios are complementary.
  - Systems have identified a range of opportunities for improvement which, whilst expressed differently, share common themes.
  - Merger has been identified as the most beneficial way to improve the services we deliver and the sustainability of the Trusts thereby supporting improvements in our systems
  - Benefits delivered will be in the domains of: enhancing delivery of care; improving support to our staff; maximising the use of resources.
  - We do not anticipate that there will be any material costs to deliver the transaction.
  - System partners have been engaged and are supportive of our plans.
- x. The key message from our analysis of the Underlying Transaction Risk is that – given the Trusts performance, standing and willingness to merge – risk is modest and suitable mitigations have been identified.
- xi. The key messages from our consideration of our Full Business Case (FBC) readiness are:
- Subject to the necessary support and approvals from our Boards, stakeholders, and regulator, our intended 'go-live' date for the merger is 1 April 2026.
  - As we progress to FBC, we will carry out appropriately targeted due diligence, taking advice as to our approach and areas of concern from our legal advisors. We will continue to update our due diligence right up until the proposed merger receives final approval.
  - The development of the FBC, Post Transaction Implementation Plan (PTIP) and Patient Benefit cases will take place under a workstream structure.
  - Programme governance structures are in place with involvement of executive and non-executive directors.

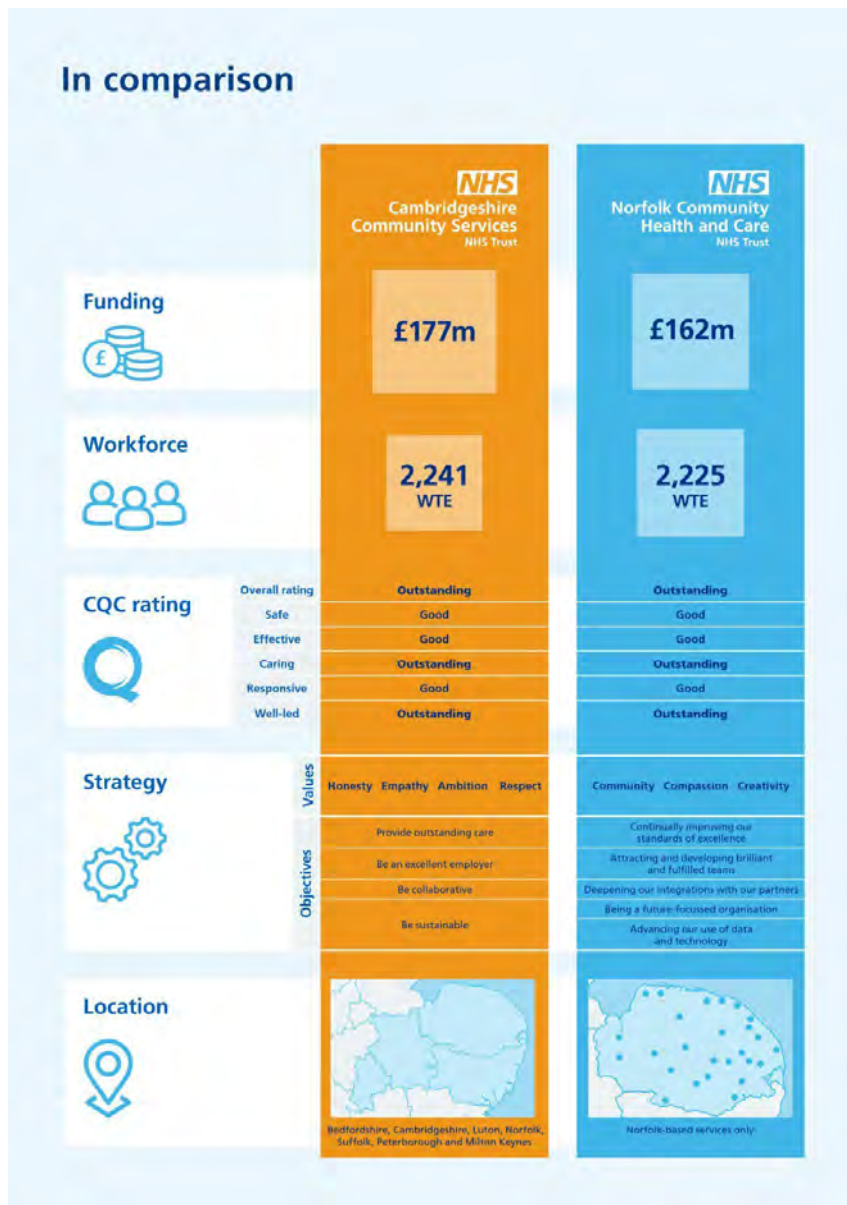
- We are developing the following strategies and implementation plans:
  - A clinical and service strategy that is underpinned by a clear operating model. Supporting strategies to underpin our clinical and service strategy will be:
    - Our people strategy and cultural development
    - Digital and data
    - Estates and facilities
    - Improvement and transformation
    - Stakeholder communications and engagement
- Within our clinical strategy, there will be four themes that we will focus on over the next two-four years to get the maximum benefit of work across the single Trust:
  - Aligning all of Norfolk Children and Young People's (CYP) services.
  - Developing transition services for CYP across all of our geographies.
  - Further enhancement and development of the Community Virtual Ward (VW) and Urgent Care Hub in Bedfordshire and Luton and the Community Virtual Ward in Norfolk based on shared learning and expertise and best practice.
  - Development of Integrated Neighbourhood teams to provide care for our elderly frail patients.
- Where appropriate we will bring together under single management structures services that we deliver across geographies to enhance learning and service delivery. This is a programme of work which has already begun in CYP and Musculoskeletal (MSK) services.
- We are continuing to develop the merged Trust's operating model and associated leadership arrangements. These are being implemented now and mostly completed pre-transaction.
- Our approach to our staff is critical to the success of the proposed merger and will be designed to support the delivery of the Clinical and Service strategy.
- A new Group Chief Information Officer (CIO) has started to bring together the two Trusts digital and data teams. This will enable us to improve the use of digital technology and data across the merged Trust and the wider system.
- We will use the combined estates of the merged Trust to aid the delivery of our clinical and service strategy. This will enable us to provide safe, effective, high quality clinical and social care, support wider work to prevent ill health, and enable care closer to the patient or service user's home.
- Both Trusts are committed to continuous improvement and have existing Quality Improvement, service improvement and programme management models and teams delivering change and efficiencies.
- We are developing a communications and engagement plan to support the merger, and our communication aims are to:
  - Provide regular communications about the work that the Trusts are doing jointly, helping to create an environment of one team working together.
  - Support the proposed merger between our two organisations with communications and appropriate engagement to each stage of the process.
  - Communicate, inform, and engage appropriately on the joint work of the two Trusts and our route to merger to our wider system partners.
  - Communicate, inform, and engage appropriately about what a merger means for us

- We have received legal advice on how the Trusts could ‘*establish a group model of governance between the Trusts by April 2025 with a view to forming a single organisation by no earlier than April 2026*’, and are acting accordingly

## 2. Strategic Rationale

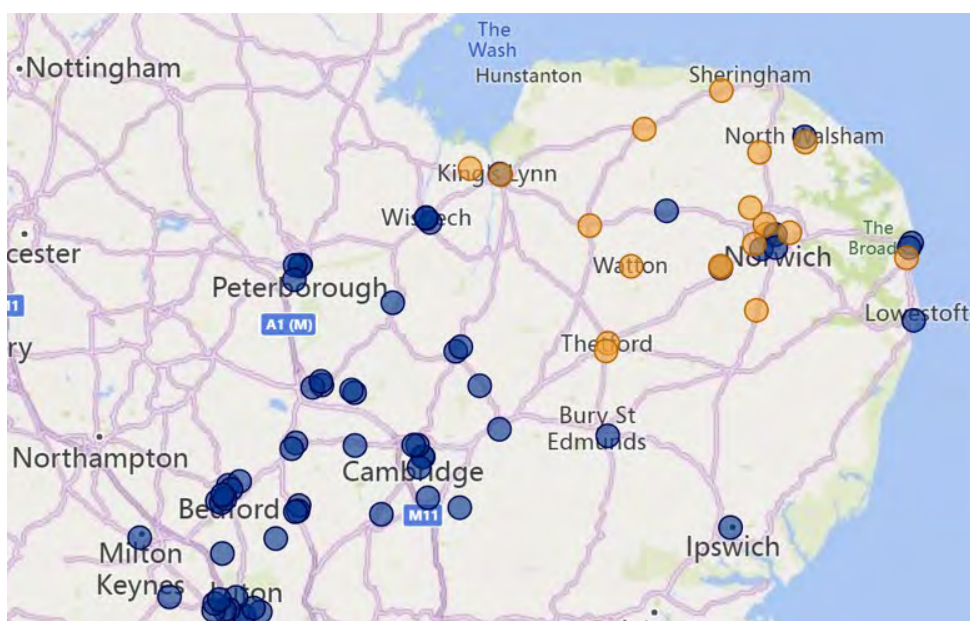
### 2.1 – Background to the Trusts

- Both CCS and NCHC are specialist community health and care providers established in 2010. Between us, we cover a population of c3.5m people, providing children and young people’s, adults with disabilities, and older people’s community health and care services. A simple comparison is set out in Figure One below:



**Figure One: Trust Comparison**

2. The Trusts deliver services from many locations across a number of counties as shown in Figure 2 below:



**Figure 2: Map of Delivery Locations**

3. Both Trusts have Outstanding CQC ratings. A summary of outstanding actions raised at our most recent CQC inspections is at Table One below:

	<b>'Should do'</b>	<b>'Must do'</b>
NCHC	14 'should do'. Of which 3 are ongoing: <ul style="list-style-type: none"> <li>• Fridge temperatures – checking and monitoring processes to be improved.</li> <li>• Air Flow Mattresses – improved process required for setting and monitoring.</li> <li>• Capacity and Waiting Times within the NDS pathway – improvements sought.</li> </ul>	One 'must do' - actioned.
CCS	13 'should do' - actioned	One 'must do' – <i>“The service must continue to monitor and actively recruit to ensure that there is an adequate number of nursing staff with the appropriate skill mix to care for children and young people in line with national guidance and to ensure that service provision can be maintained.”</i> (see paragraph 4 for status)

**Table One: CQC Outstanding Actions**

4. Since 2019, CCS has continued to monitor its compliance with the 'must do', ensuring that improvement is continuous and that the needs and health inequalities of the populations we serve are prioritised and accounted for within any pathway or service redesign. Multiple strands of work have been undertaken to recruit and retain, to skill mix teams, to review service provision and improve performance.
5. Quality performance across both Trusts is monitored closely through governance structure to ensure continuation of outstanding care:
- NCHC Operational and Quality performance is reported in the Trust Performance Report at Enclosure One.

- CCS Quality Performance is reported in the Trust's Quality Dashboard at Enclosure 2 and a summary of operational performance is at Annex A.
6. Health and social care services across the East of England are struggling to meet the increasing demands of an ageing population, a rising number of people with complex or long-term health conditions and increasing demand for CYP services. We have begun transforming our models of care although much of the resource in our geographical areas is still focused on reactive, bed-based care, rather than preventative and community-based services that facilitate prevention and early intervention. Bringing together our combined breadth of service knowledge into a single entity will enable us to maximise the use of our capacity and streamline pathways to improve equity of access and performance.
  7. The systems within which we operate are all financially challenged to varying degrees. The needed change in capacity to deliver the rising health and social care demands against limited resources will not be addressed through stretching, organisationally based, cost improvement plans. We need to change the way that services are delivered to the local population to support healthier lives and deliver high quality care in a sustainable way.
  8. Our visions are aligned, based around a mission to deliver outstanding care that supports people to lead their best and healthiest lives. This integrated approach will be characterised by collaboration with patients, communities, and partners.
  9. Our operating models, structures, ethos, culture and approaches are very similar and therefore it is an obvious choice for us to integrate. We share an ambition to enhance how and what community health and social care services are provided and thus we will formalise our collaboration.
  10. Our Boards have considered other structural options of collaborative working within the NHS. We decided that our symmetry, alignment, and desire to work together creates the best opportunities to form a new organisation that builds on the stand-out elements of both Trusts to transform how care is delivered.
  11. Our decision to integrate our Trusts will not dilute the important formal relationships/partnerships with hospitals, primary care, mental health trusts, community interest companies, the voluntary sector, early year services and education and councils across our geographies. These partnerships will always be core to our operations for children and adults' community services.

### A history of joint work

12. Prior to our decision to form a 'Group' board we had already begun sharing key roles with our Chief Executive and Medical Director roles being shared. We have now completed our work on appointing a Group Board that will be in place for 1 April 2025. We can see and feel the benefits of learning, sharing and leadership that comes with these roles. For example, the appointment of our shared Medical Director, Caroline Kavanagh, has allowed a focused approach to medical job planning with internal, cross group, benchmarking of roles and responsibilities. As well as supporting a consistent approach to the quality to service delivery, this has also delivered a 2024/25 financial saving of c.£23k (and a recurrent saving of c.£2.5k) through utilising existing licences rather than implementing a new system and identified more patient facing time in many consultant job plans.
13. Moving to one Group Board in April 2025 has reduced overall board costs by c.£600k.
14. Recently our collaboration has extended to include shared leadership roles for Children and Young People's (CYP) services in Norfolk, strategic estates, emergency preparedness planning and resilience and a resuscitation officer. This has allowed existing skills and leadership to be leveraged across organisations allowing a wider view of opportunities as well as avoiding additional costs of leadership team expansion. We will expand our shared expertise soon, particularly in data and digital developments, so both organisations can benefit from the developments happening in each Trust. This collaboration highlights our willingness and capability to work together effectively, setting the stage for us combining into a new organisation.

15. The NHS Long Term Plan notes the need to accelerate the redesign of patient care to future-proof the NHS for the decade ahead<sup>1</sup>. Our Trust Boards believe strongly that we now need to merge and move to a single board, budget, and governance structure to maintain transformation at the pace required.

## Alignment of services

16. Our portfolios align across the geographies our organisations serve, most notably where patients come to us in clinical settings and children and young people's care. Our care provision is similar, and we will provide the same high standards of care for all of our patients to ensure we address the health inequalities we see across the East of England. We want to ensure that all of our services provide the care that our patients need and bringing our Trusts together will enhance the oversight and organisation of this.

**[DN: Tables 2 and 3 will be subject to a final accuracy check before this Case is submitted]**

17. As shown in Tables 2 and 3 below, our services are largely complementary and provide opportunities to support our communities by expanding our existing operations into neighbouring geographies:

---

<sup>1</sup> NHS Long Term Plan, page 6.

ICB	Bedfordshire, Luton and Milton Keynes			Cambridgeshire and Peterborough		Norfolk and Waveney	Suffolk and North-East Essex
Population '000	764			897		971	711 (excluding Waveney and Essex)
County	Bedfordshire	Luton	Milton Keynes	Cambridgeshire	Peterborough	Norfolk	Suffolk
<b>CYP Services</b>							
Audiology	CCS	CCS		CCS			
Health visiting	CCS	CCS		CCS	CCS	CCS	
School nursing	CCS	CCS		CCS	CCS	CCS	
Children's Community nursing	CCS	CCS		CCS		NCHC	
Continuing care	CCS	CCS	CCS	CCS			
Nutrition and Dietetics	CCS	CCS		CCS	CCS		
Community paediatrician	CCS	CCS		CCS		NCHC	
Family Nursing Partnership				CCS	CCS	CCS	
National Child Measurement Programme						CCS	
Neuro Developmental Services	CCS	CCS		CCS		NCHC	
Emotional Health and Wellbeing service/ MHST				CCS	CCS	CCS	
Health Training						NCHC	
MASH	CCS	CCS		CCS	CCS	CCS	
Children in Care (LAC)	CCS	CCS		CCS	CCS	CCS NCHC	
Epilepsy						NCHC	
Psychology						NCHC	
Post Covid Service						NCHC	
Short breaks						NCHC	
TB Service Children's						NCHC	
Eye services	CCS	CCS					
SLT	CCS	CCS		CCS		CCS	
Specialist Paediatric continence						NCHC	
OT	CCS	CCS		CCS		NCHC	
Physio				CCS		NCHC	
Wheelchair service - children's						NCHC	

**Table 2: Children's and Young People's services**

	Bedfordshire	Luton	Milton Keynes	Cambridgeshire	Peterborough	Norfolk	Suffolk
<b>Adult Services</b>							
Acute Diabetic Foot podiatry Team						NCHC	
Admissions Avoidance/ UEC / Rapid response	CCS	CCS				NCHC	
Amputee Rehabilitation Inpatients						NCHC	
Biomechanics						NCHC	
Bladder and Bowel Health						NCHC	
Cardiac Rehabilitation		CCS				NCHC	
Cardiac Vascular Disease						NCHC	
Cancer Care		CCS					
Community Dental / Dental Access / MOS	CCS			CCS	CCS	CCS	CCS
Community Matrons		CCS				NCHC	
Community Nursing and Therapy		CCS				NCHC	
Community Podiatry						NCHC	
Community Palliative care		CCS				NCHC	
Continence		CCS				NCHC	
Chronic Obstructive Pulmonary Disease		CCS				NCHC	
Dementia (Admiral Nurse)		CCS					
Dermatology						NCHC	
Diabetes		CCS				NCHC	
Dietetics						NCHC	
Epilepsy		CCS				NCHC	
Environmental Controls						NCHC	NCHC
Falls Service		CCS					
High Intensity User Service (Frequent Attenders)						NCHC	
Heart Failure		CCS				NCHC	
Inpatient Rehabilitation						NCHC	
Inpatient Specialist Stroke Rehabilitation						NCHC	
Inpatient Specialist Neuro						NCHC	
Inpatient Palliative and End of Life Care						NCHC	
Integrated Discharge Team		CCS				NCHC	
Lymphoedema						NCHC	
MSK Physiotherapy				CCS	CCS	NCHC	
MSK Occupational therapy						NCHC	
Neuro rehab / ABU	CCS	CCS				NCHC	
Out of Hours Unplanned care		CCS				NCHC	
Oxygen Management						NCHC	
Parkinson Service		CCS					
Pharmacy Technicians		CCS				NCHC	
Phlebotomy		CCS				NCHC	
Podiatry						NCHC	
Post Covid Service						NCHC	
Pulmonary Rehab		CCS				NCHC	
Respiratory		CCS				NCHC	
Sexual Health (iCaSH)	CCS		CCS	CCS	CCS	CCS	
Speech and Language Therapy						NCHC	
Tissue Viability		CCS				NCHC	
TB service - adults		CCS				NCHC	
Virtual Ward	CCS	CCS				NCHC	
Wheelchair service - adults						NCHC	

**Table 3: Adults' services**

## Financial stability

18. The Trusts have consistently delivered financially. Accounts for the year to 31 March 2025 are in draft and will be available for the FBC. Accounts for the year ended 31 March 2024 (including 2023 comparators) are at Enclosures 3 and 4.
19. A summary of 2023, 2024 and forecast 2025 results are summarised in Table 4 below:

	CCS			NCHC		
	2022/23	2023/24	Forecast 2024/25	2022/23	2023/24	Forecast 2024/25
	£'m	£'m	£'m	£'m	£'m	£'m
Income	180.1	177.0	179.7	151.5	161.6	169.6
Adjusted Surplus / deficit	0.4	0.0	0.0	0.0	0.2	0.0
Net current assets	11.2	4.2	2.0	15.9	15.3	19.7
Balance sheet total	77.0	89.9	93.6	87.0	114.3	128.1
CIP in year	2.7	3.3	5.3	4.0	5.6	8.4

***Table 4: Financial Summary***

20. This Strategic Case sets out the high-level rationale for merging the two Trusts, our developing plans for how the merged Trust will operate, the expected benefits, and the next steps we will take once we receive approval to move to Full Business Case stage.
21. We are working closely with our system partners as we develop our plans and will continue to reflect any changes to their priorities and national guidance – for example the example the upcoming '10 Year health Plan for England' in our development of the Group strategy, Full Business Case and implementation timetable.

