Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

# Liverpool Heart and Chest NHS Foundation Trust

Mutuals in Health Pathfinder Programme

Research Project Report

31 March 2015

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# 1 Executive Summary

## 1..1 Introduction

Liverpool Heart and Chest Hospital NHS Foundation Trust is one of nine NHS organisations taking part in the Mutuals in Health Pathfinder Programme, which is jointly sponsored by the Cabinet Office and the Department of Health. The programme was established to research new ways of empowering and engaging staff and to consider the associated potential costs, benefits and risks. As part of this, it would help the Trust to understand what mutualisation, which in this context means setting up an organisation so that the majority of it is owned by employees, could mean and to identify potential barriers to implementation.

## 1..2 Purpose of this report

This report sets out the findings and conclusions from the research work that has been undertaken since the beginning of January 2015. The outcomes from the research work have been used to inform a decision making process on how the Trust should progress work to better engage and empower staff.

A Steering Group has been established specifically for this project. This group has made a decision on its preferred option to improve staff engagement and has developed recommendations for the Trust, local health economy partners, regulators and the central government to consider. The Steering Group's decision and its recommendations are outlined in this report.

## 1..3 Background to the Trust

Liverpool Heart and Chest Hospital is a single site centre providing specialist services in cardiothoracic surgery, cardiology, respiratory medicine, including cystic fibrosis and diagnostic imaging in the hospital, and increasingly in a community setting. The Trust serves a population of 2.8 million people with a catchment area spanning Merseyside, Cheshire, North Wales and the Isle of Man with an increasing rate of national referrals for highly specialised services such as aortic surgery.

The Trust has a clear vision **'to be the best integrated cardiothoracic provider'** and its mission is to provide excellent, compassionate and safe care for every patient every day. It has been rated as the top performing hospital for overall patient care in the CQC's National Inpatient survey for 7 out of the last 8 years.

In order to respond to changing patient needs and ensure future sustainability of services the Trust recognises that it cannot be an island of excellence and must build stronger clinical and organisational relationships to deliver care in a more integrated way.

The Trust's strengths lie in its strong market share and presence, its proven track record of delivery, reputation for excellence and ability to attract and retain high calibre staff.

As a small, stand-alone provider with a narrow portfolio of services though the Trust is threatened by service reconfiguration, increased competition for services, a reduction in number of specialist places for doctors in training, tariff structural deficiencies and tight financial constraints. There are opportunities for growth through the ability to position LHCH as prime cardiac provider and network lead across Cheshire and Merseyside and to develop integrated pathways of care through enhanced partnership working with local Acute Hospitals, many of whom are experiencing difficulties in recruiting cardiologists and

delivering cardiac services that meet clinical standards. There are also opportunities for growth in community services and private patient market share which are being proactively pursued. The Board believe firmly that patient experience, clinical outcomes and research and treatment opportunities would be compromised if it were unable to retain its independence and build upon its reputation for excellence.

### 1..4 What are the key drivers for change?

Research shows that the way staff feel about their workplace has an impact on the quality of patient care, as well as on the efficiency and financial performance of an organisation. This was been driven home by the Boorman review on the importance of health and wellbeing in the NHS. Research also demonstrates a positive link between staff satisfaction and mortality rates, that higher staff satisfaction is linked to higher patient satisfaction, and that staff experience shapes patients' experience, rather than the other way around. The consequence is that organisations with a disengaged workforce are more likely to deliver care that falls short of acceptable standards.

Yet despite these studies, national NHS staff engagement – as measured by a score from the NHS staff survey, which takes account of measures including staff involvement and overall job satisfaction – fell for three consecutive years from 2009 before rising slightly in 2012. Only 55% of staff would recommend their organisation as a place to work. At Liverpool Heart and Chest Hospital NHS Foundation Trust, that figure is currently (69%) based on the 2014 Staff Survey results.

The Pathfinder Programme is part of a renewed effort to examine new ways to better engage and empower staff across the NHS, with Liverpool Heart and Chest Hospital NHS Foundation Trust viewing staff engagement as a key priority. The Trust wants to unleash the power of its staff to drive service improvements and innovations that transform care, including maximising the discretionary effort staff bring to caring for patients. This is why Liverpool Heart and Chest Hospital applied to take part in the Pathfinder Programme.

### 1..5 Short list of options that have been appraised

This project has focussed its research on a short list of four options which were as follows:

- Option 1 - Do nothing
- Option 2 - Improve staff engagement and empowerment as a FT
- Option 3 - Improve staff engagement and empowerment as a FT Plus which would require legislative changes
- Option 4 - Improve staff engagement and empowerment as a public service mutual, an employee owned organisation

After the research work was completed and the potential costs, benefits and risks of each option were identified, the Steering Group met to appraise each option against pre-agreed weighted evaluation criteria. The Steering Group awarded Option 3 the highest score and it was agreed that this should be the Trust's preferred option.

An outline of the discounted options and the reasons why are set in the table below.

| # | **Outline of discounted option** | **Main reasons for discounting option** |
|---|---|---|
| 1 | The "Do Nothing" option means that the Trust should not take any action as a result of the project. It was included to provide a benchmark for VFM (value for money) during the appraisal process. | This option was ranked fourth as it was evident that the other three options would provide better VFM. The strength of evidence that improved staff engagement leads to better patient outcomes means this is not a viable option. |
| 2 | The "Improve Staff Engagement and Empowerment as a FT" option means to implement a plan which seeks to dedicate more time, attention and resources to staff engagement. However, it means keeping the status quo in terms of legal form, i.e. remaining as a foundation trust. | This option was ranked second. The main reason this option lost to the preferred option was because the Steering Group felt that it would not enable growth and collaboration with public sector partners to the same extent as Option 3. The rationale for this was that the research had showed that current regulatory behaviour, e.g. top-down intervention, is encouraging risk adverse leadership behaviours and disempowering the Trust which consequently stifles innovation and collaboration which may improve the quality of care patients receive. |
| 4 | The "Public Service Mutual" option means to continue work to further explore the costs, benefits and risks associated with transferring all of the Trust's services into an employee owned organisation as a way of empowering staff so that they can have a greater say in the running of the organisation. | This option was ranked third. It was acknowledged that this option may in future be able to provide the greatest benefit both in terms of staff engagement and financial benefit but only if central government takes action to remove barriers to implementation, e.g. VAT. However, the option is currently viewed as the most risky option. The key risks identified were:<br>▪ Staff are currently very resistant to mutualisation so becoming a public service mutual may in fact defeat the objective that the Trust is trying to achieve especially in a region where staff could more easily switch employment in a competitive NHS job market.;<br>▪ Concerns over cost of and access to capital<br>▪ Requires the greatest initial investment of all four options and least certain financial return<br>▪ Significant and additional costs incurred relating to VAT and insurance which may fully offset any productivity gains made.<br>▪ Risk of insolvency if the new entity becomes financially distressed, i.e. no failure regime. |

## 1..6 Overview of preferred option and why

The Steering Group found that option 2 and option 3 came up very close on the scoring, indicating a clear preference for focus on staff engagement. However, by a marginal difference, the Sterring Group chose as its preferred option to improve staff engagement but also to seek legislative changes to the existing foundation trust model which could help to further empower staff. This option means to implement a plan which seeks to dedicate more time, attention and resources to staff engagement. It also means to remain as a foundation trust but to specifically seek changes to:

- legislation so that it could increase the number of staff governors within the Council of Governors so it could further empower staff; and
- the way regulators intervene with organisations to role model the types of leadership behaviours that help to engage and empower staff rather than disempower them.