## 2.2 ICS and provider challenges that the transaction will address

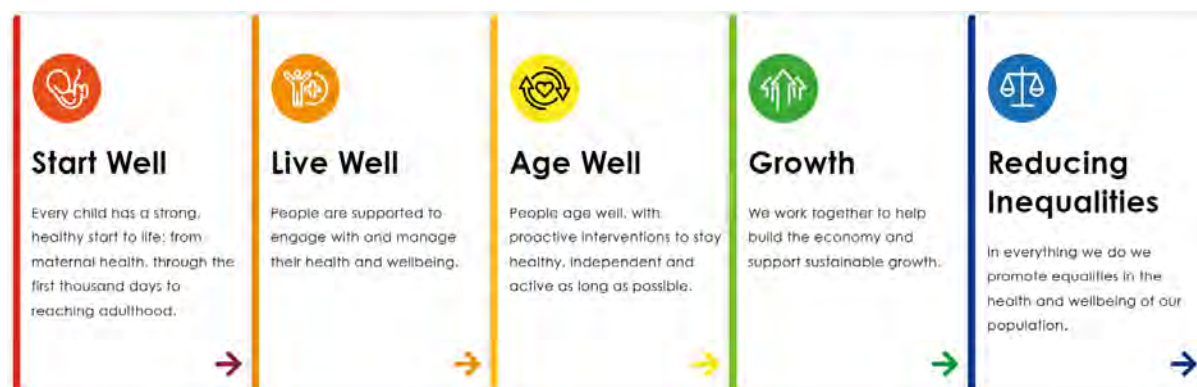
22. The scale of challenge to improve health and wellbeing and reduce health inequalities across the East of England is immense and no individual organisation has what it takes to respond to these challenges alone. As providers and commissioners, we need to bring our skills, knowledge and resources in health and social care, together with those of our colleagues in education, housing, and the voluntary sector if we are to tackle health inequalities and enable our communities to thrive.
23. Both organisations are relatively small organisations (in an English NHS context), and therefore struggle to sustain infrastructure which can support and transform how care is delivered. This is especially true in the expanding areas of digitalised care and the use of data. Once operating with a larger infrastructure and a broader cost base, we will enhance our capability to deliver cutting-edge care to people in the community. We will be able to invest in advanced telehealth and digital platforms, which will help improve access and outcomes for our clients and patients.
24. The community health care sector is often viewed as a 'poor cousin' in how policy/priorities are implemented, and resources are allocated. This means that, for successive years, we have had revenue growth that barely covers inflationary pressures and does not cover the cost of meeting current demand and complexity of need within our local populations (which was well-articulated by The Nuffield Trust in their recent analysis<sup>2</sup>). This challenge already manifests in increasing waiting times for children's and clinic-based services. We are also facing significant population changes. In parts of West and North Norfolk, for example, more than 40% of the population is over the age of 65. In Luton, there has been an overall 11% population growth over the last decade.
25. All these factors mean our staff are continually stretched trying to keep up with the demands, across all age ranges, in every geography where we operate.

<sup>2</sup> Nuffield Trust Report

26. Both organisations are mature, confident, passionate advocates of the need for specialised community health and social care provision to improve outcomes for residents and reduce the costs faced by the taxpayer for health and social care services.
27. Following the Health Act 2022, integrated care systems described priorities in their Health and Care strategies and delivery mechanisms in their Joint Forward Plans.
28. All systems share a common mandate to:
- Improve outcomes in population health and social care.
  - Tackle inequalities in outcomes, experience and access.
  - Enhance productivity and value for money.
  - Help the NHS support broader social economic development.
29. In their system strategy<sup>3</sup>, **Bedfordshire, Luton and Milton Keynes (BLMK)** set an overarching ambition to increase the number of years people spend in good health and reduce the gap between the healthiest and least healthy in their community. BLMK identify two significant challenges in the system:
- Living well is more difficult for everyone:
    - The cost of living has increased, and many families are struggling to pay their bills.
    - Our local councils, NHS, and our suppliers, are also feeling the pressure of rising costs and the need to manage greater demand within stretched budgets.
    - Our staff are feeling the effect of their huge contribution during COVID. Vacancies have been increasing and are now around 14% for staff in the NHS and 10% in adult social care, and this further affects staff morale.
    - Environmental factors, including air pollution and access to green spaces, and climate change events such as heat waves, storms, floods, and pandemics are increasingly affecting our health and livelihoods.
  - Residents' health and care needs have changed over the pandemic:
    - Children and young people's lives have been disrupted. There are now more referrals to Councils for safeguarding, and to the NHS for conditions such as anxiety and eating disorders.
    - Demands on primary care, especially GP and dental services, are increasing, and local people report access to a GP as one of their greatest concerns.
    - People coming forward for support are more likely to have conditions diagnosed at a later stage or more than one condition, making care more complicated.
    - More people are using our urgent care services, and we need to work to reduce waiting times for planned care in the wake of the COVID pandemic.
    - People who are discharged from hospital need more complex packages of care, requiring more staff time and more involvement from specialists.
30. BLMK has identified five strategic priorities shown in Figure 3 below:

---

<sup>3</sup> BLMK Health and Care Strategy dated January 2023.



**Figure 3: BLMK Strategic Priorities**

31. In their Joint Forward Plan<sup>4</sup>, BLMK identify shared complex, critical and stubborn issues as:

- Rapid population growth and demographic shifts, specific to each Place.
- Challenges accessing core primary care, including GP and dental services.
- Life challenges experienced by people in our communities including poverty, poor education and other things that may make a person vulnerable to inequalities as set out in the Denny Review of Health Inequalities.
- Impact of COVID on residents, including:
  - Deconditioning of people with frailty.
  - Increased safeguarding and mental health issues for children and young people.
  - Delays in accessing routine elective surgery.
- Cost of living crisis affecting families.
- Poor health of the population including obesity and long-term conditions.

32. The BLMK Health Services Strategy 2024-2040 identifies 6 priority workstreams:

- BLMK Mental Health Learning Disability and Autism Collaborative.
- Children and Families – Incorporating the work of the Local and Maternity Neonatal System.
- Cancer Board.
- Long Term Conditions Health Optimisation.
- Improving urgent and emergency care and reducing unnecessary hospital stays.
- Fragile Services – Access to secondary care, critical mass, peer support and learning.

33. The COVID-19: Evidence of Needs & Impact Report for **Cambridgeshire & Peterborough (C&P)**, showed that:

- COVID exposed and exacerbated inequalities, as demonstrated by the differential impact on our Black, Asian, and Minority Ethnic communities and those living in our most deprived areas.
- There are more people in poverty, which has a long-term impact on health.
- The mental health of local people has been impacted by the pandemic, particularly children and young people.
- Obesity has increased and affects around a third of our Year 6 children and up to 60% of adults.
- Our health service is under significant pressure and the way that people access health care and preventative health care has changed.
- There are risks and opportunities to our environment as a result of the pandemic.
- There is also a need to focus on safety and prevention of harm in our service delivery as pressures on services increase.

34. In their system strategy<sup>5</sup>, C&P build on their extant vision – *All Together for Healthier Futures* – and identify four priorities shown in Figure 4 below:

<sup>4</sup> BLMK JFP Living and Longer Healthier Life

<sup>5</sup> Cambridgeshire and Peterborough Health and Wellbeing and Integrated Care Strategy dated December 2022.

### Priority 1: Ensure our children are ready to enter education and exit, prepared for the next phase of their lives

We want to help local children get the best out of their education during their formative years. This includes making sure that every child is ready to start going to school, when they reach the right age to do so, and supporting children's physical and mental wellbeing so they can have a positive experience whilst in school.

We want to reduce the number of young people aged 16 and 17 who are not in education, employment or training. We are also working to reduce inequalities for children – giving every child the best possible start in life, regardless of their personal circumstances or background.

### Priority 2: Create an environment to give people the opportunity to be as healthy as they can be

We know there are lots of different factors that will impact a person's health during their lives. This includes health behaviours such as diet, infrastructure including access to public transport, socio-economic factors like wealth and level of education, and availability of green spaces and clean air. Together, these factors make up the environment that affects a person's ability to live a healthy, happy life.

As a partnership of Voluntary, Community and Social Enterprise organisations, local authorities, and NHS partners, we want to improve both opportunities for better health that the NHS provides and wider factors that impact health.

### Priority 3: reduce poverty through better employment, skills and housing

Poverty has a severe negative impact on people's ability to live as healthy and happy a life as possible. That's why we're committed to reducing poverty, through better employment, skills and housing.

Together, our partnership as an ICS employs thousands of people across the local area. As a group of large employers, we recognise that we have a direct role to play to treat our staff well. We are also working with wider partner organisations on the economy, housing, employment, and health.

### Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing

The mental health and wellbeing of our local people is as important to us, as their physical wellbeing. That's why we've committed to promoting early intervention and prevention measures to improve the mental health of local communities. By focusing on early intervention and prevention, we can help people improve their mental wellbeing before their mental ill health becomes more severe.

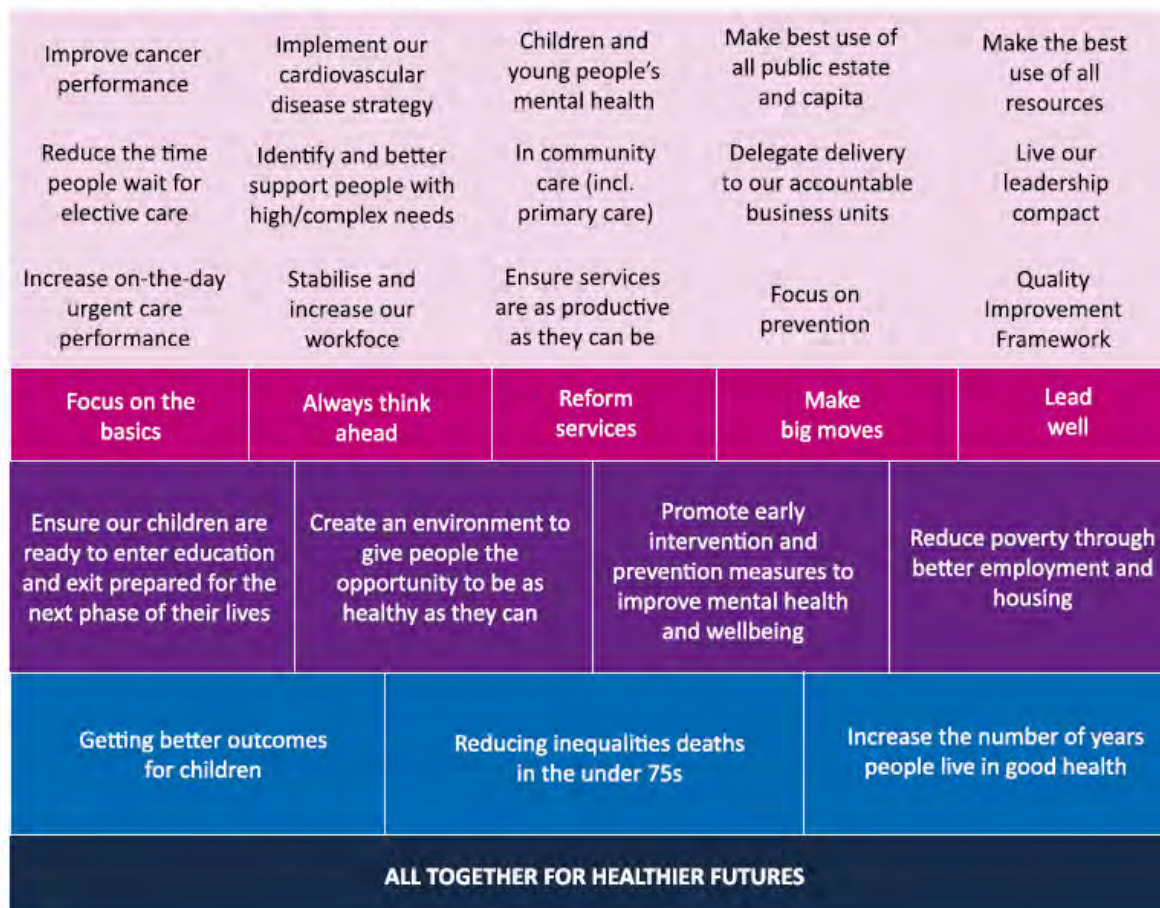
As part of this work, we're working to improve the mental health of children and young people – reducing the number of young people in our area who need to be referred to mental health services. We're also working to improve people's understanding of the things they can do to support their own mental health and wellbeing, and increase awareness of how and where people can get help when they need it.

**Figure 4: C&P Strategic Priorities**

35. The C&P JFP<sup>6</sup> identifies areas for strategic delivery and reform as shown in Figure 5 below:

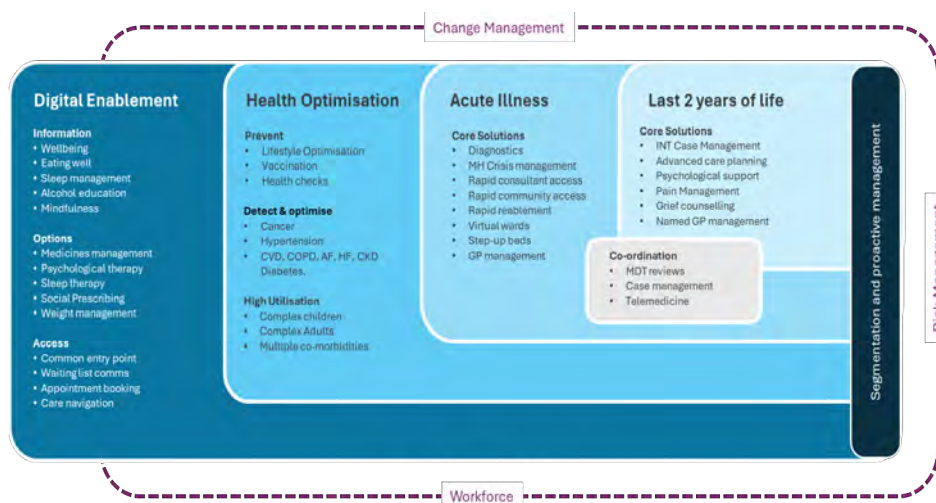
<sup>6</sup> Cambridgeshire and Peterborough JFP 2024-2029.

Our areas of strategic delivery and reform



**Figure 5: C&P JFP Strategic Focus**

36. In response to the core system challenge of forecast rising demand for acute beds, the C&P ICB plan to implement a Health Utilisation Model (widely referred to as the 'New Care Model')<sup>7</sup> illustrated in Figure 6 below:



**Figure 6: C&P Health Utilisation Model**

37. In their system strategy<sup>8</sup>, **Norfolk and Waveney (N&W)** set out their vision:

<sup>7</sup>C&P Draft Commissioning Plan 2025-2028.

<sup>8</sup> Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy.

*'Our vision is working as a single sustainable system that enables us to achieve our overarching mission to help the people of Norfolk and Waveney to live longer, healthier, and happier lives'.*

38. N&W have developed an overarching mission to help the people of Norfolk and Waveney to live longer, healthier, and happier lives and to fulfil the mission have three goals:

- **To make sure that people can live as healthy a life as possible** – This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.
- **To make sure that you only tell your story once** – Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have, which medication they are on. Services have to work better together.
- **To make Norfolk and Waveney the best place to work in health and care** – Having the best staff and supporting them to work well together will improve the working lives of our staff and means you will get high quality personalised and compassionate care.

39. N&W system priorities are:

- **Driving integration** – Collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them.
- **Prioritising prevention** – A shared commitment to supporting people to be healthy, independent, and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.
- **Addressing inequalities** – Providing support for those who are most vulnerable using resources and assets to address wider factors that impact on health and wellbeing.
- **Enabling resilient communities** – Supporting people to remain independent whenever possible, through promotion of self-care, early prevention, and digital technology where appropriate.