This option scored highest during the options appraisal for the following key benefits:

- Improved staff engagement and empowerment
- It achieves the highest financial benefit (or Net Present Value) in the expected case scenario and least variability in financial return, i.e. least risky. There is an expected recurrent productivity gain of between £0.75m to £1.65m if staff engagement improves.
- Staff are least resistant to this option and are likely to support the Trust's intentions to engage and empower them better
- No uncertainty over the retention of the VAT refund on contracted out services
- Affordable cost of implementation

## 1..7 Outline of key barriers to implementation of a public sector mutual model

Six key barriers to implementation for a public service mutual were identified during the project. They are:

- Staff concerns about need for change
- Loss of VAT refund on contracted out services
- Cost of and access to capital
- VAT on assets
- Commissioner buy-in
- Indemnity against clinical negligence

The most significant barriers to implementation are felt to be staff resistance to change and the loss of the VAT refund on contracted out services.

Currently, the majority of staff at the Trust are strongly opposed to the idea of a public service mutual. This is the most significant non-financial barrier to implementation. Before a public service mutual could be established, management would need to overcome this resistance to change and gain the buy-in of the majority of staff.

To do this, management would need to develop and outline a strong and compelling case for doing so. In particular, management would need to highlight the benefits of creating a public service mutual for staff. It is unlikely that this could be achieved quickly and it would likely need a well-structured and sustained programme of staff engagement over a number of years.

The loss of VAT refund on contracted out services in the region of £1.5 million to £2 million per annum is the most significant financial barrier to implementation for a public service mutual.

To make a public service mutual financially attractive for a specialist acute provider such as Liverpool Heart & Chest Hospital NHS Foundation Trust, central government would need to agree to extend the VAT refund on contracted out services to a public service mutual.

With regards to the preferred option, there are two other barriers to implementation. These both relate to issues which would be dependent on changes which would need to be made by regulators and central government.

### 1..8 Outline of initial recommendations for the Trust

The proposed recommendation is:

- Given the strength of evidence which shows that there is a positive correlation between staff engagement and patient outcomes, the overarching recommendation from the options appraisal is that the Trust needs to dedicate greater time, attention and resources to considerably improve staff engagement. It is a subject that should demand regular discussion and reflection at all levels of the organisation, including the Trust Board. The Trust should seek to embed staff engagement into the culture of the organisation so that it is resilient to changes in the management team. In addition, the Trust could seek legislative and regulatory changes which would also help to empower staff to have a greater say in the running of the organisation.

### 1..9 Outline of initial recommendations for local health economy partners

The proposed recommendation is:

- As part of the Healthy Liverpool Programme, which is aiming to design a new health and social care system to transform the health in Liverpool, commissioners should work with local providers to consider where with the system the creation of public service mutuals could help to deliver improvement in the care that patients receive.

### 1..10 Outlines of initial recommendations for regulators

The proposed recommendations are:

- Regulators should review whether to change the way in which they regulate if they agree with the evidence that shows that improved staff engagement will help to improve the quality of care that patients receive. The Trust fully endorses the recommendation already made in the 2014 report *Improving NHS Care by Engaging Staff and Devolving Decision-Making: Report of the Review of Staff Engagement and Empowerment in the NHS* (Ham, 2014) which encourages regulators to role model the types of leadership behaviours that deliver better staff engagement.

### 1..11 Outline of initial recommendations for central government

*The proposed recommendations are:*

- HMRC and the Department of Health should review whether to extend the VAT refund on contracted out services to public service mutual that provide NHS care to remove this cost distortion and significant barrier to implementation.
- The Department of Health could with Monitor consider whether it would be possible to provide flexibility over the composition of the Council of Governors by removing the minimum requirement that public governors must be in the majority. This would allow organisations to increase the number of staff governors to increase their power and influence where it is felt it would help to improve staff engagement and empowerment.
- Whilst new sources of capital have been recently developed such as Big Society Capital which have helped to improve access to capital for public service mutuals, The Trust believes that further work is required to improve access to capital and financial support for public service mutuals that provide NHS care to remove this cost distortion.
- The Department of Health work with the NHS Litigation Authority to review whether to extend access to all schemes to public service mutuals that provide NHS care.
- The Cabinet Office should consider making publically available data which evidences the improvement made by existing public service mutuals that provide NHS care since they transferred out of the NHS on a range of metrics such as job satisfaction and productivity.

1..12 **What were the key challenges faced during the project and how were they overcome?**

The key challenges through this research that had to be overcome throughout this project are outlined in the table below.

| **Key challenges** | **Solutions** |
|---|---|
| Staff views, myths and perceptions | The Trust has engaged staff throughout the project and aimed to bust any myths that existed through staff communications. See Section 3 for more detail on the engagement work undertaken during this project. |
| Lack of data to financially appraise options involving other providers | The Trust had to focus on options that could be financially appraised within the deadline |
| Lack of comprehensive evidence base to support the improvements made by existing public service mutuals that provide NHS since they transferred out of the NHS on areas such as productivity gains, reduced staff turnover and lower absenteeism. | The Trust undertook sensitivity analysis to developed best and worst case scenarios to reflect that the evidence to support assumptions in some areas was mixed. |
| Completing the project within deadline | Clear scope and project plan in place from the start and regular project communication |

| | |
|---|---|
| Competing priorities for management's time | Steering Group established and strong project management to keep the project on track |

1..13 **Overview of next stage of planning and implementation**

The Trust will be working on the following plans to improve staff engagement:

- Further develop a highly visible, supportive and inclusive leadership style
- Improve staff involvement in developing strategic direction and service transformation
- Exploring increased employee representation
- Encourage regular feedback from employees
- Further develop governors, especially staff representatives, to effectively hold to account
- Use of non-financial recognition schemes

# 2 Introduction

## 2..1 Background to the project

The Trust is one of nine NHS organisations taking part in the Mutuals in Health pathfinder programme, which is jointly sponsored by the Cabinet Office and the Department of Health. The research programme started in January and would conclude by 31 March 2015.

The Cabinet Office has provided the Trust with up to £100,000 worth of support from our external partner, KPMG LLP. The programme is designed to help participating trusts to research new ways of empowering and engaging staff and to consider the associated potential costs, benefits and risks. As part of this, it would help the Trust to understand what mutualisation could mean and to identify challenges and potential barriers. The outcomes from this work will feed into the Government's broader programme of work in 2015/16 to enable a range of new options for providers of NHS care, alongside recommendations resulting for the review led by Sir David Dalton. In addition, the findings from this programme will be brought together next year and used to set out clear actions Government could take to address any practical barriers that exist.

## 2..2 Purpose of this report

This report describes the findings and conclusions from the research work that has been undertaken in the last three months.

The primary purpose of the research project is to:

- identify a range of options which might help the Trust to better engage and empower staff, including exploring the feasibility of a public service mutual model.
- assess the cost, benefits and risks of the options identified.

A short list of options was developed by a Steering Group which was established specifically for this project.

The outcomes from the research work for each option has been used to inform a decision making process on how the Trust should progress work to better engage and empower staff. The Steering Group has made a decision on its preferred option to improve staff engagement and has developed recommendations for the Trust, local health economy partners, regulators and the central government to consider. The group's decision and its recommendations are outlined in this report.

It is important to note that an option appraisal is an iterative process that is repeated a number of times before any decisions are taken and a project is implemented. Given the tight and short timeframe for the delivery of this project, it should be recognised that the costs and benefits can only be high level and indicative at this stage. If the Trust Board decided that there was merit in further exploring this project, these costs and benefits would need to be reviewed and refined to become more specific and accurate.

## 2..3 What is a mutual?

One of the options that would be assessed as part of the research project is a public service mutual. There are many preconceptions of what a public service mutual is and therefore it is important to be clear on the definition of a public service mutual.

Public service mutuals are organisations with the following 3 characteristics:

- They have left the public sector (also known as 'spinning out');
- But continue to deliver public services; and,
- Importantly, staff ownership and control is embedded within the running of the organisation

Often public service mutuals are set up because the staff believe that they:

- can run a service more effectively, achieving better outcomes for patients and the public;
- can deliver a service more efficiently, saving on costs and time;
- have identified a gap in service provision; and/or
- want greater control and autonomy over the service they work in.

## 2..4 What a public service mutual is not?

A common preconception that exists is that a public service mutual is privatisation by the back door. A private sector company has very different objectives to a public service mutual. Private sector companies aim to maximise shareholder wealth. In contrast, public service mutuals have an explicit aim of community benefit and generally may only distribute any profit made to a limited degree thus avoiding profit maximising behaviour. Also, most public service mutual have an asset lock to ensure that public sector assets cannot be sold for private gain.

***Key messages:***

- ***This is only a research project that concludes on 31st March 2015.***
- ***The Trust is one of nine NHS organisations that is taking part in a national programme to seek ways of better engaging staff***
- ***This research report provides a view on the potential costs, benefits and risks of options to better engage and empower staff***
- ***It should be recognised that the costs and benefits can only be high level and indicative.***

# 3 Strategic Overview

## 3..1 Introduction

This section of the report describes the Trust strategy and sets out why the Trust's Board chose to take part in the Pathfinder Programme.

## 3..2 Background to the Trust

Liverpool Heart and Chest Hospital is a single site centre providing specialist services in cardiothoracic surgery, cardiology, respiratory medicine, including cystic fibrosis and diagnostic imaging in the hospital, and increasingly in a community setting. The Trust serves a population of 2.8 million people with a catchment area spanning Merseyside, Cheshire, North Wales and the Isle of Man with an increasing rate of national referrals for highly specialised services such as aortic surgery.

## 3..3 National and Local Context

The Trust Board has held several sessions to review its 5 year Strategic Plan to test whether the assumptions made are still accurate and whether the implementation and development plans are still on track. The Board has worked with a number of external collaborators and commissioners to broaden thinking on strategic challenges, key risks and further horizon scanning using a SWOT analysis process. The Trust has a strong local reputation for excellence and delivery and is participating fully in NHS England's Commissioning of Specialist Services review and the Healthy Liverpool Programme developing the options to deliver sustainable quality care for the future. The Trust has also given a greater priority to building collaborative partnerships with local acute and specialist hospitals to deliver seamless, quality care. Overall the Board believe that the strategy is still valid but certain areas have been refreshed to ensure our direction of travel is aligned to national and regional policy including the Five Year Forward View, the Dalton Review of new options for healthcare delivery, the Francis Whistleblowing report, changes to commissioning of specialist services and the emerging local health landscape. The strategy has been refreshed by working with senior clinicians and operational managers to test the clinical and financial resilience and future operational sustainability assumptions.

## 3..4 What is the Trust's strategy?

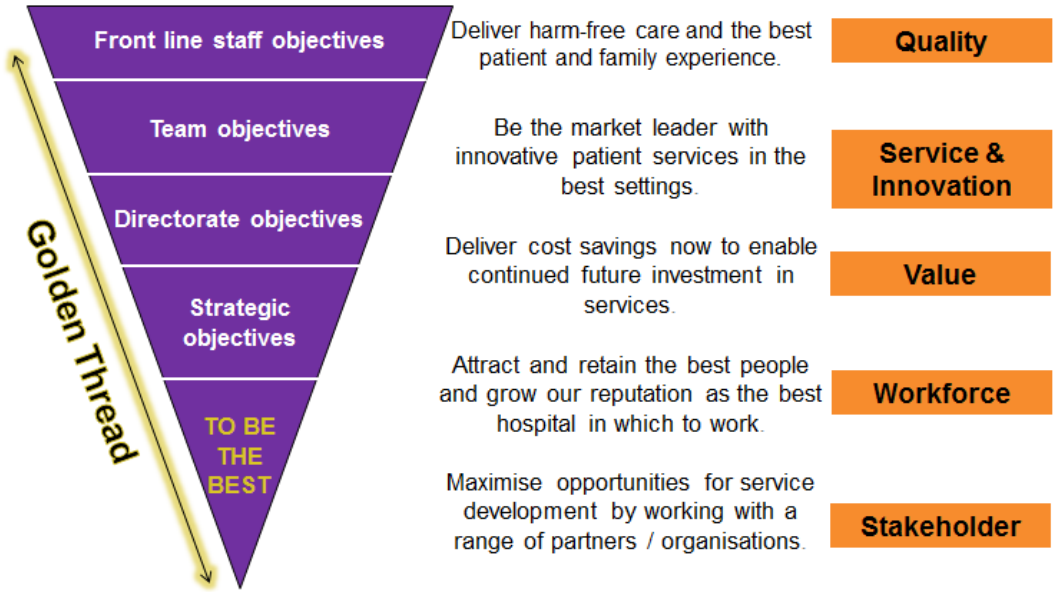
The Trust has a clear vision **'to be the best integrated cardiothoracic provider'** and its mission is to provide excellent, compassionate and safe care for every patient every day. It has been rated as the top performing hospital for overall patient care in the CQC's National Inpatient survey for 7 out of the last 8 years.

In order to achieve this vision the Trust must build on this strong foundation to: -

- Become the network leader of clinical excellence across its portfolio of services
- Deliver the 5 strategic objectives encompassing Quality, Service and innovation, Value, Workforce and Stakeholder engagement

These 5 strategic objectives have been communicated and cascaded through the appraisal process from board level to frontline staff.