40. In their JFP<sup>9</sup>, N&W set out eight ambitions for improvement:

- Population health management, reducing inequalities and supporting prevention.
- Primary Care resilience and transformation.
- Improving services for babies, children and young people and developing our local maternity and neonatal system.
- Transforming mental health services.
- Transforming care in later life.
- Improving urgent and emergency care.
- Elective recovery and improvement.
- Improving productivity and efficiency.

## 2.3 How the merger will support ICS strategies and their 5-year joint forward plans

41. The benefits of the planned transaction are grouped into four areas:

- Enhancing how care is delivered.
- Improved support to our staff.
- Maximise finance and resource allocation.
- Strengthen our organisational capability.

<sup>9</sup> Norfolk and Waveney JFP 2024-2029

42. Whilst the detail of these benefits, especially patient benefits, will be worked up for the Full Business Case, it is clear that the benefits can only support systems in delivering their priorities. For example, merged operational services in N&W will help us meet growing demand and whilst both Trusts are already members of the Norfolk CYP Alliance, merger will reduce barriers to change.

## 2.4 Anticipated benefits of the transaction

43. By joining forces, we will be better prepared and able to make the vital innovations required to more effectively support residents of our local communities optimise their own health. We will ensure people can access early help with acute and complex illnesses and provide leading edge services to receive the care they need in the last years of life.

44. In October 2024, NCHC and CCS signed a Memorandum of Understanding (MoU) in which the Trusts committed to work together for the benefit of our populations by aligning the Trusts' strategic goals and operational activities. The Trusts signed the MoU to improve services for patients, although it was not intended to be a permanent position. Moving towards acting as one Trust, but legally being two separate organisations, carries cost and time inefficiencies which are hard to justify in the long-term. There is also a risk of lack of clarity around accountabilities as we continue to integrate and blur organisational boundaries.

45. Merger will mean we are more resilient to future periods of pressure (a pandemic or otherwise) and give us greater capacity to flex and redirect our resources to areas of greatest need. It will also enable us to improve our offer to existing and potential colleagues and make the merged Trust a great and exciting place to work.

46. Since late 2023 our Trusts have a strong track record of collaborative working with Mathew Winn serving NCHC as interim Chief Executive until October 2024 when he was formally appointed as joint CEO and subsequent to the MOU, closer collaboration on children's services and the appointment of a joint Medical Director which has yielded benefits (as described earlier) for patients and our systems. However, there are limits in how far we can go in integrating services while we remain separate legal entities.

47. Separate line management structures, budgets and policies create barriers and, even when these have been overcome at individual service level, they generate delay and unnecessary cost in realising the potential benefits of collaboration. The merger will allow us to strip out these costs and increase the pace and scale at which we can drive systematic integration across our services for the benefit of patients and help deliver system long term plans.

48. As part of our planning for merger we have identified the broad benefits that we expect to deliver as a single Trust for patients, colleagues and for the systems within which we operate:

- Patients – by enhancing how care is delivered.
- Colleagues – by focusing on improved support to our staff.
- Our systems – by maximising our delivery from our finance and resource allocation and strengthening our organisational capability.

### Enhancing how care is delivered

49. There are three ways alignment of services and leadership will be enhanced:

- For like-for-like services that are provided in different geographies, we will drive the benefits of working together. This will mean testing, spreading, and adopting new ways of working across areas, standardising our professional practice and care delivery, and aligning our research activities.

We provide one of the largest sexual health and HIV services (iCaSH) in England, operating across Norfolk and Waveney, Peterborough, Cambridgeshire, Bedfordshire, and Milton Keynes. We have used scale, and access to a range of expert clinicians to improve standards across the service. This had led to better equity of provision, development of sub-specialist skills, and more expert clinical leadership. With commissioners, we have used information about local needs to ensure high quality services with a specific local focus are delivered.

- We will revolutionise how digital care is used in all community health and social care delivery, underpinned by our ability to radically improve how data is used to support improvements in care delivery.
- In all of our geographies, we would bring the children and young people's services together under single operational and clinical leadership.

Children and young people's services in Norfolk – both organisations are already part of a system collaboration with Norfolk and Suffolk NHS Foundation Trust, Norfolk & Waveney Integrated Care Board and Norfolk County Council. Bringing our portfolios together will accelerate progress and unlock opportunities for integrated working.

50. Our collaboration will lead to co-located multidisciplinary teams, that are better able to meet the needs of those presenting with needs related to neurodiversity. Bringing together Community Paediatrics, Speech and Language Therapists, Occupational Therapists, Community Nurses, and the Healthy Child Service will offer flexibility when matching children and young people to the right professional.
51. For services that are provided across multiple geographies, we will share and standardise best practice, provide senior, influential clinical leaders, and underpin our clinical work with increasing prowess in research. Harmonising clinical practice will ensure high-quality care that reflects the needs of our diverse communities is delivered across all services. This approach will benefit councils and the NHS, supporting innovation to meet the challenge of increasing demand within tight budgets.
52. Using expertise from both organisations in digital infrastructure, and designing and implementing digital care models, we will develop new skills in-house. This will give us greater capability and capacity to enhance care coordination, and give patients access to their information and our services.

#### Improved support to our staff

53. As a combined organisation, we will be better placed to attract and retain exceptional leadership and clinical talent, offering more diverse and challenging roles that will pave the way for significant opportunities for professional growth and impact. A single approach will enable us to combine our education and training resources and our strategic workforce planning expertise.
54. By strengthening our relationships with key universities and further educational providers, we will retain and attract a workforce for the future, enhance our ability to invest in new roles and expand our in-house support for employment-based apprenticeships, providing an important route into registered professional roles. These enhancements will enable our staff to improve care delivery, advocate more effectively for patient needs and contribute to shaping the priorities that reflect the specific needs of local communities.

55. As a larger Trust, we will have broader clinical and operational leadership with oversight across multiple geographies, which will enable us to share best practice and intelligence and be more resilient across our teams. By pooling our organisational infrastructure and clinical expertise, we will continue to be a great employer but also be a leader in the delivery of community services, offering new and exciting career paths for people, in a more dynamic and capable workforce equipped to meet future challenges.

Examples of the roles we would expect to develop in our hospital at home/virtual ward services both in Norfolk and Waveney, and Bedfordshire and Luton - consultant nursing, allied health professional and medical roles, shared and rotating into local acute hospitals. These will be supported by community-based senior medicine management and dispensing staff, who will support 365 day a year provision of complex therapy interventions in people's homes and local clinics.

#### Maximise the use of resources

56. Both our Trusts have a track record of delivery of financial plans, underpinned by the delivery of financial efficiencies and productivity improvements.
57. In 2025/26, to meet respective system requirements, the Trusts are both planning to deliver financial efficiencies of c.5%. Delivering these savings in isolation as relatively small Trusts is an increasingly challenging task. We have jointly reviewed and considered the NHSE productivity data and our own benchmarking data and the opportunities for further efficiency delivery outside of a single organisation are limited as we are already performing in lowest quartiles.
58. Working as a single entity will allow us to realise financial benefits not open to us as individual Trusts through creating greater economies of scale and the ability to improve financial stability. We will achieve savings by consolidating our non-clinical expenditure and support service infrastructure.
59. Aiming to reduce our overhead cost down to 12-13%, we plan to make savings of £4 to £5.5 million, realised over a two to three-year period to allow a higher percentage of our income to be focused on front line services.
60. Moving to one Group Board in April 2025 has reduced overall board costs by c.£600k; the jointly implemented freeze on support services recruitment will enable a head-count reduction through typical staff churn; and a combination of reviewing supply contracts and identifying further corporate staffing opportunities for cost reductions would enable most of the savings to be re-invested into frontline services. The remainder would allow targeted investments in key digital and clinical information posts, which would support the transformation in care provision that is core to our emerging clinical strategy.
61. Realising these benefits highlights show, that by working together, we will improve the proportion of our collective resources that are spent on direct patient care.

#### Reducing our non-clinical costs would involve:

- Bringing together support services across both organisations into one structure, operating as one.
- In preparation for the merger we will, from 1 April 2025, have moved to a single Board and executive team, thereby, reducing costs.
- Moving to a single larger contract for common services that we buy to support our clinical infrastructure (employment and financial services, supplies, utilities, etc)
- Improving our buying power for the products and services we buy, currently totalling £93 million.

### Transaction and transformation costs

62. We plan to cover the full cost of the proposed merger from the Trusts' budgets and are intending to keep costs low by minimising use of external advisers and using in-house resources where practical. This approach has the additional advantage of ensuring ownership and retention of the developing thinking and planning.
63. Given the developmental approach to delivering the transaction and benefits, we do not anticipate there being any material costs that would not be funded from existing 'BAU' planning. We will prioritise the use of funds to deliver the Transaction and optimise the benefit return. In this way we will not increase the financial burden on the systems in which we operate.

### Value for money

64. Delivering incremental cash releasing savings through a focus on corporate headcount and supply contracts, leveraging knowledge and skills across the combined organisation whilst enabling contract savings through increased buying power - delivered with no material transaction costs will contribute to addressing the ongoing financial sustainability of the merged organisation and will strengthen our delivery of system financial targets to contribute to reducing system deficits (but clearly will not eradicate all deficits).

### Risks to financial delivery

65. The NHS financial regime creates a significant risk to the detailed financial model that will be required for the Full Business Case due to the lack of certainty about the future framework and funding flows. To some extent this can be mitigated through a focus on incremental costs and savings.
66. The challenging financial positions of the systems in which we operate may constrain ability to invest in the change necessary to deliver future benefits, for example where there is a time lag between costs incurred and savings delivery or where there is an element of risk or uncertainty as to outcomes. This can be mitigated through continued systems commitment to longer-term sustainability and robust change management.

## 2.5 How system partners have been engaged in developing the proposals, and how feedback has been considered and incorporated into plans

67. In developing our proposals, we have fully reflected the strategy, priorities and aspirations of the local health and care systems we operate within. Integrated Care Board chief executives and chairs have been actively involved throughout the process of developing our joint approach. The Local Authority CEO and director of adult social care in Norfolk County Council have also been fully engaged and involved, given the importance of the approach to deliver the outcomes of the s.75 with the Authority.
68. All of the ICBs have taken the approach, that a resilient community health provider, that has greater capability and transformational capacity will support their strategic plans. The detail of the structure of the joint arrangements has, rightly, been left to the two Boards to develop.
69. Feedback from Local Authorities, NHS provider partners and ICBs has been supportive, but with important pointers about how the Group and ultimately merged organisation needs to work. This includes, local defined leadership for adult and children services for each geographical area; executive leadership for a defined ICB area; continued transparency and delivery of local arrangements, rather than everything being blended into a larger structure and (currently unresolved) the desire for each ICB to have the merged organisation 'hosted' in their respective ICBs.
70. The feedback and approach asked by partners has been incorporated into our design of the executive Board roles, operational director portfolios and will be included in the alignment of non-executive relationships from April 2025 onwards.

71. Given the merged Trust will straddle three ICBs and each ICB would like the single Trust to be 'hosted' in their own area, an unresolved issue is how this will practically operate. The Group is already working with the national transaction team, regional strategy director and will work with the ICBs to resolve this to everyone's satisfaction in time for the submission of the full business case.

## 2.6 Options Appraisal

72. Our collaborative journey began in late 2023 when Matthew Winn (CCS CEO) was seconded to serve as CEO for NCHC. This connection between the Trusts opened the way to recognising our similarities and the opportunities close collaboration offers. We then appointed a joint Medical Director in July 2024.

73. At Board sessions in April 2024, CCS and NCHC Boards discussed collaboration, organisational form and sustainability connected with the future direction of the Trusts and, through working at scale, outline ways of:

- Improving efficiency, sustainability, and quality of care.
- Consolidating corporate services for greater efficiency.
- Increasing sustainability by making better use of a limited workforce.
- Improving quality of care by standardising clinical practice to tackle variations in care across different sites.

74. Discussion was guided by NHS England's principles of:

- A shared vision and commitment to collaborate.
- Strong accountability mechanisms for members.
- Building on existing successful governance arrangements.
- Efficient decision-making.
- Embedding clinical and community voices.
- Streamlining ways of working.

75. In the context of challenges facing trusts and systems, the discussions established a clear appetite for collaboration and the potential to explore a relationship with another NHS entity. The purpose and rationale identified was to 'create a new sustainable organisation that could forge improvements in community health and care services into the future.

76. Boards discussed the 'spectrum of collaboration' (at Figure 7 below) and, considering informal stakeholder views, concluded that the most efficacious structural form would be one of: merger; forming a joint venture; or forming a group model.

## Spectrum of collaboration

Informal arrangements		Formal agreements		Group model		
Informal collaboration	Strategic collaboration	Committees	Joint ventures	Lead provider	Shared or joint leadership	Single provider/ merger
<ul style="list-style-type: none"> <li>• May have advisory group</li> <li>• May have non-binding memorandum of understanding</li> <li>• High level shared principles for working together / collaboration</li> <li>• No shared decision-making: advisory / recommendations only</li> <li>• May make use of existing authority of individuals to make decisions for their organisation</li> <li>• Can be a stepping stone towards strategic collaboration</li> </ul>	<ul style="list-style-type: none"> <li>• Advisory group or leadership board</li> <li>• Memorandum of understanding / partnering agreement</li> <li>• Terms of reference for leadership board</li> <li>• Advisory group only or decisions through individual exercise of delegated authority</li> <li>• Shared information to discuss relevant matters</li> <li>• Joint decisions by consensus</li> <li>• Aligned decision making but not shared decision making</li> </ul>	<ul style="list-style-type: none"> <li>• May be statutory committees or common or statutory joint committee</li> <li>• Memorandum of understanding / collaboration agreement</li> <li>• Terms of reference for committee(s)</li> <li>• Collective exercise of delegated functions</li> <li>• Shared information to discuss relevant matters</li> <li>• Committees in common aligned or virtual joint decision-making</li> <li>• Joint committee shared decision-making by unanimous or majority voting</li> </ul>	<ul style="list-style-type: none"> <li>• Contractual or statutory</li> <li>• Memorandum of understanding and / or joint business plan</li> <li>• Shared information to discuss relevant matters</li> <li>• Shared information to discuss relevant matters</li> <li>• Shared information to discuss relevant matters</li> <li>• Shared information to discuss relevant matters</li> <li>• Shared information to discuss relevant matters</li> <li>• Shared information to discuss relevant matters</li> </ul>	<ul style="list-style-type: none"> <li>• Contractual joint venture</li> <li>• Main contract held by lead NHS provider</li> <li>• Alliance / consortium agreement</li> <li>• Sub-contracts between lead provider and other NHS / non-NHS providers</li> <li>• Principally a mechanism for service delivery</li> <li>• Can permit joint decision making on alliance / consortium management</li> </ul>	<ul style="list-style-type: none"> <li>• Same person or people lead each provider involved</li> <li>• Boards of NHS Trusts or FTs appoint same person to multiple posts</li> <li>• Enables aligned or virtual joint decision making</li> <li>• May enable actual joint decision-making if combined with a joint committee</li> </ul>	<ul style="list-style-type: none"> <li>• Governance and legal advice required to determine feasibility</li> <li>• Must comply with NHS England Operational guidance (e.g. full business plan and due diligence requirements)</li> <li>• Internal and external approvals process</li> <li>• Stability transfer, decision and legal agreements</li> <li>• Results in single board for organisation</li> </ul>

Browne Jacobson

1

**Figure 7: Spectrum of Collaboration**

77. These Board debates led to a structured options appraisal undertaken in May 2024 where all directors from both Trusts evaluated:

- Collaboration with NHS organisations<sup>10</sup>.
- The three most efficacious structural options for collaboration.

78. Scoring was undertaken individually and subsequently moderated to establish an agreed score. Scoring was from one to 10 with no weighting.

### Collaboration Partners

79. Collaboration was evaluated against 16 criteria grouped under headings of: Strategic Advantage; Service Alignment; Scale; Culture and Place; and Partnership Viability.

80. Development of the criteria was informed by conversations with system stakeholders and structured in the light of challenges facing the Trusts and the systems in which they operate.

81. CCS scoring is in Table 5 below:

<sup>10</sup> CCS NHS Trust scored 8 organisations and NCHS scored 6 organisations; this reflects their differing footprints.