**"To be the best integrated cardiothoracic healthcare organisation"**




Each strategic objective has a detailed and credible work-plan for 2015/16 to deliver our strategy. Details of the high level objectives and some of the 2015/16 deliverables are:

**Quality and Patient experience**

*'To deliver the highest quality, safest and best experience for patients and their families by providing reliable care'* through:

- Reducing pressure ulcers by a further 30%
- Implementing the NHS Medication safety thermometer
- Increasing Friends and Family Test completion to 99.3%
- Delivering milestones of sign up to safety care bundle
- Open the newly refurbished critical care area relatives' rooms

**Service Development and Innovation**

*'To develop our service portfolio and business by expanding our current service models and developing innovative models of care'* by:

- Extending 7 day service provision for ACS transfer and radiology services
- Developing our aortic, electrophysiology (EP) and Adult Congenital Heart Disease (ACHD) services
- Win the extended Knowsley Community COPD tender bidding process
- Achieve the Clinical research network recruitment target for research
- Become a leader in patient reported outcomes

**Value**

*'To maintain financial viability and enhance service delivery through transactional and transformational change'* through:

- Delivery of the 2015/16 Cost Improvement Programme and Service Transformation Programme
- Utilise Patient level Information Costing to remove unnecessary clinical variation
- Agree and implement care pathways in collaboration with local acute hospitals
- 
- Improve occupancy levels to 85%
- Implement the new theatre scheduling system

**Workforce**

*'To be the best NHS Hospital Employer by 2019'* by:

- Improve staff survey 'Recommend as a place to work' score by 10%
- Increase overall staff engagement score by 10%
- Reduce total bank and agency spend to 3.6% of total salary spend
- Improve attendance to deliver target of 3.6%
- 
- Implement new divisional structure and leadership development programme

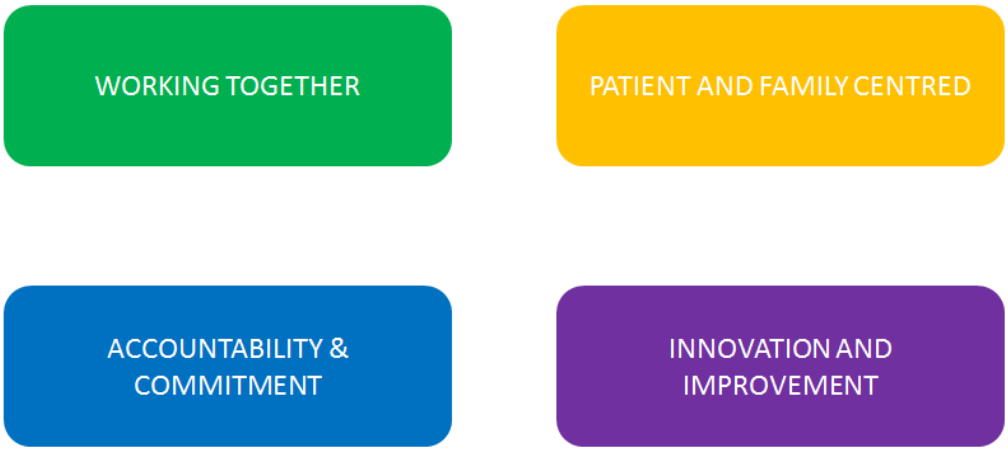
**Stakeholder Engagement**

*'To develop productive relationships and work in partnership with key stakeholders to deliver excellent care'* through:

- Implement the cardiology strategy to become Cheshire and Merseyside network leader
- Establish further joint posts in EP, pacing and imaging
- Establish LHCH@ model in secondary care
- Become a partner of choice in the Healthy Liverpool Programme

## 3..5 What are the Trust's values?

The Trust values have also being refreshed in the last 12 months following feedback from staff to focus on 4 main areas.




Detailed behaviour statements sit below the values which will be used at recruitment and during the appraisal process to enhance staff engagement and develop the right culture and behaviours to fulfil the Trust's vision.

### 3..6 What are the key strategic risks and opportunities?

In order to respond to changing patient needs and ensure future sustainability of services the Trust recognises that it cannot be an island of excellence and must build stronger clinical and organisational relationships to deliver care in a more integrated way.

The Trust's strengths lie in its strong market share and presence, its proven track record of delivery, reputation for excellence and ability to attract and retain high calibre staff.

As a small, stand-alone provider with a narrow portfolio of services though the Trust is threatened by service reconfiguration, increased competition for services, a reduction in number of specialist places for doctors in training, tariff structural deficiencies and tight financial constraints. There are opportunities for growth through the ability to position LHCH as prime cardiac provider and network lead across Cheshire and Merseyside and to develop integrated pathways of care through enhanced partnership working with local Acute Hospitals, many of whom are experiencing difficulties in recruiting cardiologists and delivering cardiac services that meet clinical standards. There are also opportunities for growth in community services and private patient market share which are being proactively pursued. The Board believe firmly that patient experience, clinical outcomes and research and treatment opportunities would be compromised if it were unable to retain its independence and build upon its reputation for excellence.

### 3..7 Why has the Trust taken part into the Pathfinder Programme?

Research shows that the way staff feel about their workplace has an impact on the quality of patient care, as well as on the efficiency and financial performance of an organisation. This has been driven home by the Boorman review on the importance of health and wellbeing in the NHS. Research also demonstrates a positive link between staff satisfaction and mortality rates, that higher staff satisfaction is linked to higher patient satisfaction, and that staff experience shapes patients' experience, rather than the other way around. The consequence is that organisations with a disengaged workforce are more likely to deliver care that falls short of acceptable standards.

Working in healthcare ought to be rewarding and interesting, yet all too often healthcare professionals feel overworked, disempowered and unappreciated. This is not a unique NHS problem: research shows it's a problem in healthcare in all the advanced economies worldwide. According to the Boorman review, healthcare staff in the UK report higher levels of stress and burnout than those in other sectors. In 2013, over a third had reported feeling unwell as the result of work-related stress in the previous year. Among nurses, the figure was 55%.

Caring for patients is hard work. It is especially hard during a period of change such as we are experiencing now, because this creates uncertainty and anxiety about job security and the future. Feeling valued, supported and listened to is crucial if staff are to have the mental and emotional stamina needed to provide the best-quality care.

NHS providers exist, first and foremost, to serve their patients. An engaged and valued workforce is not a 'nice to have'. It is a necessary condition for meeting the NHS's unprecedented challenges against a backdrop of growing service pressures and tightening finances.

Yet despite these studies, NHS staff engagement – as measured by a score from the NHS staff survey, which takes account of measures including staff involvement and overall job satisfaction – fell for three consecutive years from 2009 before rising slightly in 2012. Only 55% of staff would recommend their organisation as a place to work. At Liverpool Heart and Chest NHS Foundation Trust, that figure is currently (69%) based on our last Staff Survey.

In addition, a recent study highlighted that only one in three NHS staff say communication between senior managers and staff is effective. And while three-quarters of staff say they are able to make improvement suggestions, only 26% say senior managers act on them. Yet the research shows senior leaders report a far more positive outlook, citing staff engagement as one of their top priorities and an overwhelming confidence that staff can raise concerns.

This sort of gap between perception and reality can undermine confidence and enthusiasm and engender cynicism. It is likely to be the inevitable result of people positioned at different levels of the hierarchy having different experiences and points of view.

Bridging the gap is possible, but it requires deliberate and intentional action on the part of senior executives to overcome it. It requires clear communication, trust and acknowledgement of the experiences of others.

The Pathfinder Programme is part of a renewed effort to examine new ways to better engage and empower staff across the NHS, with Liverpool Heart and Chest NHS Foundation Trust viewing engagement as a key priority. We want to unleash the power of our staff to drive service improvements and innovations that transform care, including maximising the discretionary effort staff bring to caring for patients. This is why we applied to take part in the pathfinder programme.

### 3..8 How has the Trust engaged staff during the Pathfinder Programme?

We have proactively approached and engaged staff as well as local and regional Trade Union representatives.

- LHCH have held sessions with staff groups and unions regularly through the programme, but more frequently in January and February. Sessions with staff have been held through March also to clarify the scope of the project at LHCH. The Project Lead has had sessions with individual departments to accommodate staff availability.