	Bedfordshire FT	CPFT	CUHFT	ELFT	MKUFT	NCHC	Norfolk and Suffolk FT	NWAFT
<b>Strategic Advantage</b>								
a) Does the partnership align with the NHS's strategy to promote care at home?	3.0	4.5	1.8	8.5	1.7	8.7	2.5	1.7
b) Will the partnership be a significant advocate for community-based healthcare?	1.2	5.3	0.2	7.7	0.8	8.7	3.3	0.8
c) Does the partnership deliver the necessary ambition for care at home services?	2.8	4.5	1.8	8.5	0.8	8.7	2.5	1.7
d) Will the partnership enhance influence in local policy and system design?	4.7	4.3	3.0	7.8	0.8	7.8	3.3	1.7
<i>Sub-total</i>	11.7	18.7	6.8	32.5	4.2	33.8	11.7	5.8
<b>Service Alignment</b>								
a) Will the partnership improve the quality of care across all age groups and foster innovation?	4.5	3.7	3.8	6.2	0.8	8.7	1.7	0.8
Can overlapping services be managed to optimise care delivery?	5.5	5.5	3.8	7.0	1.7	9.0	3.3	1.7
c) Is there symmetry between organisational services?	2.5	5.5	0.8	7.8	0.8	8.8	4.7	0.0
d) Does the partnership improve geographical alignment and the potential for expanded coverage?	3.8	3.3	3.0	7.0	1.7	8.8	4.2	2.2
<i>Sub-total</i>	16.3	18.0	11.5	28.0	5.0	35.3	13.8	4.7
<b>Scale</b>								
a) Is this a partnership of equals and beneficial to both entities?	0.0	0.8	0.0	5.0	0.0	8.7	1.7	0.0
b) Will the partnership enable a reduction in running costs?	0.8	3.8	1.7	5.8	0.8	8.0	2.2	0.8
c) Will the partnership improve the ability to attract, develop talent and leadership?	2.2	0.0	3.8	4.7	1.7	6.3	0.0	0.8
<i>Sub-total</i>	3.0	4.7	5.5	15.5	2.5	23.0	3.8	1.7
<b>Culture and Place</b>								
a) Are the organisations matched in terms of quality (indicated by their CQC ratings)?	1.7	0.8	3.3	9.2	1.7	10.0	0.8	0.8
b) How well do the organisational cultures align?	0.8	0.0	1.7	5.3	0.8	7.8	0.0	1.7

	Bedfordshire FT	CPFT	CUHFT	ELFT	MKUFT	NCHC	Norfolk and Suffolk FT	NWAFT
<i>Sub-total</i>	2.5	0.8	5.0	14.5	2.5	17.8	0.8	2.5
<b>Partnership Viability</b>								
a) Are both organisations ready and capable of engaging in a successful partnership?	0.8	0.0	0.5	5.3	0.0	7.8	0.8	0.0
b) Does the partnership align with the Integrated Care Board's strategic objectives?	2.5	3.3	0.8	3.3	0.8	7.3	3.3	0.8
c) Does the partnership align with local government goals?	0.8	4.2	0.8	4.2	0.8	6.5	4.2	0.8
<i>Sub-total</i>	4.2	7.5	2.2	12.8	1.7	21.7	8.3	1.7
<b>TOTAL</b>	<b>37.7</b>	<b>49.7</b>	<b>31.0</b>	<b>103.3</b>	<b>15.8</b>	<b>131.7</b>	<b>38.5</b>	<b>16.3</b>

**Table 5: CCS Collaboration Scoring**

82. NCHC collaboration scoring is in Table 6 below:

	CCS	ECCH	James Paget	Norfolk and Norwich	Norfolk and Suffolk	Queen Elizabeth
<b>Strategic Advantage</b>						
a) Does the partnership align with the NHS's strategy to promote care at home, better health outcomes and better experiences for people?	8.5	9.2 <sup>11</sup>	1.3	4.3	5.5	4.2
b) Will the partnership be a significant advocate for investment in community-based healthcare?	9.2	8	1.3	2.3	4.3	3
c) Does the partnership deliver the change to reduce emergency care pressures and waiting time reduction?	6.3	6.2	2	5.7	3.5	5.2
d) Will the partnership enhance influence in local policy and system design?	8.5	7.3	3.5	3.7	3.8	3.7
<i>Sub total</i>	32.5	30.7	8.1	16	17.1	16.1
<b>Service Alignment</b>						

<sup>11</sup> The score of 9.2 for ECCH reflects the natural (geographical and operational) synergy between the 2 organisations.

a) Will the partnership improve the quality of care across all age groups, foster innovation and spread best practice?	8.2	7.2	1.8	5	3.5	4.7
b) Can overlapping services be managed to optimise care delivery?	7.7	8	2.2	6.2	5.2	5.7
c) Is there symmetry between the organisational services?	4.8	7.3	1.8	4.3	3.2	4.3
d) Does the partnership improve geographical alignment and the potential for expanded coverage?	6.8	7.7	3	5.2	5.5	5
<i>Sub total</i>	<i>27.5</i>	<i>30.2</i>	<i>8.8</i>	<i>20.7</i>	<i>17.4</i>	<i>19.7</i>
<b>Scale</b>						
a) Is this a partnership of equals and beneficial to both entities?	8	5.5	2.5	1.8	3	3.2
b) Will the partnership enable a reduction in running costs?	7.7	8.2	2.8	5.7	5.5	5.5
c) Will the partnership improve the ability to attract, develop talent and leadership?	7.8	6.5	2.3	5.7	5.3	3.2
<i>Sub total</i>	<i>23.5</i>	<i>20.2</i>	<i>7.6</i>	<i>13.2</i>	<i>13.8</i>	<i>11.9</i>
<b>Culture and Place</b>						
a) Are the organisations matched in terms of quality (indicated by their CQC ratings)?	9.3	6.7	3	2.7	1.5	3.2
a) How well do the organisational cultures align?	8.5	7.3	3.7	3.3	3.3	4.2
<i>Sub total</i>	<i>17.8</i>	<i>14</i>	<i>6.7</i>	<i>6</i>	<i>4.8</i>	<i>7.4</i>
<b>Partnership Viability</b>						
a) Are both organisations ready and capable of engaging in a successful partnership?	7.2	4.2	1.3	2.3	2.2	2.5
b) Does the partnership align with the Integrated Care Board's strategic objectives?	5.5	7	2.8	4.5	5.5	4.2
c) Does the partnership align with local government goals?	5.7	5.8	1.3	2.8	3	2.8

<i>Sub total</i>	18.4	17	5.4	9.6	10.7	9.5
<b>Total</b>	<b>119.7</b>	<b>112.1</b>	<b>36.6</b>	<b>65.5</b>	<b>63.8</b>	<b>64.6</b>

**Table 6: NCHC Collaboration Scoring**

83. CCS and NCHC each scored the other as the most suitable partner.

#### Collaboration Structure

84. Structural options were considered to: merge; form a joint venture; and form a group model and were scored against 10 criteria.

85. CCS scoring in respect of structural options is at Table 7 below:

	Merger	Joint venture	Group model
<b>Strategic Advantage</b>			
➤ Does the partnership align with the NHS's strategy to promote care at home, better health outcomes and better experiences for people?	8.6	3	5
➤ Will the partnership be a significant advocate for investment in community-based healthcare?	7.8	3.4	5
➤ Does the partnership deliver the change to reduce emergency care pressures and waiting time reduction?	6.4	2.2	4
➤ Will the partnership enhance influence in local policy and system design?	10	2.4	6.4
<b>Service Alignment</b>			
➤ Will the partnership improve the quality of care across all age groups, foster innovation and spread best practice?	8.8	3.2	5.2
➤ Can overlapping services be managed to optimise care delivery?	8.8	1.2	6.2
<b>Scale</b>			
➤ Will the model enable a reduction in running costs?	9.4	0.6	4.8
➤ Will the model improve the ability to attract, develop talent and leadership?	7.8	1	5

	Merger	Joint venture	Group model
➤ Will the model streamline decision making?	8.8	1	5
<b>Culture and place</b>			
➤ How well would the organisational cultures align?	7.4	1.8	5.2
<b>Total</b>	<b>83.8</b>	<b>19.8</b>	<b>51.8</b>

***Table 7: CCS Structural Options Scoring***

86. NCHC scoring in respect of structural options is at Table 8 below:

	Merger	Joint venture	Group model
Strategic Advantage			
Does the partnership align with the NHS's strategy to promote care at home, better health outcomes and better experiences for people?	7.8	2.8	6.8
Will the partnership be a significant advocate for investment in community-based healthcare?	9.3	4	7.8
Does the partnership deliver the change to reduce emergency care pressures and waiting time reduction?	7.5	3.2	6.3
Will the partnership enhance influence in local policy and system design?	9	3.7	7.5
Service Alignment			
Will the partnership improve the quality of care across all age groups, foster innovation and spread best practice?	7	3.2	5.7
Can overlapping services be managed to optimise care delivery?	8	2.5	6.3
Scale			
Will the model enable a reduction in running costs?	8.7	2	5

Will the model improve the ability to attract, develop talent and leadership?	7.7	2.7	7.2
Will the model streamline decision making?	8.7	3	6.2
Culture and Place			
How well would the organisational cultures align?	7.5	3.5	6
Total	81.2	30.6	64.8

**Table 8: NCHC Structural Options Scoring**

87. Both Trusts scored merger as by far the most efficacious structure for collaboration.
88. For completeness and reference, the Board Papers setting out the agreed outcome of the evaluations are at Enclosures 5 and 6.
89. As a stepping-stone to merger, the Trusts decided at a meeting-in-common<sup>12</sup> in July 2024 to form a group model of governance which was established from 1 April 2025.

## Summary of Key Messages

The key messages from our Strategic Rationale are:

- Both Trusts have CQC ratings of 'Outstanding', have performed well historically and continue to do so and have aligned visions.
- We have a recent history of joint working and delivering both financial and quality benefits.
- Our service portfolios are complementary.
- Systems have identified a range of opportunities for improvement which, whilst expressed differently, share common themes.
- Merger has been identified as the most beneficial way to improve the services we deliver and the sustainability of the Trusts thereby supporting system improvement.
- Benefits delivered will be in the domains of: enhancing delivery of care; improving support to our staff; maximising the use of resources.
- We do not anticipate that there will be any material costs to deliver the transaction.
- System partners have been engaged and are supportive.

---

<sup>12</sup> CCS NHS Trust and NCHC NHS Trust – Trust Board Meeting in Common minutes dated 24 July 2024.

## 3. Underlying Transaction Risk

### 3.1 Current and emerging risks and mitigations

90. We have developed an integration risk register identifying key risks related to the proposed transaction and the associated mitigations.
91. The integration risk register is a live document which we will maintain as we move through the merger process, including consideration of risks identified through the due diligence process. The integration risk register is a regular item at the Programme Board meetings.
92. The Trusts' corporate risk registers are monitored by the Trust Boards. Any significant risks relating to integration and the proposed transaction will be incorporated into the two corporate risk registers, as necessary.
93. Table 9 (below) summarises the material current/emerging quality, financial, governance or other risks that are relevant to the successful execution of the transaction and delivery of the planned benefits have been identified and how these are being mitigated or expected to be mitigated, where appropriate.

**NOTE THIS TABLE WILL BE UPDATED FOR CURRENT BAF RISKS BEFORE SUBMISSION**

Key Risk related to proposed transaction	Consequence	Likelihood	Mitigation
<b>Risks to merger planning</b>			
Lack of capacity to plan adequately for integration and undertake effective due diligence	4	3	Fortnightly executive-led Programme Board to oversee merger planning attended by Group Chair for direct communication to full Board; merger case is being prepared by a dedicated merger PMO with Group executive SRO. External advisers being used to boost capacity where needed.  We are developing a reduced scope for due diligence to reduce the burden on colleagues, taking into account the position of the Trusts.
Stakeholder support for a group model / merger wanes or is withdrawn	3	1	Engagement plan developed and enacted to ensure stakeholder management is undertaken well Performance of the organisation and transformational work is undertaken – increasing trust and confidence as we go through this process Regular 1:1s set up with key influencing leaders in local authorities and the NHS.
<b>Risks to realising benefits of merger</b>			

Optimism bias emerges when defining benefits of integration	4	3	Our Benefits Realisation Methodology will be used to identify and quantify benefits. Internal project management expertise will be used to ensure planned benefits are clearly defined with realistic timeframes. Benefits will be framed by clinical and support service colleagues, rather than being centrally defined. Board level oversight and challenge will take place.
Harmonising cultures from the two organisations while also retaining cherished local identities	3	3	Initial conversations are underway around cultural harmonisation, and we will develop a joint People strategy at Business Case stage which will include a single set of values and behaviours for the merged Trust.
Lack of support from patients, staff, ICBs, or other partners or NHSE	4	3	Close engagement with ICS partners, staff, and patient representatives, as per the Communications and Engagement plan. Regular engagement with NHSE.
<b>Risks to realising benefits of merger</b>			
Financial position of either Trust declines or distracts us from integrating services and making necessary transformational changes to services	3	3	Continuing sound financial management and close working with ICS partners to ensure investment where needed.  Financial due diligence and benchmarking to identify savings opportunities.
External uncertainties about future financial regime and/or developing legislation may impair our ability to proceed with merger or implement our integration plans	4	2	Continuing close liaison with NHSE to stay sighted on developments.
The formal merger of the two trusts is delayed due to other priorities taking precedence.	4	2	The Trusts will only delay the timetable through formal decision making, and only when the benefits of a delay to deliver other priorities in the short term outweigh the impact of delay.

**Table 9: Summary of key risks and mitigations**

### Summary of Key Messages

The key message from our analysis of the Underlying Transaction Risk is that given the Trust's performance, standing and willingness to merge risk is modest and suitable mitigations have been identified.

## 4. FBC Readiness

### 4.1 Our Planning timeline

94. Key milestones set out in the transaction delivery plan are in Table 10 (below).
95. Once we secure the necessary support and approvals from our Boards, stakeholders (importantly including the resolution of the issues in section 71), and regulator, our intended 'go-live' date for the merger is 1 April 2026. In identifying this date, and the key milestones below, we are seeking to balance the additional benefits to be delivered by formal merger (as opposed to operating within our Group model) against the resource requirements and capacity of the trusts to deliver against other opportunities to deliver benefits to the populations we serve.

Date	Milestone
May 2025	NHSE complete review of Strategic Case and confirm agreement for moving to Full Business Case
May – November 2025	Trusts acting through Group Board develop Business Case, including Long-Term Financial Model, post-transaction implementation plan, full due diligence, revised Constitution and Transaction Agreement
November 2025	Trusts submit final Business Case to NHSE following ongoing engagement and feedback from NHSE and approval from Group Board
January/February 2026	NHSEI challenge meeting with Group Board
March 2026	Boards formally approve transaction, NHSEI formally grants transaction
April 2026	Trusts merge 1 April 2026.

***Table 10: Key milestones in transaction delivery plan***

96. Further detail on the proposed timeline for the key activities needed to develop a robust FBC is included at section 4.4.
97. The draft timetable assumes there are no service changes requiring public consultation.
98. If the timetable were to slip this would increase delay the full realisation of expected benefits of merger and therefore, from the Trusts' perspective, would only be envisaged if alternative benefits were identified that, in the short term, would take precedence. This risk and mitigations are included in the Integration risk register.

## 4.2 Due diligence

### Initial due diligence

99. Due to the nature of the relationship between the Trusts – i.e. joint Chief executive, both NHS Trusts', history of financial stability, outstanding CQC rating very limited due diligence has been carried out at this stage, relying on shared executive knowledge of the Trusts.

### Further due diligence

100. As we progress to Full Business Case, we will carry out appropriately targeted due diligence, taking advice as to our approach and areas of concern from our legal advisors. We will continue to update our due diligence right up until the proposed merger receives final approval.
101. Our approach to due diligence has been approved by the programme board and is included at Enclosure 7, this includes the initial areas of potential focus.
102. Our approach recognises the outstanding ratings and financial position of both Trusts (where full audited accounts will have been approved before the completion of the FBC), the full oversight of both Trusts that the Group Board directors will have from 1 April and recognising that both parties are NHS trusts- so no assets or liabilities are transferring into or away from direct NHS control.
103. Due diligence will, therefore, primarily be focussed on issues that could prevent the delivery of the transaction benefits and will be developed during the FBC and PTIP preparation. The initial areas of focus identified in Enclosure 7 will therefore be reviewed and specific focus developed.
104. An outline of the broad areas of due diligence to be undertaken is summarised in Table 11 below:

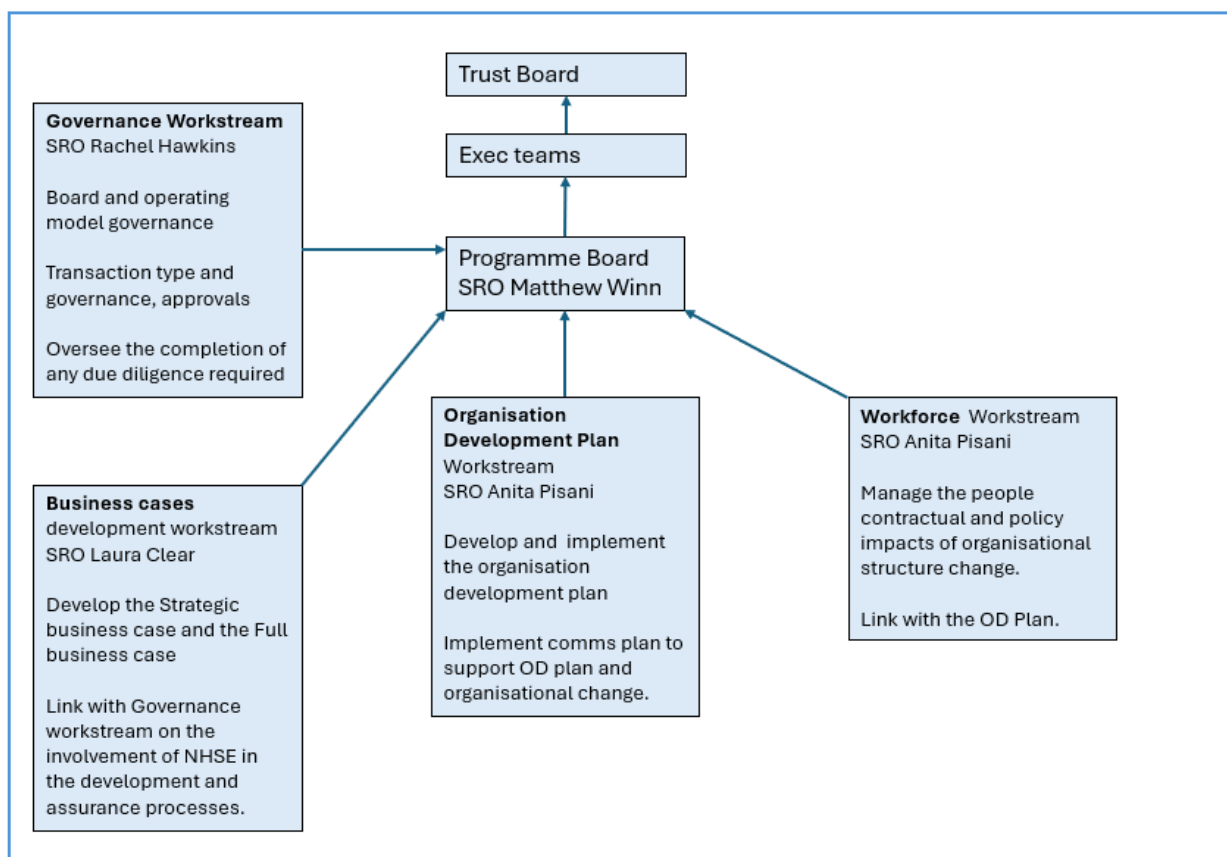
Workstream	Executive Lead(s)
1. Commercial & Governance	Rachel Hawkins
2. Contracts & Equipment	Mark Robbins
3. Estates	Mark Robbins
4. People & Organisational Development	Anita Pisani
5. Regulatory Compliance	Rachel Hawkins
6. Litigation & Claims	Rachel Hawkins
7. Environmental & Health & Safety	New CFO – in post July 2025
8. Insurance	Mark Robbins
9. Information Governance	Rachel Hawkins
10. Intellectual Property	Mark Robbins
11. Digital	Sarah Buchan
12. Charities	New CFO – in post July 2025
13. Clinical Governance	Dr Caroline Kavanagh, Kate Howard
14. Finance	New CFO – in post July 2025

***Table11: Due Diligence Areas and Responsibilities***



#### 4.5 Our Governance Structure to ensure adequate oversight of transaction development

- 107. We have rigorous governance mechanisms to oversee progress of the proposed transaction. The two executive teams have established a Programme Board which has oversight of the overall integration of the two Trusts including the case for merger. It comprises a sub-set of executives from both Trusts, including the joint chief executive and joint chair. This group reports to the two full executive teams of the Trusts and the Boards are provided with regular progress updates.
- 108. The Terms of Reference for the Programme Board are included at Enclosure 8.
- 109. The Programme Structure is summarised in Figure 9 below:



***Figure 9: Programme Structure***

- 110. The Programme board meets on a fortnightly basis and allows for direct escalation of issues to both executive and non-executive directors (through the attendance of Group chair). Similarly, responsibility for FBC workstreams sit with executive directors and, as the FBC programme develops, will be formally reported to the programme board through our standardised highlight reports. At present reporting for FBC workstreams is via the Business Cases workstream

## 4.6 Programme management structure and resourcing

111. The Senior Responsible Officer for merger planning is Laura Clear who oversees the Programme Management Office (PMO) which will work across both Trusts in managing the merger.
112. We have used a workstream approach to develop this Strategic Case. When we receive approval to move to Full Business Case stage, we will require increased internal resources to develop the Case.
113. We will continue to use the existing workstreams, supplemented where necessary with additional resources, to develop the Business Case and aid planning for Day One and beyond. Each workstream has a senior responsible officer and specified work packages determined by the key deliverables. The merger workstreams are set out in Table 12 below:

Workstream	Executive lead(s)	Scope at Business Case stage
Clinical strategy	Caroline Kavanagh & Kate Howard	<ul style="list-style-type: none"> <li>Clinical strategy design &amp; identification of patient benefits – Patient Benefit cases</li> <li>Clinical service strategies for key services</li> <li>Oversight of delivery of priority clinical integration projects</li> </ul>
Operating model	Mathew Winn	<ul style="list-style-type: none"> <li>Design and implementation of operating model for merged Trust</li> </ul>
Finance	(New CFO – in post July 2025)	<ul style="list-style-type: none"> <li>Development of the Financial Model including benefits and costs of the transaction</li> <li>Finance team support to integration projects</li> <li>Integration of Finance and Planning function</li> <li>Integration of Performance function</li> <li>Integration of Procurement function</li> <li></li> </ul>
People & OD	Anita Pisani	<ul style="list-style-type: none"> <li>Develop and implement joint People strategy</li> <li>Lead cultural harmonisation</li> <li>Colleague engagement</li> <li>Workforce planning</li> <li>TUPE transfer of staff</li> <li>Integration of HR functions</li> <li>Integration of Training and Education Functions</li> <li></li> </ul>
Estates	(New CFO – in post July 2025)	<ul style="list-style-type: none"> <li>Development of Estates strategy for merged Trust</li> <li>Integration of Estates, Capital Planning and Facilities management functions</li> </ul>
Digital	Sarah Buchan	<ul style="list-style-type: none"> <li>Develop Digital strategy for merged Trust</li> <li>Digital support to clinical and corporate integration projects</li> <li>Integration of IT function</li> </ul>
Strategy and Transformation	Laura Clear	<ul style="list-style-type: none"> <li>Integration of Improvement and Project/Programme management Teams</li> <li>Project/Programme team support to integration projects and transaction itself</li> </ul>

Workstream	Executive lead(s)	Scope at Business Case stage
Governance (clinical and corporate)	Rachel Hawkins	<ul style="list-style-type: none"> <li>• Develop clinical governance framework for new organisation</li> <li>• Develop corporate governance for new organisation</li> <li>• Draft Heads of Terms and Transaction Agreement</li> <li>• Coordinate Due Diligence</li> <li>• Integration risk management</li> <li>• Integration of clinical and corporate governance functions</li> <li>• Integration of information governance function</li> <li>• Integration of EPRR function</li> </ul>
Communications	Rachel Hawkins	<ul style="list-style-type: none"> <li>• Colleague and stakeholder communications</li> <li>• Communications strategy for new organisation</li> <li>• Integration of Communications function</li> </ul>
Commercial/legal	Rachel Hawkins	<ul style="list-style-type: none"> <li>• Ensure smooth transfer of key contracts/agreements</li> </ul>
Merger Case and Programme management	Laura Clear	<ul style="list-style-type: none"> <li>• Prepare Business case and supporting submissions</li> <li>• Prepare Post-Transaction Integration Plan including Day 1 preparations</li> <li>• Maintain, monitor, and report progress against Integration Programme Plan</li> <li>• Coordinate and support integration workstreams</li> <li>• Coordinate programme of integration projects</li> </ul>

**Table 12: Merger Workstreams**

114. We will use in-house resources to deliver the transaction as far as possible, to maintain ownership, retain skills, and keep costs down. Each workstream lead will develop a detailed plan and assess what, if any, additional resource is required to
115. We are applying project management methodology to the transaction itself and to all our integration projects. Our approach ensures projects are consistently managed and reported, and all have a senior owner with agreed timelines and progress indicators.
116. Progress on integration will be overseen by the Programme Board consisting of members of the Group executive team.

#### **4.7 Development of detailed benefit proposals and implementation plans**

117. Our detailed implementation plans, and consequent benefits identified, will be based upon the underlying strategies which are being developed and / or refined from existing strategies.
118. Support for development will be provided by the Trusts' project management and quality improvement teams, using tried and tested approaches to quality improvement and benefit realisation, and planning for development will ensure that appropriate clinical resource is available. The benefit of moving to the Group structure is already seen in expanding the clinical management resource available to support workstream development.
119. The following pages provide high level summaries of our approach to strategy development.

## 4.7.1 Clinical strategy

### Development of our clinical and service strategy

120. We are developing our clinical and service strategy bearing in mind the current and expected future needs of the people of the communities we serve.
121. Our clinical and service strategy will include, and deliver, our approach to quality and patient experience and will be the key to enhancing patient care and delivering our vision of outstanding care and support to the populations we serve.
122. Senior clinicians from both Trusts will lead the development of the clinical and care strategy, with involvement from a wider group of colleagues in an 'engagement group' role. This group will include representatives from patients and carers, primary care, local authorities, acute care and the local voluntary sector to ensure the strategy meets the needs of the populations we serve.
123. The development of our clinical and serviced strategy will be informed by, and set measurable improvement outcomes (where appropriate) based upon:
  - Clinical data.
  - Friends and Family Test (FFT) / patient feedback.
  - Patient / staff stories; and
  - National frameworks and plans.

### Clinical and service strategy for merged Trust

124. Our health and social care services will be centred on the people they serve, listening and responding to what is important to them and their loved ones. Colleagues will make sure people feel well supported and that their needs are clearly understood through active listening, co-production and collaboration.
125. We will co-produce changes to our services with the people who use them. There will be close collaboration between partners and a focus on learning and continuous improvement to get care right for everyone. This will not just be in terms of *what* care we provide, but also how we provide care, where and by whom. We will give prominence to valuing patients' time, both with regard to the time they spend in healthcare and by maximising their years of healthy life.
126. Working with partners we will continue to work to streamline and standardise care pathways to remove duplication and inefficiencies and break down further the barriers that exist between health and care services. We want our pathways to be easy for patients, carers, and colleagues to understand and navigate. Patients, their families, and carers will only have to tell their story once, and clinical and administrative approaches will be consistent to support improved patient and carer experience. Our estates development programmes will focus on supporting quality of care and creating spaces for patients that have greater therapeutic value.
127. We will work closely with the developing neighbourhood care teams to provide care in people's homes and in the community. We will provide increased support and advice to primary care and ensure healthcare colleagues are able to help people access neighbourhood resources to improve their health and wellbeing.
128. We will also increase our work with partners to support prevention, self-management, and early intervention to prevent avoidable illness and escalation of health or social care need. For example we want to provide more specialist support to primary care and the voluntary sector, give information to people with health needs to help them self-manage, and ensure that at every stage we are taking steps to prevent avoidable illness and disability.
129. Population health management techniques and data analysis will help us identify those groups most at risk of deteriorating health. We will also ensure people only receive bed-based care when it is right

for them, to avoid harms such as deconditioning.

130. We will give equal priority to urgent and planned care, supporting our own and acute waiting list recovery, preventing deterioration, and ensuring that patients get the care they need in a timely manner no matter where they live. By delivering more care in neighbourhoods through the shift in activity from acute settings we will release capacity to continue with more elective care during the winter. We will address other health inequalities to ensure people get the care they need no matter who they are or where they live. We will also improve health outcomes, in particular for people with complex needs, through the provision of personalised, co-ordinated care.
131. We believe that our patient-centred clinical and service strategy and the decentralised way we will implement it, will motivate colleagues, and help create a great place to work. We also know that we cannot deliver population health on our own, so effective working with our partners will be key to our success.
132. Our primary driver for merger is to improve the health of our population by increasing the scale and improving the quality of the care we provide. We believe that doing the right thing for patients will drive efficiency more effectively than focusing on cost saving schemes which bring the risk of poorer patient care and/or experience.
133. The experience of other healthcare systems, e.g. Jönköping in Sweden, Canterbury in New Zealand and the Montefiore model in New York, has shown that an intense focus on the person and what matters to them, and making sure all elements of the system deliver the right care for people, drives down the overall cost of health and social care services<sup>13</sup> and improves outcomes.<sup>14</sup>
134. As a merged Trust we will strengthen our relationships with other care and support and work with them to understand where there are gaps in provision both in health and other services. We will support other agencies to do the right thing for our populations, to improve population health and benefit all involved.

### Valuing time

135. Valuing time - both patient and colleague time - is a key part of our clinical strategy. For most people, the outcome they want from health and social care services is to be as well as possible to be able to do the things that matter to them. That means spending as little time as possible in healthcare and staying healthy for as long as possible. Furthermore, we want to explicitly value colleague time and make doing the right thing for patients, the easy thing to do.
136. We want to give time to patients through interventions which increase their healthy life expectancy and avoid taking time from patients through long waits or interventions of little clinical value.
137. We intend to use time as our primary measure to ensure people are spending the right amount of time in healthcare settings. This supports our focus on putting patients at the heart of our services and maximising the time they have to do what matters to them. Using time as a measure allows us to focus on the dignity and autonomy of the people we serve, as well as demonstrate our humanity and compassion. Time is simple to understand and is engaging for patients and colleagues alike. It also supports our aim of making the right thing the easy thing. Some of the ways we will demonstrate our commitment to valuing patient and colleague time are set out in Table 13.

<sup>13</sup> Specifically, reduced admissions and readmissions to ED.

<sup>14</sup> The Montefiore Health System in New York, Ben Collins, The King's Fund, July 2018; The quest for integrated health and social care A case study in Canterbury, New Zealand, Nicholas Timmins and Chris Ham, The Kings Fund 2013; Population health systems: going beyond integrated care. Hugh Alderwick, Professor Sir Chris Ham, David Buck. The Kings fund 2015.

<p><b>Valuing patient time means we will:</b></p> <ul style="list-style-type: none"> <li>• work to increase healthy life expectancy</li> <li>• act early to prevent avoidable illness</li> <li>• reduce the period between the time of need and the fulfilment of that need (i.e. waiting times)</li> <li>• streamline pathways to reduce waits and time spent in healthcare</li> <li>• safely reduce the time spent in our services having treatment</li> <li>• reduce the time spent waiting for diagnostic results</li> <li>• avoid non-value adding healthcare interventions, and unnecessary follow-up appointments</li> </ul>	<p><b>Valuing colleagues' time means we will:</b></p> <ul style="list-style-type: none"> <li>• maximise the time colleagues spend on patient interventions and training</li> <li>• maximise time spent working at the top of their registration to make best use of colleague skills</li> <li>• support colleagues in determining how much time patients need to spend in health care interventions and in taking calculated risks if that promotes self-management for patients</li> </ul>
<ul style="list-style-type: none"> <li>• reduce the time spent accessing and navigating health and social care streamline administrative procedures and remove duplication so patients only have to tell their story once reduce unnecessary travel to receive care.</li> </ul>	<ul style="list-style-type: none"> <li>• reduce bureaucracy to the minimum and remove non-value adding tasks.</li> </ul>

**Table 13: Valuing patient and Colleague Time**

138. We already collect data about time spent in healthcare processes, e.g. length of stay in inpatient units, number of outpatient appointments, number of home visits for treatment etc. We will work with system colleagues to supplement these with indicators of increased healthy life expectancy and outcomes from treatment pathways.

[Plan on a page](#)

139. A summary of the approach to our clinical and service strategy for the merged Trust is shown in our 'plan on a page,' see Table 14 (below). We will continue to develop this plan on a page as our clinical strategy develops. We have started to identify the clinical integration projects which we will take forward as part of the proposed merger.

<p><b>Where are we now?</b></p>	<ol style="list-style-type: none"> <li>1. We are working towards the development of the Group Model.</li> <li>2. We are working towards an alignment of Children's Services within Norfolk and Waveney.</li> <li>3. We recognise there are similarities in the services of the 2 separate Trusts where best practice could be shared.</li> <li>4. We recognise there are different cultures and governance processes in some areas across the Trusts, with similarities in other areas.</li> <li>5. Both organisations work with communities where there are health inequalities.</li> <li>6. Both organisations are judged to be outstanding by the CQC.</li> </ol>
<p><b>What's our aim?</b></p>	<ol style="list-style-type: none"> <li>1. To meet the health needs of our patients across the communities we serve.</li> <li>2. To provide high quality, safe, outcome focussed patient care.</li> <li>3. To reduce inequality.</li> <li>4. To develop a single set of values and behaviours.</li> <li>5. To align services where it makes sense to do so, reduce duplication and share best practice.</li> <li>6. To develop a single set of metrics and quality indicators.</li> <li>7. To be the Trust of choice for patients to receive care and for staff to recommend us as an employer.</li> <li>8. To meet our financial obligations</li> </ol>
<p><b>What's our approach?</b></p>	<ol style="list-style-type: none"> <li>1. Scope our position, and identify the case for change, understand the national and local drivers and frameworks that underpin our services.</li> </ol>

	<ol style="list-style-type: none"> <li>2. Identify priorities with our colleagues, patients, carers and stakeholders.</li> <li>3. Build the strategy based on our priority conversations.</li> <li>4. Engage with stakeholders, request feedback on the strategy priorities.</li> <li>5. Confirm priorities and monitoring requirements, make sure we have clear outcomes and metrics.</li> <li>6. Start to develop the key performance indicators/ metrics, and governance arrangements.</li> <li>7. Understand the resource requirements and ensure the right resource is available.</li> <li>8. Executive Group Board sign off of the strategy.</li> </ol>
<p><b>What are our enablers or principles?</b></p>	<ol style="list-style-type: none"> <li>1. Engage colleagues, patients and carers with a shared vision/ goal.</li> <li>2. Strong, trusted relationships with external stakeholders.</li> <li>3. Robust co-production and collaboration ethos.</li> <li>4. Strategy ownership is shared.</li> <li>5. Capable and empowered leaders.</li> <li>6. Robust communication plan.</li> <li>7. Clinical and non-clinical staff are highly skilled and trained.</li> <li>8. Understanding the resource need.</li> <li>9. Advancing our clinical practices.</li> <li>10. Building our research and audit capacity.</li> <li>11. Ensuring our technology and data capacity development links to the strategy.</li> </ol>
<p><b>How do we know when we have been successful?</b></p>	<ol style="list-style-type: none"> <li>1. When the enablers have been embedded.</li> <li>2. Our strategy has been implemented and is being monitored.</li> <li>3. Evidence of a strong, community voice within the system.</li> <li>4. When our developed Key Performance Indicator / metrics are showing a positive position (including patient outcome measures and feedback).</li> <li>5. Staff Survey shows a positive position in relation to 2 core questions:             <ul style="list-style-type: none"> <li>▪ Do staff recommend us as an employer?</li> <li>▪ Do staff recommend us as a place to receive treatment and care?</li> </ul> </li> <li>6. Improved waiting times.</li> <li>7. High reporting culture.</li> <li>8. When our children’s services in Norfolk and Waveney have been aligned.</li> <li>9. When our patients and carers provide positive feedback on their experience.</li> </ol>

***Table 14: Clinical and Service Strategy development – ‘Plan on a page’***

140. As a provider, we want to provide care at the lowest level appropriate for the person’s needs, starting with self-management and only escalating through increasing levels of care if the person’s health needs require it.

**Next Steps**

141. We are already working on developing the clinical strategy and will continue with this as part of our joint working as a Group.

**Clinical Transformation Programme**

142. We have started to identify the projects and programmes that will deliver our clinical strategy. We are future focused and see these themes, or golden threads, as ways to improve the health and wellbeing of our population, with a focus on prevention and high-quality care. We will use our enablers, e.g. digital services, to allow us to focus on desired outcomes for patients, benchmarking, and setting a lead example for providing excellent care for patients.