- The Trust has met with staff side in December right at the beginning of the project and shared initial plans with those attending the meeting.
- LHCH was the only trust in the North West to attend the Partnership Forum in January to explain to all the attending unions what the scope of the project was at LHCH.
- LHCH held a session with Unions at the trust in February.
- The Trust invited Mr Andrew Burnell, CEO of City Health Care Partnership CIC (CHCP) in Hull to participate in an open forum with staff to talk about the journey that CHCP had gone through and to answer questions from LHCH staff about mutuality.
- LHCH attended a workshop in March organised by the RCN on mutualism in the NHS

The Trust has ensured engagement with staff and Trade Union representatives is timely, appropriate and regular throughout the programme.

- LHCH has had an open survey on the intranet for all staff to give their opinions about the project and what it means to them. The survey was launched at the beginning of December 2014 and has remained open until the end of the project as it has proven to be an excellent way for staff to communicate with the project team. To date we have had over 200 responses, and we still receive new input every week.
- We continue to engage with staff as it is very important that staff are fully aware of the progress in the project.
- Any progress has also been shared with unions.

The Trust  has ensured that staff and trade unions have been properly involved in the feasibility work for the mutuals programme. They have had the opportunity to be fully informed about the intent and implications of the programme, as well as have the opportunity to take part in active discussions with those leading the Programme in each Pathfinder and the CEO and senior team.

- We have held two workshops in January (where unions were present) to look at the feasibility work.
- Feedback from staff has been essential for this part of the work.

The Trust has provided regular updates to staff and Trade Union representatives.

- Every week an update has been posted through the trust e-bulletin; staff union reps have access to this and can share with their unions.
- New information or updates have also been posted through the intranet in the mutuals homepage.
- The Project Initiation Document has been shared with staff side and has been posted in the intranet page

The Trust has shared any plans for staff engagement with Trade Union representatives.

- unions have been informed through the meetings held with staff side and with the unions separately. LHCH has invited unions to the open forum session held on the 18th February, which was very well attended by all.

The Trust has been open and transparent about the Programme, its intent and any emergent findings.

- We have aimed to be transparent and honest with any progress and any updates have been posted through the intranet and the weekly e-bulletin.
- The final report will be made available to all staff through the e-bulletin and the intranet page. The Board of Directors believe that it is extremely important that all staff have access to the report.

The Trust has ensured that staff and trade unions representatives have had access to and are aware of relevant mechanisms for raising questions and any concerns about the programme.

- Staff are continuously reminded that they have a direct line of communication to the Project Lead via e-mail or through the survey that is still open in the intranet page.
- Unions have also the same access and they have been provided with contact details.

Following the conclusion of this research programme, if the Board were to choose to further explore potential mutual models, the Trust would continue to ensure that staff were engaged as part of the process.

***Key messages:***

- ***The Trust remains committed to its vision "to be the best integrated cardiothoracic healthcare organisation"***
- ***The Trust has taken part in this programme because it wants to significantly improve staff engagement***
- ***Strong evidence exists which shows that the way the staff feel about their workplace has an impact on the quality of patient care, as well as on the efficiency and financial performance of an organisation***
- ***The Pathfinder Programme is part of a renewed effort to examine new ways to better and engage staff***
- ***The Trust has engaged with staff as part of this programme to understand their views and this report will be shared with them.***

# 4 Overview of Research Project

## 4..1 Introduction

This section of the report describes the process which the Trust has followed as part of this research project which aims to consider new ways to engage and empower staff at Liverpool Heart and Chest NHS Foundation Trust.

## 4..2 What options did the Trust appraise and why?

The long list of options included:

- Part of the trust (e.g. cardiology) spun out into an employee owned public service mutual which bring together services from other local providers to create an integrated service pathway across the region which would be jointly owned by local providers.
- Part of the trust spun out into a joint venture or LLP with other providers to create an integrated service pathway which if successful could then be spun out into an employee owned public service mutual
- Whole trust spins out into an employee owned public service mutual
- Whole trust becomes a FT Plus (dependent on legislative changes)
- Remain as a FT but do more to improve staff engagement within the current model
- Do nothing

For the options where a part or the whole of the trust becomes a public service mutual, the cost, benefits and risks of a number of legal forms have been explored including social enterprise, charity and community interest company.

After some initial work, it was decided that the 31 March 2015 deadline set by the Cabinet Office prohibited a high level appraisal of the first two of the long list of options outlined above. Initial discussions with our external stakeholders revealed that both of these options may be strategically and financially attractive to both our commissioners as well as other local providers as a way of improving cardiology care across the region. However, engagement with commissioners and providers to obtain their buy-in to these options would take time and until their buy-in is secured we would not be able to produce a commercial and financial appraisal of these options due to a lack of data on services not currently provided by Liverpool Heart and Chest NHS Foundation. As a result, it was decided not to further appraise these options as part of this research project. These options could however continue to be explored by management through their regular discussions with commissioners and other local providers as part of the Healthy Liverpool review.

That left four options for which we have considered at a high level their costs, benefits and risks:

- Do nothing
- Improve staff engagement and empowerment as a FT
- Improve staff engagement and empowerment as a FT Plus
- Improve staff engagement and empowerment as a public service mutual

### 4..3 How did the Trust appraise each option?

The outcome from the option appraisal is intended to support and justify a decision to proceed with the project. It does this by identifying a preferred option which is expected to demonstrate that the project will deliver the benefits required and provide good value for money.

A rigorous appraisal of the shortlist of options in terms of their expected non-financial benefit was completed at a workshop on 11 March 2015. This was a very important appraisal since any change resulting from this project is expected to deliver significant benefits for patients and staff.

In summary, the workshop appraisal involved:

- Reviewing each of the shortlisted options so that workshop participants clearly understand the scope and differences between each option.
- Discussion and agreement on a set of evaluation criteria and the weighting of these to reflect the workshop group's view of their relative importance.
- Examining each option against the criteria and agreeing how that option met the criteria and agreeing a score for each option against each weighted criterion.
- Computing an overall weighted benefit score for each option. This weighted benefit score is simply a measure of how well the workshop participants considered each option was likely to deliver the benefits required from the project

The workshop was facilitated by the independent adviser from KPMG who had no vested interest in the outcome of the appraisal but was able to guide the participants through the process to ensure that it was conducted in accordance with good practice.

Whilst the aim was to reach a consensus score on each option against each criterion, it was recognised that with a relatively large workshop group this was not always possible and the facilitator recorded pessimistic and optimistic scores where individual group members had reservation on the consensus score.

### 4..4 What criteria was used to appraise each option?

The criteria set out the table below was used to score each of the options. The Steering Group weighted the evaluation criteria to reflect their relative importance on a scale of one to four. Those criteria which were considered to be of greatest importance were given a higher weighting.

| Theme | Evaluation Criteria | Weighting |
|---|---|---|
| **Strategic** | Fit with strategic vision, values and objectives | 4 |
| | Fit with external stakeholder views, e.g. commissioners | 2 |
| | Fit with patient user views | 2 |
| | Fit with staff views | 4 |
| **Staff** | Ability to engage and empower staff | 4 |
| | Quality and security of terms and conditions for staff | 4 |

| | | |
|---|---|---|
| | Quality and security of pensions for both existing staff and new hires | 4 |
| | Ability to recruit and retain staff | 4 |
| **Financial and commercial** | Ability to access financing & financial support | 4 |
| | Financial benefit, i.e. level of cash savings | 4 |
| | Time to realise savings | 4 |
| | Investment required | 4 |
| | Ability to improve growth | 4 |
| | Scope for collaboration arrangements with other public sector bodies | 4 |
| **Quality** | Ability to maintain and improve quality of care | 4 |
| | Scope for innovation in design and delivery | 3 |
| **Management** | Degree of organisational change required | 1 |
| | Organisational flexibility to respond to changing circumstances | 3 |
| | Impact on organisational risk profile | 3 |

Appendix 2 includes the options appraisal scoring matrix that was used. It shows the scores that the Steering Group attributed to each evaluation criteria for each option.