## Neurodevelopmental Disorders

143. Nationally, and locally, there is a long, and growing, waiting list for children needing assessment for Neurodevelopmental disorders (NDD) and its subsequent management.
144. All our NDD assessment teams are already working in their localities to reduce these waiting times and to provide the care that our CYP need, and they have been adopting different approaches to this issue.
145. We have already brought all our CYP service leads and clinical leads together to review the required service provision, our approaches to managing the waiting lists, and to share best practice and learning. We are now working together to support and improve our locality-based plans, which focus on the needs of our local populations, through a groupwide approach to innovation, transformation and service improvement across our shared geography.
146. As this work with NDD assessment is ongoing, we considered other themes to focus on to improve care for CYP, as well as adult care and the four themes that we will particularly focus on over the next two-four years will be:
  - Aligning all of Norfolk CYP services.
  - Developing 'Preparing for Adulthood' transition services for CYP across all our services.
  - Development of Urgent Care practices to include the development of the community virtual ward (VW) and Urgent Care Hub in Luton and the further development of the community virtual ward in Norfolk based on shared learning and expertise and best practice.
  - Development of Integrated Neighbourhood teams to provide care for our elderly frail patients. This will have a focus on prevention and early interventions at home.

Further details of these focus areas are:

### Aligning CYP services in Norfolk

147. There are 238,000 CYP aged 0-25 in Norfolk and 167,000 aged 0-18 years. There has been a significant national focus on increasing integrated working across the children's system e.g. NHS 10-year plan, Stable Homes, Built on Love Strategy, SEND and AP Improvement planning.
148. There is a system collaborative across Norfolk, and at present some services for CYP are managed by CCS and others by NCHC. There is a focus by Norfolk County Council to streamline processes, reduce bureaucracy and increase the use of technology across Children's services to proactively identify needs through the intelligent use of data.
149. Aligning all these services together with clear leadership and planning will promote the consistency in approach for our CYP across all of Norfolk. This will ensure a more holistic approach which will promote a 'Think Whole Child' and 'Think Whole Family' approach as services will not be siloed or separate.
150. This will enable the sharing of knowledge and expertise, and the provision of care based on best practice. This will also provide the opportunity for enhanced co-production of services across Norfolk and the full alignment facilitates this approach. There will be fewer providers for families to interact with and they will be able to 'tell their story only once' across their care provision. There will be improved boundaries around safeguarding for CYP who sit between counties, and a stronger patient voice for CYP across Norfolk.
151. Norfolk County Council are keen to create a county where every child can flourish and bringing all the Norfolk CYP community service together is a positive step in this direction. This aligns with the NWICS Joint Forward Plan and the third ambition of this plan, Improving Services for Babies, Children Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS).

152. Aligning all our CYP services across Norfolk will ensure that CYP have the best start to life, through a focus of collaborative working with system partners. We will promote health prevention recognising the importance of a strong start in life for children and young people.

#### Developing 'Preparing for Adulthood' transition services for CYP across all our services

153. Transition services for CYP with complex needs, as they prepare for adulthood, can often be ill-defined and a difficult path for families to navigate. There are many providers, which can feel like a challenge as CYP move to adult services and families are often anxious about this time of transition and transfer of care. There are national initiatives to develop and improve transition services for CYP at this unsettling time.
154. Together across NWICS, C&P and BLMK we can use our shared expertise to look at our transition arrangements and standardise practice to ensure great care for our families. We can adopt a 'ready-steady-go' approach over 2-3 years prior to the transfer of care to adult teams. We can review what the best practice is for CYP with complex needs and use that knowledge to improve our management of this process.
155. Once we have our ideas and plans in place, we can approach our system partners for their thoughts and look to develop guidance and pathways for transition and transfer. We will create joint working groups to develop this across all our CYP services. We will take our expertise of our different teams and bring it together for the benefit of our patients and will also facilitate the development of specialist roles for our staff encouraging their resilience and engagement. We will also involve co-production to ensure the patient voice is heard through this process. We can also then benchmark our services and use data to improve our services.
156. This aligns with the JFP from our three core ICBs. In C&P they have a strategic aim to identify and better support CYP with high complex needs; within NWICS there is a plan to improve services for children any young people and Norfolk County Council are keen to develop adolescent and therapeutic services to ensure we can meet the growing demand for support in this area; BLMK ICS aim to provide a local integrated model of care for people with complex needs.
157. All the ICB JFP's align with improving transition pathways of care for children with complex needs.
158. This plan also aligns with the CQC focus of transition services and their report 'From The Pond To The Sea' focusing on children and young people with complex needs. There has also been national 'ready-steady-go' programmes as well as work undertaken by charities such as The Well Child Charity.

#### Hospital at Home / Virtual Wards and Urgent Care Hubs

159. Patients can be managed in the community through urgent care hubs and virtual wards. This enables people to have care at home and reduces the bed pressures of the acute providers with admission avoidance being a suture focused plan.
160. We have hospital at home/Virtual Wards in Luton/Bedfordshire and Norfolk, both of which have strong relationships with local acute organisations. Both models operate somewhat differently based the services developed and there is the opportunity to work and learn together to provide the best care for patients requiring care in the Virtual Ward.
161. The Urgent Care Hub in Norfolk is established and works well, an Urgent Care Hub has just opened in Bedfordshire and Luton. We will share learning, expertise and best practice to develop both Virtual Wards together and for our NCHC team to help in ongoing development of the hub in Luton.
162. This will result in less time navigating services (Hub) and more horizontal integration with partners. We can build upon ICS collaborative partnerships to further promote joint working, innovation and new ways of working. We can then have a single care plan for patients, and a single governance agreement across the hub, which will reduce risk and improve safety for patients. This will result in a

reduction in admissions to acute providers and allow a more structured urgent care response.

163. Each ICS that we are in partnership with has Virtual Wards in their forward plan, as they are an integral part of the 10-year plan and the recent planning guidance. The development of Urgent Care Hubs has also been a set-wise progression in the management of Urgent Care with true partnerships across providers to ensure seamless care for patients providing what they need.

#### Integrated Neighbourhood team development

164. We have an aging population with more people living with long-term conditions and living longer, which can lead to health inequalities. We are keen to ensure that a focus on prevention will help our population to age well, living as independently as possible through longer, happier, healthier lives. We want to facilitate patients to feel heard and respected and know they will be treated as individuals.
165. This approach aligns with the Joint Forward Plan for NWICS (ambition 5), BLMK (Longer Happier Healthier Lives, Focus On Prevention, Right Care First Time). C&P have a focus on aging well, prevention, and reducing hospital admissions which this plan will facilitate.
166. We will co-produce pathways aiming to maintain the independence of older people and to ensure early intervention and reablement at home. This focus will reduce crisis interventions and promote wellbeing.
167. Our integrated neighbourhood focus will involve collaboration with Primary Care, Social Care, the Voluntary and third sectors. This will ensure smooth pathways for patients throughout their lives with shared care records and care plans.
168. The recent 2025-26 Planning Guidance has a focus on the development of Integrated Neighbourhood teams and collaboration with a focus on prevention, early intervention and crisis avoidance. Our focus will fit and enable this guidance to flourish and have an impact of patient care at home with reduced admissions and reduced episodes of deterioration for our aging population.

#### Service integration

169. Where appropriate we will bring together under single management structures those services that we deliver across geographies to enhance learning and service delivery. This is a programme of work which has already begun in Children's services and MSK.
170. This work will be driven by the services themselves and, as services integrate, we will support teams to consider how their service will focus on population health, tackle inequalities, shift acute delivered care into neighbourhoods, and adopt a personalised care approach. Services will be asked to focus on getting things right for the person who is receiving the care and their carer(s) and ensure the time of all those who work in and receive our care is valued.
171. Each clinical service will set its own priorities and timeline based on what they believe is best for the people they serve. This process will be overseen by the relevant Service Directors.

#### Clinical and stakeholder engagement

172. Our clinical and service strategy is being developed and led by clinicians from both Trusts and will be developed with the involvement of senior representatives from local primary care and social care.
173. We will also work with public and patient representatives including people with personal, carer and volunteer experience of not only our own community delivered services but system acute and mental health services to understand how we can support and deliver more community services outside of hospitals. This group will help to shape our developing clinical strategy and inform our thinking around healthcare buildings and technology.

174. Our clinical and service strategy notes our intention to co-produce our transformation plans with the input of people with experience of our services as well as wider system colleagues. We want to make this easy to do and normal practice.
175. At Business Case stage we will undertake a wider engagement exercise across both Trusts and the wider health and social care systems, to share the key messages of the clinical strategy and help our colleagues identify the key clinical and nonclinical priorities in their areas. Our clinical strategy will not work in isolation from other health and care partners. We will engage all our colleagues as we need everyone to be motivated to drive innovation in the merged Trust. We will continue to work closely with People, Digital and Estates colleagues to ensure their developing strategies fully support the clinical strategy.
176. We know that a positive inclusive approach, good relationships with stakeholders, and ongoing communication are key to the development of a robust and embedded clinical strategy. We already have strong links with other Trusts and providers in our geographies and will continue to build and widen these links.
177. We will use a variety of approaches, including group engagement sessions, written information, one-to-one meetings, and focussed work with individual teams to share our plans. We will also develop a short video to tell the story of why we need to transform and how we intend to do it.

#### Benefits of merger

178. The proposed merger will enable us to develop and implement integrated clinical pathways initially within Norfolk's children's teams, whilst ensuring that best practices and lessons are shared across the wider organisation. It will also improve our clinical resilience and provide a larger platform for the voices of our patients and carers to be heard.
179. As a larger organisation, the scope to improve practice and drive innovation within care will be greater, this will include bringing together the wealth of experience in research, quality improvement and audit to bring about wide scale changes and new treatment opportunities for our patients and population.
180. As a larger and more diverse organisation we will be able to use our skills, knowledge and impact to influence the health inequalities agenda both internally and across our geography. Economies of scale will support us to develop systemwide responses to meet the needs of our patients, whilst ensuring practice are shared across teams.
181. The proposed merger will support us to develop and embed co-production and involvement across the whole organisation, ensuring that our patient representatives have an equal voice and influence in relation to the clinical priorities and potential outcomes.
182. One of the core elements of merging the organisations will be taking the best clinical practices from each Trust and developing services based on experiences and tested interventions, with the expectation that patient outcomes are prioritised.
183. Our Clinical strategy will address how we will realise the benefits we have identified.

#### Timeline for implementation of clinical and service strategy

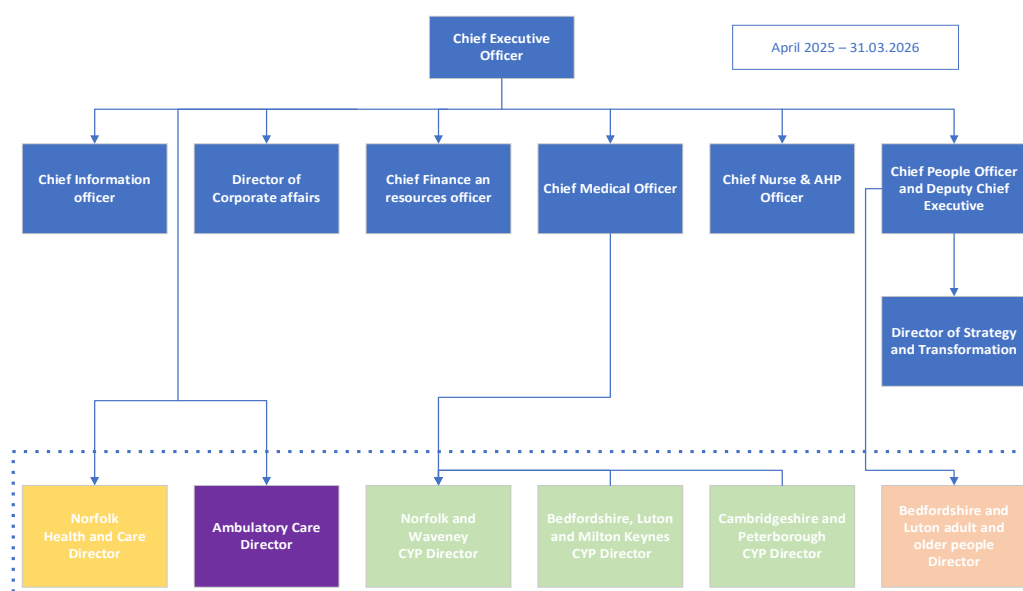
184. We will use a prioritisation tool (based on the aims of our clinical strategy) to help us identify the order in which we take forward our proposed programmes of work and begin to implement this approach from the beginning of the Group model. Our Post Transaction Integration Plan (PTIP), will also set out the detail of our approach to implementing the clinical strategy and proposed timelines for when we receive approval to proceed with the full merger.

## 4.7.2 Operating model

185. We are continuing to develop the merged Trust's operating model and associated management arrangements which will largely be implemented pre-transaction under the Group model – these arrangements will support the delivery of the clinical strategy. The operating environment and context are important considerations when thinking about the operating model for the merged Trust. We recognise that there is no ideal solution and we are establishing structures and ways of working that best support the delivery of our strategic objectives and the clinical strategy. In particular, the following issues will need to be considered:

- The merged Trust will offer a wide scope of service provision, operating from multiple sites and in peoples' homes. These services and sites will vary significantly in scale and size.
- Geographically, the Trust will cover a population of c.3.5 million residents spread over an area in excess of 14,100 square kilometres, with a mix of rural and urban areas and demographic profiles.

186. Our Group management structure is summarised in Figure 10 below:



**Figure 10: Group Management Structure**

187. We have agreed the following high-level principles which have been used to inform the operating model and associated structures for the merged Trust. The operating model will:

- Enable the ambitions set out in the Trust vision, strategic objectives, and the clinical strategy to be realised. This includes a population-centric approach, supporting physical and mental health and social care needs.
- Support colleagues to thrive in their roles in a culture that is open and inclusive, whilst embracing and celebrating the individual identities of different services and teams.
- Structure our care delivery around neighbourhoods and localities for the delivery of health and social care to the population and that more specialist services will be managed at a level that makes most sense in terms of scale, efficiency, and sustainability.
- Develop clear ways of joint working with other local partners, including acute care, primary care, social care and the voluntary sector in a way that supports population health management and the integration of care.
- Integrate services and staff across multiple organisation in a way that makes most sense to the people we serve, and do so in a way that is streamlined, consistent and efficient without unnecessary duplication.
- Allow for flexibility to recognise the breadth and scope of the service portfolio and the range of care settings, whilst ensuring equity of access for patients, carers, and families.

- Be underpinned by a data and analytics driven approach to service planning, population health management and great clinical care.

188. In the coming months, we will develop these principles further and consider options for the operating model with input from colleagues and learning from other models, both in the UK and internationally.

#### 4.7.3 Our People strategy and Cultural development

189. Our approach to People is critical to the success of the proposed merger, the successful implementation of our Clinical and Service strategy and consequently the realisation of the benefits we have identified that a new enlarged community Trust can achieve.

190. Our People strategy will support the delivery of the Clinical and Service strategy. The latter will be ambitious and wide-ranging, and we need highly engaged clinical and care teams to drive through the level of change needed. We will need the appropriate mix of highly motivated, skilled, diverse and compassionate colleagues. They will also need a clear understanding of our clinical and service strategy, and the autonomy to work collaboratively, creatively and innovatively in support of that strategy. Our People strategy will set out our plans to ensure the climate our colleagues are working in promotes this way of working.

191. There are varying cultures within NCHC and CCS largely because of the breadth of services and sites that the two Trusts operate. We want to retain local identities whilst harmonising and developing a new shared culture, one that builds on the best from both organisations. We are committed to creating an environment where all our colleagues feel they belong, have autonomy and can innovate and flourish.

192. Our People strategy will also be designed to address the challenges that we face and realise the benefits that are set out in the sections below.

193. We will use the principles In Figure 11 below to inform the development and delivery of the People strategy:



**Figure 11: Principles that will inform our People Strategy**

### Current challenges

194. In common with most NHS organisations both Trusts currently have difficulty recruiting to some posts, particularly in specialist services or harder to reach geographical areas.
195. The relatively small size of some of the Trusts' services means they are less resilient, and our career pathways and learning opportunities can be more limited than those offered by larger trusts.
196. In addition to the above, we recognise that there will be challenges associated with creating a new Trust, these include the effect of:
- **Different organisational cultures** – different leadership styles, values and ways of working which may lead to resistance to change
  - **Low staff morale and uncertainty** – concerns about job losses, changes in roles, new working practices can create anxiety
  - **Communication barriers** – inconsistent or unclear communication about the future changes can fuel misinformation and disengagement
  - **Resistance to change** – long standing employees may be reluctant to adopt new systems, policies and procedures
  - **Inequalities and legacy issues** – differences between organisations could lead some staff to feel undermined or unfairly treated.
197. Our People strategy will set out how we will mitigate against these challenges.

### Benefits of merger

198. The proposed merger will enable us to develop and implement a joint People strategy that will enable us to attract and retain good, high calibre and diverse applicants. It will also improve our resilience and enhance our expertise as a larger employer.
199. The proposed merger will also benefit our Equality, Diversity, and Inclusion agenda by enabling us to bring together initiatives of good practice in each Trust. This will help our work to ensure all colleagues are free from discrimination, feel equally supported in achieving their career aspirations and have a high level of job satisfaction. It will also help us progress our objectives for attracting, developing, and retaining a diverse workforce by offering new and more flexible career opportunities.
200. As a larger and more diverse organisation we will be able to offer a more attractive and rewarding offer to existing and potential colleagues due to greater career and training opportunities across our county-wide community nursing and specialist services. This will be supported by the use of flexible/rotational roles and support to colleagues to work to the full extent of their capabilities.
201. We will develop a joint recruitment process for colleagues who join the merged Trust with the increased size giving opportunities for:
- Enhanced colleague training and opportunities to share skills.
  - Broader and more vibrant colleague networks.
  - Wider research opportunities resulting from the focus on population health, broader range of services and the higher volume of patients served by the enlarged Trust.
202. Our People strategy will address how we will realise the benefits we have identified.

### Next steps

203. As the People Strategy needs to be shaped and informed by the Clinical and Service Strategy, we will be developing the joint People Strategy alongside its development, so that we can ensure that we have the workforce to successfully deliver the clinical and service strategy.

204. We will also develop our full joint people strategy by drawing on data about our strengths and areas for development from sources such as the latest staff survey results and our People Key Performance Indicators (KPIs). We will bring together our senior People teams so they can talk about the work they are proud of, discuss the risks and challenges. We will exchange detail about our ways of working and HR systems. This work will help us shape our strategy and identify our longer-term priorities.
205. We will engage with our colleagues across both Trusts to understand their perspective and link with our systems as we develop our strategy. We will ensure the objectives of the national and regional People Plans are woven through our strategy. We will adopt a phased approach to ensure good engagement and regard for colleagues as we go through this change and start to shape our future.
206. Our joint People strategy will set out how we will deliver HR, recruitment, education, and training services across the merged organisation. It will also set out the new and innovative career pathways and roles we will offer and how we will support agile and flexible ways of working.
207. Our joint People Strategy will also set out our approach to Organisational Development (OD) and our work to engender the decentralised operating model that will be required if our clinical and service strategy is to take root.
208. However, we know that it is essential that we support our colleagues as we move through the transaction process and as we to start to shape the future of the new Trust. We will therefore adopt a phased approach to developing and implementing our People strategy and plans. Our initial priorities as we move from SBC to FBC will be to:
- Continue our engagement activities which will communicate and keep people informed, involve colleagues in the vision of the future and their role in delivering it.
  - Understand individual Trust cultures and design interventions which will help us develop a shared culture reflecting the strengths of both Trusts, which includes developing shared values, behaviours, ways of working, principles and expectations.
  - OD Support to enable the structural changes associated with our move to a Group model; changes that have been made at Service and Leadership levels.
  - Produce individual Trust improvement plans in response to the 2024 Staff survey results and identify at least one improvement action that we will implement across the Group.
  - Design and put in place a Leadership development programme across the Group that supports new managers, middle and senior managers, and promotes the development of collective and compassionate leadership style.

#### 4.7.4 Digital

209. The success of the proposed merger and delivery of the expected benefits depends in large measure on getting digital and data integration right.
210. We have recruited a new Chief Information Officer (CIO) for the Group model to drive bringing together the two Trusts' Digital teams to enable us to improve the use of digital technology and data across the merged Trust and the wider system. We will connect health and social care providers, improve outcomes and put people at the heart of their own care.
211. Digital development and integration are fundamental to the delivery of our clinical strategy and operating model. Our 'digital first' approach will enable us to drive improved quality of care, safety, and financial efficiency across clinical and corporate services. Each of our clinical aims will be supported by digital processes and technology, including patient support and information, appointment bookings, remote monitoring of long-term conditions, virtual clinic appointments and the operation of virtual wards. Implementation of our digital strategy will support the transformation of our services and the way we deliver care in our estate.

### Current challenges

212. A mix of digital systems are currently in operation at the two Trusts, together with different approaches to the delivery of service support (e.g. service desk delivery). The new CIO will lead the integration strategy to identify across both Trusts the best systems and equipment and drive standardisation and efficiency.
213. Our current capability to generate actionable population health data, both within the Trusts and across the ICBs is still developing. Our digital teams are stretched due to ever increasing legal requirements, the drive to modernise, and central requirements for information e.g. relating to the pandemic response. In addition, the digital capability and readiness for digitally-driven change of our front line colleagues is mixed, and is low in some cases.

### Benefits of merger

214. Combining our two digital teams means we would be able to draw on the strengths of each Trust and create a larger pool of IT resource to be deployed flexibly across the new Trust. CCS's digital team has a track record in app development and process automation. NCHC is a leading provider of digital services and support to its ICS partners.
215. Merger would enable us to strip out duplication in reporting and system maintenance and redirect the freed-up resource elsewhere. Merger would also facilitate more cost effective procurement due to the greater purchasing power of the combined Trust.
216. As a single legal entity, information sharing issues would fall away making it easier to share data which supports patient safety and promotes efficient operation.
217. Delivering a 'digital first' agenda across our service provision provides opportunities to manage the way we work across the county, building on the opportunities for remote working and new ways of working embedded since the pandemic drove digital change.

### Enabling the clinical strategy

218. There are a number of ways in which the digital agenda will support the implementation of our clinical strategy. These include:
  - **Population health:** The ability to gather, store and share clinically valid population health management data, supported by data analytics, to support the targeting of resources to reduce health inequalities and enable people to stay healthier.
  - **Integrated, personalised care:** A shared health and care record to support integrated care. Optimising the patient pathway and putting individuals in control of their healthcare is key to delivery and patient access to records. The provision of options for accessing healthcare including remote consultations, remote assessment, provision of information to support individuals in their care.
  - **Valuing people's time:** Using artificial intelligence will enable quicker and more reliable diagnosis to improve patient safety and reduce waits. Single sign-on for colleagues to access electronic records.
  - **Supporting self-management:** Enabling patients to have easy access to their health and care information and input their own data to their health records or link to their own devices. This would give greater depth of information, enable new ways to support patients alongside face-to-face consultations, and improve patient experience.
  - **Efficiency:** Deploying new solutions e.g. enhancing Patient Initiated Follow Up (PIFU) self-serve booking systems to increase responsiveness and control for patients in booking their appointments and reduce administration costs and errors.

- **Continuous improvement and innovation:** Using business analytics and intelligence to support the continuous improvement of our services, via clear and consistent measurement in line with national best practice, led by the GIRFT and the emerging community Model Hospital approaches.

### Next steps

219. As a group we will fuse and refine into a joint digital strategy. This will be informed by national and international best practice, benchmarking, SWOT analysis of our teams and services, estimated costs and benefits, and options for service models and staffing models. As the digital strategy progresses there will be continued focus on co-production and patient engagement regarding digital solutions and the use of patient data. This will be allied to an ongoing programme of colleague engagement and training.
220. We will also conduct a detailed audit of our combined digital workforce by band and function and catalogue all our digital systems and relevant budgets. We will review the digital maturity of each Trust and agree the standard practices to be adopted across the new merged team.
221. Development of our joint Digital strategy will be clinically-led and support the connected healthcare model, which uses digital technology to help patients play an active role in supporting their own health. Our joint Digital strategy is likely to include the following:
- Increasing our capacity to generate population health management data to support informed decision-making.
  - Developing our automation capability to support operational and clinical processes.
  - Investing in the development of digital skills across the merged Trust, including the training and up-skilling of staff in using digital tools, and raising colleagues' digital confidence in day-to-day work activities
  - Ensuring the inter-operability of our systems using national open standards to enable a single view of the patient
  - Investing in artificial intelligence to support quicker, more reliable clinical diagnosis
  - Continuing the drive to digital solutions to realise efficiencies, including automated self-service processes
  - Rolling out processes which enable patients to share personally collected health data
  - Joint procurement of digital system replacements.
  - Closer working with transformation and clinical teams to understand their services' data and improve the merged Trust's benchmarked performance.

### 4.7.5 Estates and facilities

222. We will use the combined estates of the merged Trust to aid the delivery of our clinical strategy by facilitating the provision of safe, effective, high quality clinical care, support wider work to prevent ill health, and enable care closer to the patient or service user's home. We are developing our estates and digital strategies in close conjunction, because the way we use digital to deliver care now and, in the future, has a strong influence on our estates requirements. The estate and environment in which we provide our services are much more than a place to house our services. The provision of therapeutic environments which are easily accessible and have access to outdoor space, is core to our clinical strategy and there is good evidence of their role in accelerating and supporting recovery.

### Challenges

223. The programme for bringing the two Estates service teams together does face some considerable challenges, but can be set within the following broad themes:
- a. **Workforce** – NCHC teams are more robustly resourced and have a clear structure that helps provide focus on the breadth and depth of fulfilling Trust Estates obligations. CCS workforce have been reduced through attrition for a number of years, leaving capacity and capability challenges that can be supported by earlier alignment of form and function to support integrating estates processes.

Both teams are carrying establishment vacancy which may offer some efficiency as alignment and scope of responsibility is brought together (ironing out duplications). Attention needs to be given to capacity for key roles and sufficient attention to resourcing this is required. Workforce capability will need to be supported by strong programmes for orientation of knowledge to the geography and nuance of each others' estate and service arrangements. A skills audit will be needed to help identify areas for development and any over provision.

- b. **Service Contracts** – development of major service contracts will require implementing new service strategies that account for inherited or bridging delivery arrangements. This should lead to efficiency and standardised approaches over time. There is commercial opportunity in ensuring early alignment of decision making, ensuring neither Trust sets arrangements in place that inhibit flexibility in adopting improved service arrangements across the group. Management of service contracts could improve to delineate between major and minor contracts, deploying strategic and operational contract management more effectively. The CCS model provides good practice to focus on commercial aspects of contract performance, releasing energy to allow SME voices to interact with the operational delivery and focus on quality aspects. Assimilating existing contractors to the wider estate and any changes to the service contract scopes will be a challenge but can be managed through the contracting process.
- c. **Accommodation management** – each Trust manages its estate differently, but there are comparable in day-to-day site management which align. Use of booking systems have assisted NCHC establish a stronger culture around accommodation management, leading to more flexibility in managing allocation of spaces to Trust activities. This area also covers the notion of how each Trusts estate can be used to open up opportunities to further support service delivery.
- d. **Capital funding alignment** – navigating the application of funding coming from separate ICS systems means we need to ensure strong separation of projects and their delivery until each Trust is bedded into one host system and capital funding is consolidated from one source.

### Current capital programmes

224. Each Trust manages its own investment pipeline. For a range of reasons, each programme is at different stages of maturity in its formation and delivery. The following information provides overview of the key areas driving investment decisions.
  - a. **Asset Surveys** are used in the NHS to establish building condition, suitability, and a few other elements of estate information.. NCHC has up to date condition surveys from 2023. CCS have limited information from 2018/19, with some detail from a recent test exercise on one site. CCS have an asset verification exercise defined and procured to be completed during 2025-26. Asset condition drives and informs investment in life cycle replacement and reactive maintenance processes.
  - b. **Decarbonisation Investment** is a subset of asset condition, based upon elements that generate renewable energy, insulation of buildings and improvement to flexible management of buildings (sub meters and building management systems). NCHC have used 2023 survey data to drive and secure funding for LED lighting replacement, submetering and have applications pending for investment in renewable forms of energy. CCS successfully secured large investment in 2024-25 to invest in their freehold estate. Both programmes remain focussed on brining forwards project ready investment to match to funding opportunities.
  - c. **Critical Infrastructure risk (CIR)** is drawn from the significant and high risk categories of backlog maintenance data. Its reduction always has both Trusts' highest priority because it poses the highest risk to our clinical services. Its valuation is not always accurate because it is drawn from asset data surveys which age over time. Maintaining accuracy is done through inflationary measures that are not always applied. In 2025-26, NHSE have released national funding to tackle CIR investment – both Trusts are submitting programmes to invest through this additional funding opportunity.

- d. **New build investment** is limited across the Trusts. Our focus on estate efficiency now includes programmes that may require new builds to replace aged buildings. Funding opportunities remain unclear and the positioning of these in ICS capital priorities remains a challenge the Group will need to face on an ongoing basis.

### Benefits of merger

225. Coming together would mean we can make the most of each other's expertise, capacity, and resources, by leveraging our synergy to standardise processes and deliver efficiency.
226. We will develop a Trust wide capital strategy and strategic portfolio of works which would strengthen the merged Trust's delivering efficiencies of co-location of services and colleagues where appropriate. It will also allow the prioritisation of our investment to complement and enable Trust and system service strategies – allowing the biggest impacts in estate condition and estate efficiency to be delivered.
227. We will standardise high priority investment programmes and run single procurements which will yield savings. Likewise, a combined facilities management team would also benefit from greater buying power.
228. Combining the talents of our two estates and facilities management teams will create a bigger critical mass of estates and facilities expertise, support the sharing of best practice, and bring greater capacity and resilience to work flexibly across the new Trust. Merger offers the opportunity to rationalise and align teams to reduce travel time across the geography and ensure efficient use of resources.
229. Combined teams would also offer improved career and development opportunities for individuals, thereby improving recruitment and retention, and strengthen team succession planning. A combined facilities management would also have greater capacity to respond in the event of a major incident or site issue.
230. Both Trusts currently have significant outsourced workforce managed through Hard and Soft Fm contracts - mostly in cleaning and maintenance roles. Bringing these service contracts together will support the standardisation of processes and contract management and provide opportunities for cost reduction.

### Enabling the clinical and Service strategy

231. Our estates are a key enabler to the delivery of our clinical strategy. Merger offers the opportunity to broaden our use of the existing properties across the geography within the two Trusts' combined portfolio and direct them in the service of the clinical strategy.
232. We are committed to ensuring our estates work for the people that use them and help deliver our clinical strategy. Our estates will be safe, well-maintained, effective, and welcoming, and support our aim to value all people alike. They will also reflect our design aspirations. We have already agreed some principles which will underpin our joint Estates Strategy where our estates will:
- Work for the people that use them
  - Help to deliver our clinical strategy
  - Be safe, well maintained, effective and welcoming
  - Support our aim to value all people alike
233. We will deliver these principles by ensuring that the health estate:
- meets the objectives of the clinical strategy through promoting safe, effective, high quality care delivered in the most appropriate setting and through enhancing health and wellbeing.
  - promotes colleague wellbeing and productivity

- is fully and effectively utilised and reducing estate where it is not required or not cost effective to maintain
- is fit for purpose
- is delivered at the best value to maximise financial savings

234. It is essential that our services are environmentally sustainable, and we aim to be a carbon neutral Trust by 2040 . We will focus on the design and operation of our facilities over the next ten years to meet this target, as well as our interim aim to reduce our carbon footprint by 80 per cent by 2032.

235. The role of digital in helping us reduce our carbon footprint and estates requirements will be a core element of the estates and clinical strategies. For example, the impact of remote working on commuting and on-site office space requirements, the potential to coalesce office space into hubs on both sites, and the role of virtual clinics all have the potential to decrease non-clinical space needs and travel associated with healthcare. How an increase in digital models of care delivery and remote working impacts our carbon footprint will be closely monitored and accounted for.

#### Supporting social and economic development

236. Improved estates (and closely associated investment in digitally-enabled care) will help drive improved patient care and experience, less time spent in healthcare and improved quality of life. This in turn frees people to have more productive social and work lives, thereby contributing to the broader social and economic development of the county.

237. The development of a joint sustainability plan will support the delivery of the net zero carbon target by 2040 and ensure we are at the forefront of delivering environment sustainability within the geographies we serve.

#### Next steps

238. We are now proceeding to develop a joint estates strategy that is based on two key foundations: our agreed clinical strategy, and our shared understanding of future demand. Our joint estates strategy will include capital pipeline development which reflects the capital programme over the next 5 years, including the maintenance programme, and will ensure that funding is directed where in the county it is needed most. We will also agree the operating model for estates delivery, facilities management, and capital development across the merged Trust.

#### 4.7.6 Governance

239. Both Trusts are already rated Outstanding by the CQC and have a strong Governance structures and ethos. From 1 April 2025 the two Trusts will be operating under a 'Group Board', the start of the journey to prepare for merger.

#### Benefits of merger

240. Bringing the two Trusts' integrated governance functions together will offer greater assurance over the safety and quality of care of patients and colleagues across the county. A single risk register will help us set the goals of the merged Trust and ensure investment decisions are informed by knowledge of where risk lies across all our services. As a combined governance team we will be able to make better use of intelligence, learning and best practice to drive improvements in care.

241. We will be able to provide improved specialist advice, information, education and understanding of governance to our colleagues. We will also be able to support teams and services to develop better and more joined up systems of governance right along patient pathways. Merger will also reduce costs (by removing duplicate reporting) and increase the resilience of the combined governance team.

### Next steps

242. Our organisational strategy will set out the shared vision and strategic objectives of the merged Trust and we will use this as the framework for the integrated governance of the merged trust. Under our Group Model we will merge our Board Assurance Frameworks (BAF) into a single approach to focus Board and Sub-Committee attention on achievement of our agreed objectives. The BAF will be supported by Key Performance Indicators to assure improvement and/or flag risks to achievement.
243. We will align our processes used to identify, report, and manage clinical and non-clinical risks so that we can ensure a consistency of understanding and reporting of risk across all our clinical services and central functions. The risk register for the merged Trust will be reviewed on a bi-monthly basis at the key operational committees and by the Group Board, with the overall process for risk management being overseen by the Audit Committee.
244. The Group Board will develop a single framework of governance assurance reporting, representing the full scope of compliance requirements across all services, including clinical governance, information governance and health and safety, aligned to the delivery of the agreed strategic objectives and legal and regulatory requirements. We will develop a single process for learning from incidents and other events to ensure shared learning across the merged Trust.
245. Quality Governance will be a key element of the overall governance arrangements of the merged Trust. The Board will have oversight of quality through the bi-monthly Quality Committee and Service Assurance Committees.

### 4.7.7 Improvement and transformation

246. Both Trusts are committed to continuous improvement and have existing Quality Improvement, service improvement and programme management models and teams delivering change and efficiencies.

#### Benefits of merger

247. Merger will enable us to pool our improvement and transformation resource and use it flexibly to address system priorities. Shared resources will allow us to develop better relationships and awareness by team members working across locations. Crucially, blending the teams will support us to guide teams to seek collaborative solutions that make the best overall use of resources rather than focussing on traditional siloed solutions.
248. Merger will make it easier to combine our two Improvement teams to work across all of our geographies and services. In turn, this enables us to:
- Bring together the improvement and transformation strategies and priorities into a single system-wide approach.
  - Drive cultural change by supporting teams to own and implement change within their teams and services.
  - Drive collaborative, system-level solutions to problems that make best overall use of resources
  - Make more efficient use of the specialist expertise of our Improvement, Transformation, and programme management colleagues, and create a more resilient Improvement team.
  - Implement a single evidence-based approach to improvement, using a single suite of tools, templates and reports and a single set of project management and Quality Improvement training programmes.
  - Streamline our governance and reporting processes to enable visibility, coordination, and the tracking of benefits against system priorities
  - Deliver system-wide changes more quickly and at greater scale.