### 4..5 What was the preferred option?

The results from the options appraisal workshop are summarised in the table that follows.

| | **Weighted benefit scores** | | | |
|---|---|---|---|---|
| **Options** | **Optimistic** | **Consensus** | **Pessimistic** | **Rank (based on consensus score)** |
| 1. Do nothing | 162 | 162 | 162 | 4 |
| 2. Improve staff engagement as a FT | 206 | 203 | 200 | 2 |
| 3. Improve staff engagement as a FT Plus | 208 | 204 | 200 | 1 |
| 4. Public service mutual | 172 | 170 | 168 | 3 |

The results in the table above show that there is a considerable difference in weighted benefits scores between the "Do Nothing" option and the other three options. This is a good outcome since it confirms that the proposed investment is expected to produce a step change in the benefits delivered to patients and staff. Hence it confirms that the project is a worthwhile one with an expected significant return on investment in terms of both financial and non-financial benefits.

The third option "Improve Staff Engagement as a FT Plus" scored highest with a relatively high overall weighted benefits score of 204 compared to the maximum possible score (264).

Sensitivity analysis has been undertaken to examine the robustness of the ranking of options and the selection of a preferred option.

In terms of the evaluation criteria, the weighted benefits scores derived from the optimistic and pessimistic scoring at the workshop have been used to calculate corresponding weighted benefit scores. These are shown in the table above.

The table shows that the adoption of the optimistic or pessimistic scoring scenarios does not change the ranking of options which indicates a robust result i.e. one that does not change when realistic and plausible changes are made to the scoring.

It is also worth noting that the relatively small differences in weighted benefits scores between the three scoring scenarios (optimistic, consensus and pessimistic) broadly indicates a high level of consensus reaching by the Steering Group.

The results therefore from the options appraisal of the short listed options in terms of benefits shows that overall the "Improve Staff Engagement as a FT Plus" option is ranked highest in terms of its benefits. Furthermore, the sensitivity analysis has shown that under a realistic and plausible range of assumptions in terms of changes in scoring, this option remains the highest ranked. The Steering Group considered Option 3 to be the preferred option overall.

***Key messages:***

- ***The Trust is considering four options as part of this research project – do nothing, remain as a FT, FT Plus and whole trust spin out into a public service mutual***
- ***Other options exist, such as a spin out of cardiology to bring together services across Liverpool, which may be attractive in the medium-to-long term but have not been considered as part of this research project due to timescales set by the Cabinet Office.***
- ***An options appraisal process was followed. The preferred option was "to implement a plan to improve staff engagement and empowerment and seek legislative changes to change the FT model"***

## 5 Analysis of Costs, Benefits and Risks

### 5..1 Staff

This section of the report describes the costs, benefits and risks associated with each option from a staff perspective.

### 5..2 How could we seek to better engage and empower staff under each option?

The table below sets out the most common ways in which we could seek to engage and empower staff within the Trust.

With the exception of co-ownership and employee elected directors with voting rights, most of the options available can be taken as a FT, FT Plus or as a public service mutual.

| **Options available** | **FT** | **FT Plus** | **Public Service Mutual** |
|---|---|---|---|
| Co-ownership | No | Probably not.<br>This is highly unlikely if the Trust remains as part of the NHS. | Yes, if company limited by shares |
| Highly visible, supportive and inclusive leadership style with open lines of communication with management team | Yes | Yes | Yes |
| Involve staff in developing strategic direction and service transformation | Yes | Yes | Yes |
| Employee representation forums (e.g. Council of Governors, Staff Partnership Forums, Listening in Action, Roadshows) | Yes, staff governors who sit on Council of Governors represent staff. It would be possible to increase the number of staff governors but they would still need to be in the minority under current legislation.<br>Possible to do more but dependent on willingness of management team | Yes<br>The composition of the Council of Governors could change so that there is greater representation from staff governors Role of Monitor may change so that power of Council of | Yes but option to do differently so that management is accountable to staff rather than Monitor. |

| | | | |
|---|---|---|---|
| | rather than an obligation.<br>Accountability is largely to Monitor though which undermines staff empowerment. | Governors to hold to account increases. | |
| Regular feedback from employees (e.g. Listening in Action, staff survey) | Yes | Yes | Yes |
| Corporate Social Responsibility activities (e.g. Access to Medicine, apprenticeships) | Yes | Yes | Yes |
| Staff conferences / Annual General Meeting | Yes | Yes | Yes |
| Organisational development programme to equip staff and governors so they can effectively hold to account | Yes | Yes | Yes and becomes increasingly important to do so. |
| Sharing of strategic information with staff | Yes | Yes | Yes |
| Performance related pay or other non-financial rewards (e.g. extra leave) | Yes | Yes | Yes |
| Indirect financial incentives (i.e. retained surplus by service lines) | Yes | Yes | Yes |
| Employee elected director(s) of the Board with voting rights | No | No | Yes |
| Constitution setting out decision making protocols | Yes, some decisions require Council of Governors approval | Yes, some decisions require Council of Governors approval.<br>However, could increase the powers | Yes, could require some decisions to require staff consultation. For example, John Lewis has a partnership council which regularly vote on the confidence |

| | | | |
|---|---|---|---|
| | | and duties of the Council of Governors. | they have in the executive chairman's leadership. |

The most significant advantage of co-ownership over the current FT model is that it can bring more influence to staff's participation in making key decisions about the running of the organisation. Under the current FT model, although it is the duty of Council of Governors to hold the Trust Board to account, it is Monitor in practice which holds trust boards to account for performance. In a public service mutual, which would be regulated as an independent provider by Monitor, it is more likely that the accountability of the Board would rest with staff. Therefore, co-ownership can help to empower employees to have a greater say in the running of the organisation.

In addition, co-ownership may make staff engagement more durable to changes in management personnel. In the FT model, the extent to which the Trust seeks to engage employees is dependent on the views of management. However, within a public service mutual, co-ownership means that management would be obliged to engage employees otherwise they would risk losing their employment. For example, John Lewis has a Partnership Council (which is similar to a Council of Governors albeit it consists only of staff elected council members). The Partnership Council meets 4 times a year to set and discuss strategic direction. At the end of each council meeting, there is a vote by council members on their confidence in the leadership of the executive chairman. If lost, the executive chairman would lose his employment. This vote, along with co-ownership which prevents the executive chairman from getting rid of this vote, ensures that the executive chairman properly engages employees and addresses their concerns for the benefit of the business.

A key question that needs further consideration therefore is whether accountability to staff would provide greater benefits to the organisation and more importantly patients compared to accountability to Monitor.

### 5..3 What are the benefits associated with co-ownership?

Based on available evidence, there are a number of potential benefits for both employees and the organisation of co-ownership. We believe the strength of evidence which supports these potential benefits is mixed. Whilst there is a strong link between some of the benefits and co-ownership, for others the evidence is inconclusive. For example, the evidence is largely based on successful employee owned businesses and does not include organisations which may have gone out of business.