### Next steps

249. The next steps in the integration of our Improvement teams are:

- deploy Verto (the PMO tool currently) across the NCHC improvement teams. This will allow a single view of all programmes and projects, assessment of benefits, timelines, and dependencies
- deploy Improvement team resources to support the clinical and operational strategies including benefit realisation
- develop a new improvement model to support the integration of the two Improvement teams at NCHC and CCS into a single team, working to a single improvement agenda.

### Approach to benefits realisation

250. We are applying our Benefits Realisation Management (BRM) approach to the transaction itself and to all integration projects, clinical and in support services.

251. As described above, the combined Improvement Team will operate across the merged Trust and will support project teams to use BRM to identify and measure the realisation of integration benefits and ensure projects are consistently managed and reported on.

252. A summary of our approach to benefits management, as presented to the Programme Board, is attached as Enclosure 9.

## 4.8 Stakeholder Communications and Engagement

253. Our ability to deliver the planned benefits of merger depends on each of our clinical and corporate integration projects delivering their specified benefits. This requires close working with colleagues at all levels, and for clinical projects we will need strong clinical engagement. As part of the development and implementation of the Group model and preparation and planning for the merger we have already begun this engagement with colleagues and stakeholders.

254. We have a communications and engagement plan to support the merger and our communication aims are to:

- Provide regular communications about the work that the Trusts are doing jointly, helping to create an environment of one team working together.
- Support the proposed merger between our two organisations with communications and appropriate engagement to each stage of the process.
- Communicate, inform, and engage appropriately on the joint work of the two Trusts and our route to merger to our wider system partners.
- Communicate, inform, and engage appropriately about what a merger means for us.

255. Successful delivery of the plan will mean that:

- Colleagues at both Trusts, our stakeholders, patients, partners, and the public receive regular, open, and timely communications about the joint work that we are undertaking that describes:
  - The reasons for the merger with specific focus on the benefits to patients, carers, and communities.
  - What the changes will mean for colleagues, patients, and services.
  - Developments and our progress to create a new organisation.
  - How the new Trust is building the best from both legacy Trusts, and decisions are made in the interests of continuing excellent patient care.
- Communications supports the engagement activity that is taking place regarding the merger of the two Trusts.

- Colleagues at both Trusts are provided with opportunities and mechanisms to input into the planned merger of the Trusts and creation of a new organisation, and to feedback on our communications.

256. Underpinning our plan development are a number of key principles:

- Visible, joint leadership through communications and engagement
- Consistency of narrative and synchronicity of delivery across both Trusts
- Colleagues at the heart of the new organisation we want to create, receiving information first and having a voice in the creation of the new organisation
- Patient/service user benefit of change articulated in all communications and engagement activity.

257. The communications and engagement plan will include a comprehensive stakeholder map to ensure that we communicate and engage effectively and consistently with all stakeholders in line with our communications principles in order to achieve our aims and objectives.

258. Where required, tailored communications will be created. We have identified the stakeholder audiences in Table 15 below:

Stakeholder audiences	
Audience	Activity
<p><b>Key partners, groups and organisations:</b></p> <p>ICB contacts and colleagues, Primary Care colleagues, GPs, Pharmacies, health and wellbeing boards, PCNs</p>	<p>Keep audience informed and reassured. In addition to the regular Group stakeholder update briefing that will be sent out, specifically:</p> <ul style="list-style-type: none"> <li>• Engagement via medical director colleagues in both Trusts</li> <li>• Content for ICB newsletter to Primary Care colleagues and GP bulletin contributions</li> <li>• Proposed marketing and engagement programme aligned to development of clinical strategy</li> <li>• Contribute content to local Pharmacy Committee bulletins</li> <li>• Communications and engagement with ICS chief executives</li> <li>• Via working relationships with ICB colleagues</li> <li>• Via ICB's internal communications channels</li> <li>• Updates for PCN board meetings</li> </ul>
<p><b>Other NHS providers/providers of NHS services:</b></p> <p>All NHS Trusts in our working areas, East of England Ambulance Trust, NHS111 providers, ECCH</p>	<p>Keep audience informed. In addition to the regular Group stakeholder update briefing that will be sent out, specifically:</p> <ul style="list-style-type: none"> <li>• Tailored written, phone and face to face contact as needed and in line with communications and engagement programme.</li> <li>• Submit content for communications channels where relevant to colleagues at these organisations</li> </ul>
<p><b>Local council partners:</b></p> <p>Norfolk County Council adult services, Cambridgeshire County Council (CCC) children's services, Peterborough City Council (PCC) children's services, Cambridgeshire County Council public health, Peterborough City Council public health, All four unitary Councils (children, adult and public health functions in BLMK)</p>	<p>Keep audience informed and reassured. In addition to the regular Group stakeholder update briefing that will be sent out, specifically:</p> <ul style="list-style-type: none"> <li>• Bespoke contact as needed and in line with communications and engagement programme.</li> <li>• Submit content for communications channels where relevant to colleagues at these organisations</li> </ul>

Audience	Activity
<p><b>MPs:</b></p> <p><b>Bedfordshire</b>            Bedford: Mohammad Yasin            Hitchin, Alistair Strathern            Mid Bedfordshire: Blake Stephenson            North Bedfordshire: Richard Fuller            Dunstable and Leighton Buzzard: Alex Mayer            Luton North: Sarah Owen            Luton South and South Bedfordshire: Rachel Hopkins</p> <p><b>Milton Keynes</b>            MK North: Chris Curtis            MK Central: Emily Darlington            Buckingham and Bletchley: Callum Anderson</p> <p><b>Suffolk</b>            Bury St Edmunds and Stowmarket: Peter Prinsley            Central Suffolk and North Ipswich: Patrick Spencer            Ipswich: Jack Abbott            Lowestoft: Jess Asato            South Suffolk: James Cartlidge            Suffolk Coastal: Jenny Riddell-Carpenter            Waveney Valley: Adrian Ramsay            West Suffolk: Nick Timothy</p>	<p>Keep audience informed and reassured. In addition to the regular Group stakeholder update briefing that will be sent out, specifically:</p> <ul style="list-style-type: none"> <li>• Written, phone and face to face contact as needed and in line with communications and engagement programme.</li> <li>• Open invitation to meet and discuss further</li> </ul>
<p><b>Patient advocacy groups:</b></p> <p>Norfolk,            Cambridgeshire and Peterborough,            Bedfordshire, Luton and Milton Keynes and ,            Suffolk Healthwatch's',            Parent Carer Forums, Family Voice</p>	<p>In addition to the regular Group stakeholder update briefing that will be sent out, specifically:</p> <ul style="list-style-type: none"> <li>• Written, phone and face to face contact as needed and in line with communications and engagement programme</li> <li>• Via The Voice newsletter</li> </ul>
<p><b>Staff representative/advocacy groups:</b></p> <p>Staff Side            Trade Unions</p>	<p>Keep audience informed and reassured, specifically:</p> <ul style="list-style-type: none"> <li>• Updates provided at NCH&amp;C Staff Management Council</li> <li>• Updates provided at CCS union meeting</li> </ul>

**Table 15: Stakeholder Audiences**

259. The stakeholder map will include joint stakeholders and those held individually by each Trust and communications messages and engagement will be mapped to each audience, ensuring that we maintain regular communications with them and engage appropriately. This stakeholder map will be jointly held and managed.
260. Overarching messages will be developed and tailored according to key milestones as the merger programme progresses and will be tailored as appropriate for each stakeholder group. They will set out:
- Why our two organisations are merging and both the national and local context.
  - What the merger will mean for patients and carers.
  - What the merger will mean for colleagues.

- What it means for our partners (primary care, local authority, acute sector, voluntary sector).
- What kind of organisation we want to create, incorporating what we want to achieve as one organisation and how it will be structured and managed
- The route to merger and milestones.

261. We will use a range of methods of communication such as:

- Written briefings and updates.
- Stakeholder letters and meetings.
- Stories and articles that bring to life how our merger could benefit our stakeholders.
- Blogs in a variety of media to enable engagement from a varied audience
- Social media activity.
- Video and podcasts.
- News releases and media work.
- Webinars.

262. We will work through both Trusts' communications channels to reach our internal stakeholders and set up new joint channels of communication where we identify these are needed.

263. Internal channels are at Table 16 below:

Internal channels – NCHC	
Tool	Action
<b>Weekly Messages</b>	Share regular updates as a drip feed approach
<b>The Loop</b>	Share regular updates, a place for people to refer back to and learn more
<b>Huddle</b>	Ensuring managers and leaders understand and are engaged with the key messages and benefits and are able to disseminate effectively and also have supportive and positive conversations with their teams
<b>TMT</b>	Ensuring leadership understands the benefits and aims and are engaged with the milestones
<b>Staff engagement sessions</b>	Online and in person sessions with the exec aimed at answering questions and building engagement with it
<b>Desktop background</b>	Raise awareness and drive audience to different channels for more information
<b>Posters</b>	Share important updates, drive audience to different channels for more information
<b>All staff emails</b>	For trust wide announcements that need ownership of the CEO and/or the Chair
<b>Ask the CEO</b>	Responding the staff questions, proving we are open and transparent and building engagement opportunities with the Exec
<b>The Handover – Trust podcast</b>	Build emotional connection and encourage conversation with staff
<b>MyNCH&amp;C</b>	Easy access for frontline staff to regular updates
<b>Social media</b>	Share regular updates to show transparency and build external reputation
Internal channels - CCS	
Tool	Action
<b>Communications Cascade</b>	Share regular updates as a drip feed approach
<b>Service newsletters</b>	Share regular updates as a drip feed approach
<b>The intranet</b>	Share regular updates, a place for people to refer back to and learn more
<b>Huddle</b>	Ensuring managers and leaders understand and are engaged with the key messages and benefits and are able to disseminate effectively and also have supportive and positive conversations with their teams
<b>Wider Executive Team</b>	Ensuring leadership understands the benefits and aims, and are engaged with the milestones
<b>Leadership Forum</b>	Ensuring leadership understands the benefits and aims, and are engaged with the milestones
<b>Staff side</b>	Ensuring union representatives understand the benefits and aims and can express views on implementation

<b>Network champions</b>	Keeping networks engaged in the process and providing opportunities to explore how this impacts different groups
<b>Staff engagement sessions</b>	Online and in person sessions with the exec aimed at answering questions and building engagement with it
<b>Desktop background</b>	Raise awareness and drive audience to different channels for more information
<b>Posters</b>	Share important updates, drive audience to different channels for more information
<b>All staff emails</b>	For trust wide announcements that need ownership of the CEO and/or the Chair
<b>Exec Q&amp;A</b>	Responding the staff questions, proving we are open and transparent and building engagement opportunities with the Exec
<b>Social media</b>	Share regular updates to show transparency and build external reputation

**Table 16: NCHC and CCS Internal Communications Channels**

264. External channels are at Table 17 below:

<b>External channels – both NCH&amp;C and CCS</b>	
<b>Tool</b>	<b>Action</b>
<b>Trust websites</b>	Share regular news, updates and benefits to patients and stakeholders
<b>Careers websites</b>	Build awareness of why together, CCS and NCH&C is a great place to work
<b>Social media</b>	Share regular updates to show transparency and build external reputation and engagement
<b>Media relations</b>	Pitch positive news stories about the development to generate accurate and positive coverage. To be sent out as joint news story showing that we are already working in partnership
<b>CCS partner newsletters</b>	Share regular updates, raise awareness of benefits to local populations
<b>Stakeholders</b>	Regular joint update briefing to sent to all stakeholders giving latest news and developments and building reassurance of how merger will positively benefit stakeholders. Further communication and engagement as below
<b>The Voice – NCH&amp;C's Patient Experience Newsletter</b>	Share regular updates and how the project will benefit our patients and staff

**Table 17: External Communication Channels**

## 4.9 Legal Advice Received

265. During the development of this Strategic Case we have engaged Browne Jacobson to advise on how the Trusts could 'establish a group model of governance between the Trusts by April 2025 with a view to forming a single organisation by no earlier than April 2026'.

266. Their full report is attached as Enclosure 10.

267. Their advice is repeated, verbatim, as follows:

- *There is no statutory or policy prescribed form for an NHS hospitals group but generally NHS provider trusts may exercise statutory joint working and delegation powers to do so in compliance with NHS legislation and NHS England guidance*
- *We recommend the Trusts enter into a partnership agreement (PA) which sets out the governance for the group arrangements including the appointment of a joint committee as a group board*
- *We recommend the group board is constituted as a formal joint committee with delegated functions that are to be jointly exercised. The partnership agreement will prescribe terms of reference (ToR) for the group board setting out its membership and delegated authority to exercise joint functions*
- *We recommend the joint committee comprises all statutory (voting) directors of the Trusts. Therefore, we recommend that the Trusts seek to put in place shared leadership across both Trust*

boards. The pace and process for this will need to be determined by the Trusts

- *The partnership agreement will also set out the reserved functions, which are those functions that cannot be delegated to the group board or functions that the boards do not agree to delegate. These functions will either need to be retained by the individual Trust boards (e.g. signing off the annual accounts) or may be exercised through committee in common arrangements (e.g. audit committees).*

268. In addition, we are engaging Browne Jacobson to support with Due Diligence, and the areas for potential investigation included in the Programme Board submission (Enclosure 7 as described in section 4.2) were provided by them.

## Summary of Key Messages

The key messages from our summary of FBC Readiness are:

- Once we secure the necessary support and approvals from our Boards, stakeholders, and regulator, our intended 'go-live' date for the merger is 1 April 2026.
- As we progress to Full Business Case, we will carry out appropriately targeted Due Diligence, taking advice as to our approach and areas of concern from our legal advisors. We will continue to update our Due Diligence right up until the proposed merger receives final approval.
- The development of the FBC, PTIP and Patient Benefit cases will take place under a workstream structure.
- Programme governance structures are in place with involvement of executive and non-executive directors.
- The following strategies and implementation plans are in development:
  - Clinical care and support strategy
  - Operating model
  - Our people strategy and cultural development
  - Digital
  - Estates and facilities
  - Governance
  - Improvement and transformation
  -
- We have the projects and programmes that will deliver our clinical strategy and the 4 themes that we will focus on over the next 2-4 years will be:
  - Aligning all of Norfolk CYP services.
  - Developing transition services for CYP across all of our services.
  - Development of Urgent Care practices to include the development of the VW and Urgent Care Hub in Luton and the further development of the VW in Norfolk based on shared learning and expertise and best practice.
  - Development of Integrated Neighbourhood teams to provide care for our elderly frail patients. This will have a focus on wound care and pressure ulcer disease.
- Where appropriate we will bring together under single management structures those services that we deliver across geographies to enhance learning and service delivery. This is a programme of work which has already begun in Children's services and MSK.

## Summary of Key Messages - Continued

- We are continuing to develop the merged Trust's operating model and associated management arrangements which will largely be implemented pre-transaction under the Group model – these arrangements will support the delivery of the clinical strategy.
- Our approach to People is critical to the success of the proposed merger and will be designed to support the delivery of the Clinical strategy.
- We have recruited a new Chief Information Officer (CIO) for the Group model to drive bringing together the two Trusts' Digital teams to enable us to improve the use of digital technology and data across the merged Trust and the wider system.
- We will use the combined estates of the merged Trust to aid the delivery of our clinical strategy by facilitating the provision of safe, effective, high quality clinical care, support wider work to prevent ill health, and enable care closer to the patient or service user's home.
- Both Trusts are already rated Outstanding by the CQC and have a strong Governance structures and ethos. From 1 April 2025 the two Trusts will be operating under a 'Group Board', the start of the journey to prepare for merger.
- Both Trusts are committed to continuous improvement and have existing Quality Improvement, service improvement and programme management models and teams delivering change and efficiencies.
- We are developing a communications and engagement plan to support the merger and our communication aims are to:
  - Provide regular communications about the work that the Trusts are doing jointly, helping to create an environment of one team working together.
  - Support the proposed merger between our two organisations with communications and appropriate engagement to each stage of the process.
  - Communicate, inform, and engage appropriately on the joint work of the two Trusts and our route to merger to our wider system partners.
  - Communicate, inform, and engage appropriately about what a merger means for us
- We have received legal advice on how the Trusts could '*establish a group model of governance between the Trusts by April 2025 with a view to forming a single organisation by no earlier than April 2026*', and are acting accordingly

**Figures:****Page**

1	Trust comparison
2	Map of delivery locations
3	BLMK strategic priorities
4	Cambridge and Peterborough strategic priorities
5	Cambridge and Peterborough JFP strategic focus
6	Cambridge and Peterborough health utilisation model
7	Spectrum of collaboration
8	FBC development summary
9	Programme Structure
10	Group Management Structure
11	Principles that will inform our People Strategy

**Tables:**

1	CQC outstanding actions
2	Children's services
3	Adult services
4	Finance summary
5	CCS Trust collaboration scoring
6	NCHC Trust collaboration scoring
7	CCS structural options scoring
8	NCHC structural option scoring
9	Summary of key risks and mitigations
10	Key milestones in transaction delivery plan
11	Due Diligence Areas and Responsibilities
12	Merger Workstreams
13	Valuing patient and Colleague Time
14	Clinical Strategy development – 'Plan on a page'
15	Stakeholder audiences
16	NCHC and CCS internal communication channels
17	NCHC and CCS external communication channels

**Annex:**

A	CCS Performance dashboard
---	---------------------------

**Enclosures:**

1	NCHC Trust Performance Report (TPR)
2	CCS quality dashboard
3	NCHC Annual Report 2023-24
4	CCS Annual Accounts 31.3.24
5	CCS Board Paper – Future Collaboration 22 May 2024
6	NCHC Board Paper - Collaboration and Organisational Form 15 May 2024
7	CCS and NCH&C Group Model and Joint Working – Due Diligence Approach
8	Programme Board Terms of Reference
9	Benefits Realisation
10	Legal advice