Many of the statistics quoted below have been taken from the Employee Ownership Association (EOA). The EOA is a not for profit and politically independent organisation that works in close partnership with its members to champion, promote and provide insight into the business case for employee ownership.

The potential benefits for employees are:

- Greater job satisfaction – an average of 80% of employees are happy to recommend their workplace as a place to work within employee owned organisations. A similar number experience a sense of achievement in their jobs (source: Employee Ownership Association website, 2015). Since spinning out of the NHS, Locala and Central Surrey Health have both enjoyed a 9% improvement in overall staff satisfaction (source: local and national staff surveys). In addition, 89% of Central

Surrey Health's staff say they value working for an employee-owned organisation (source: CSH and NHS staff surveys, 2013)

- Greater say in the running of the organisation – although research suggests employee ownership does not automatically lead to this. The constitution and governance model of the organisation needs to be designed a way that embeds staff engagement. For example, the constitution may allow staff to participate in decision making around pay and pension provision.
- Financial incentives – e.g. greater financial reward or more evenly distributed than other businesses. The ratio between the highest paid director and average pay is generally lower in an employee owned organisation.
- Positive impact on job security
- Positive impact on health & safety

It would be important that these potential benefits were clearly communicated to staff so that they would be aware and understood them. If they were not clearly communicated, staff might not realise what co-ownership might mean for them and the opportunities that could become available to them.

The potential benefits for the organisation:

- Higher productivity of employees – an average 4.5% year-on-year productivity increase within employee owned organisations (source: Employee Ownership Association website, 2015)
- Lower absenteeism - At City Healthcare Partnership, the staff sickness absence has reduced by 1% since spinning out of the NHS into an employee owned organisation. CHCP's staff sickness absence rate is 3.3% which is 0.8% better than the NHS average (source: CHCP Annual Report 2014)
- Greater input from employees on how to improve the organisation's performance.
- Positive impact on recruitment and retention, i.e. lower staff turnover
- Higher growth rates (11.1% growth on average of employee owned businesses in the UK compared to 0.6% of non-employee owned businesses)
- Longevity and sustainability of organisations
- Better quality of service - Since becoming a social enterprise, CHCP have seen an increase of 14% in those who rated their care and support as excellent (source: CHCP Annual Report 2014)
- Less regulation from Monitor which lowers administrative overheads and provides management with greater freedom. The organisation would still be subject to Monitor regulation as an independent provider of NHS care however this is less onerous than the regulation that a foundation trust is subject to.
- Greater innovation because staff feel more empowered if they have a greater say in the running of the organisation but also because there is less regulation which may inhibit risk taking

The potential costs and risks for the organisation:

- No regulatory support if the organisation gets into financial difficulties
- Decision making may be slower
- There may be a tendency to avoid unpopular decisions
- It may be harder to access financing
- There is a need to manage employee share schemes

5..4 **Which option is best for staff engagement?**

The table below summarises the initial views of the project team.

| | **FT** | **FT Plus** | **Public Service Mutual** |
|---|---|---|---|
| **Advantages** | Most of ways in which we can engage and empower staff can be done under the FT model<br>Likely to be the easiest and least risky to implement as it does not require legislative change or spinning out of the NHS. | Might be able to mimic co-ownership by making staff engagement a legislative requirement. | Co-ownership can help to embed staff engagement into the culture of the organisation that would survive the tenure of future management teams.<br>The Trust Board would be truly accountable to staff, not Monitor, which would empower them in the greatest way. |
| **Disadvantages** | Empowerment of staff would always be significantly undermined by Monitor's role. Real accountability would always be with Monitor, not staff no matter what we do. | Wholly dependent on legislative changes around the composition of Council of Governors and the role of Monitor which may not occur | Would require spinning out of the NHS and associated risks of doing so.<br>Hardest to implement and most risky. |

Further research is required to determine an answer as to which option is best. However, it is clear that as a FT the Trust can do a lot more to better engage and empower staff without the need to spin out of the NHS. That would seem to be the easiest and least risky way forward for the Trust. However, it is important to highlight the fundamental drawback that Monitor's role as it currently stands would undermine the extent to which staff can be empowered and their influence on the Trust Board. The best way to truly empower staff would be to make them co-owners and ensure the constitution of the organisation gives them a greater say in the running of the business.

5..5 **How could the Trust reward and recognize staff under each option?**

As part of this project, the Trust is committed to ensuring that the terms and conditions of staff are not diminished in any way under any of the options. That is a principle that is fundamental to this entire project.

The ways in which staff could be rewarded and recognised do not differ significantly under each option. As a foundation trust in theory the Trust already has some power to depart from national pay and conditions (i.e. Agenda for Change providing the total 'pot' of money available is not reduced) and implement local pay arrangements. Indeed, many examples of local pay enhancements already exist for staff employed by the Trust.

Aside from pension provision, which is discussed next in this report, the only other difference that may occur is that the Board could issue a dividend to staff if they co-owned the organisation through share ownership. However, in practice, none of the existing public service mutual that deliver NHS care do this. In addition, it may be morally tax payers money adverse to reward staff in this way even if the Trust has performed well and could afford to.

Therefore, the ways in which the Board could improve the way in which the Trust rewards and recognise are likely to be similar under each option. As a result, for the purpose of the options appraisal, we would just consider the options for pension provision for both existing staff and new hires under each option.

### 5..6 If the Trust remains as FT, what could pension provision look like?

Current Pension costs are 14.3% of pensionable pay (from 1 April 2015) for the NHS Pension Scheme and 1% of pensionable pay for staff in the Auto Enrolment Scheme with NEST (National Employment Savings Trust).

As a foundation trust there is little scope for change to the financial impact of pensions as the FT would continue to provide access to the NHS Pension Scheme for all current and all future staff.

There is a degree of flexibility that the FT can explore to provide alternative reward structures for individuals who may not wish to participate in the NHS Pension Scheme (perhaps because of potential Pension Tax issues), or who are unable to join the NHS Pension Scheme as they are prohibited by the Scheme regulations.

Such individual discussions and agreements are not common place but may serve as useful incentives to retain (or recruit) key staff. Care should be taken if agreeing to alternative rewards that the staff member is not able to take the alternative offered and then choose to join the NHS Pension Scheme without giving these up

### 5..7 If the Trust became a public service mutual, what could pension provision for both existing staff and new hires look like?

The Trust currently participates in the NHS Pension Scheme and also provides access to NEST to comply with Employer Duties associated with Pensions Auto-Enrolment for any member of staff who is unable to join the NHS Pension Scheme (through being prohibited by the Scheme regulations).

The Trust is exploring options to improve staff engagement and empowerment. This includes an option to potentially spin out of the NHS into an employee owned organisation. Initial discussions with staff identified that pension provision is a key issue and that this extends beyond current staff to include provision for new hires.

The NHS Pension Scheme is the pension scheme made available to the vast majority of workers associated with the delivery of public healthcare. In England and Wales approximately 1.3 million workers are in the scheme and these are spread across over 10,000 employers.

There are several sections of membership depending in the date that a worker joined the NHS, their employment type, and whether they elected to change sections when offered.

A new NHS Pension Scheme 2015 is being introduced from 1 April 2015 and approximately 75% of members will move to this new Scheme for their future pension accrual. New entrants to the NHS after 1 April 2015 will join this section.

Membership criteria is wide ranging and most NHS workers are able to join when starting work for an NHS employer. Membership is automatic for new joiners and the Scheme is the NHS's Qualifying Pension Scheme (QPS) for Auto-enrolment (AE) purposes. Those whom the regulations prevent from joining must be provided with an alternative Qualifying Pension Scheme (QPS) under separate legislation to comply with Auto-Enrolment (AE) requirements. The selection of the QPS is an individual employer decision. The date that an AE QPS is required to be provided depends on the PAYE (Pay As You Earn) size of an organisation and whether it has determined to postpone or defer its "staging date". By 2018 all employers are required to have an AE compliant QPS in place.

For each consideration we have outlined how the new organisation may have access (or not) to the NHS Pension Scheme. There are options for the new body to be classified as an NHS Employing Authority, TUPE (Transfer of Undertakings-Protection of Employment) and new Fair Deal to apply or the new body may apply for Approved Employer status through the Access route.

**Key consideration 1 - All current staff would maintain access to the NHS Pension Scheme.**

To achieve this consideration each option explored would allow for current staff to remain in the NHS Pension Scheme if applicable.

There might be a need for change to the regulations of the Scheme if the new body were to fall outside of the current definition of NHS Employing Authority (or for the Secretary of State to agree). There might also be decisions required to confirm that new Fair Deal would apply and also if the Approved Employer route was selected which level of access was suitable.

Under Access if the new organisation was to deliver additional non-NHS work this might mean that staff working on that work might lose eligibility for membership of the Scheme.

**Key consideration 2 - New staff would be able to join the NHS Pension Scheme.**

This consideration is that to maintain a consistent pension provision for transferred staff and new recruits the NHS Pension Scheme would be offered to new staff (subject to the scheme eligibility criteria). Under the options outlined only becoming an NHS Employing Authority provides unlimited access to the NHS Pension Scheme for new recruits.

Approved Employer Open Access status would provide access for all staff who work on NHS contracts so the new organisation would need to consider whether it offered "non-NHS work" and the potential implications on pensions for staff carrying out such work.

Under Closed Access it is highly likely that some new recruits would not be able to join the NHS Scheme and alternative provision would be required. New Fair Deal would not allow new entrants to join the NHS Pension Scheme.

**Key consideration 3 - New staff would not join the NHS Pension Scheme**

This consideration assumes that transferred staff stay in the NHS Pension Scheme and new recruits are not able to join. This option would likely create differing pension provision

and create a "two-tier" workforce. This consideration might impact on recruitment and retention but might allow for financial savings. Equally, it could cost more.

Eligibility requirements for some options may not make this possible. Under the options outlined becoming an NHS Employing Authority provides unlimited access to the NHS Pension Scheme for new recruits so would not suit this consideration; Approved Employer Open Access status provides access for all staff who work on NHS contracts.

Under Closed Access it is highly likely that some new recruits would not be able to join the NHS Scheme and alternative provision would be required.

New Fair Deal would not allow new entrants to join the NHS Pension Scheme and this option would best suit this consideration.

**Key consideration 4 - An alternative pension scheme would be offered**

The first three considerations focussed mainly on the new organisation maintaining access to the NHS Pension Scheme for current staff, new recruits (or both). Some options would require the organisation to consider alternative provision for some staff.

The organisation might determine that an alternative to the NHS Pension Scheme was offered, either to new staff or also to transferred staff.

Many alternative pension structures are available to be considered and we have outlined three key options for assessment;

- A scheme that "mirrors" the NHS Pension Scheme by providing benefits that can be classified as "broadly comparable".
- An alternative Defined Benefit pension scheme
- A Defined Contribution pension scheme.

Within each option there are key decisions to be made regarding the level and design of benefits and the costs of providing these.

Additionally, as each option is outside of the Public Sector framework there would be a need to establish investment funds and governance structures.

When considering a new Scheme all options are open and the type of scheme and contribution levels would be important to explore.

A mirror scheme would provide the best match to the NHS Pension benefits and an AE compliant the lowest benefits for the least cost.

Selecting what level of provision was provided is likely to also require interaction with other parts of the reward package.

**Summary**

The organisation would need to set clear objectives for pension provision to allow for the selection of the most appropriate method of providing access to the NHS Pension Scheme, or alternative Scheme(s) as might be required to meet those objectives. It is also important to clarify that although all staff have access to the NHS Pension Scheme, they can also opt out from this should that be their preferred option.

Whilst many of the options would provide continued access to the NHS Pension Scheme (for current and new staff) some do not and detailed analysis of alternative pension

provision would be required to allow for the appropriate pension scheme design to be selected.

It is feasible that alternative pension provision could be made that had a lower or higher cost than continued participation in the NHS Pension Scheme. Costs are an important consideration for the employing organisation and also for the staff members (along with value) so the link between pension and total reward would also need to be carefully considered. However, the Trust is absolutely committed to maintaining access to the NHS Pension Scheme for all eligible staff and therefore is not considering offering an alternative pension provision as an option.

Finally, pensions are an emotive subject, very close to staff hearts and high on the trade union's agenda. It would be important to include clear communication strategies to keep staff informed, whatever decisions were taken.

5..8 **What are the initial views of employees on each option?**

Throughout this research project, a series of stakeholder engagement sessions have been held to ascertain the views and opinions of staff and external stakeholders. The focus of initial engagement events with staff so far was to understand their views about the idea of mutualisation.

The main concerns that have been raised by staff are:

- They do not believe that their hard work is properly recognised and rewarded;
- They do not feel sufficiently empowered or engaged by management;

However, they also stated that:

- They want to remain part of the NHS because they want to be part of a bigger family rather than a small, independent organisation
- They do not see the need for change – they believe the Trust is performing relatively well compared to other providers both locally and nationally
- The perception is that a public service mutual is a form of or step towards privatisation of the NHS – it should be noted that this is not true but remains a myth which the Trust would need to dispel;
- Greater autonomy brings risks (e.g. lack of financial support) as well as potential benefits
- Significant concerns over job security and quality of terms and conditions of their employment / pensions. This unsurprisingly was one of their greatest concerns despite reassurance that the Trust would not seek to diminish their overall reward package.

These views are not uncommon. All of the pathfinders have engaged staff and received similar concerns about the idea of mutualisation.

It is clear that should the Trust ever consider the option of exploring spinning out any of its services into a public service mutual, the Trust would need to win the hearts and minds of staff before it could do this. As an example, City Healthcare Partnership which is a highly successful community interest company which provides NHS care, held 265 staff engagement sessions over a period of 2 years after deciding that spinning out of the NHS was their objective. It still took another two additional years of sustained staff engagement

before they became a community interest company. However, as a result, they now enjoy the benefits of one of the most engaged workforces that provide NHS care.

***Key messages:***

- ***A lot more could be done within the current FT model to better engage and empower staff***
- ***However, under current legislation, staff's influence is low. For example, staff governors must be in the minority in the Council of Governors under the NHS Act 2006. Also, Monitor's power and influence in holding trust boards to account would always undermine the extent to which a FT can truly engage and empower staff.***
- ***Spinning out the NHS into an employee owned organisation is arguably the best way to engage and empower staff.***
- ***Access to the NHS Pension Scheme would be maintained for both existing staff and new hires in a public service mutual***
- ***Staff representatives at the Trust have raised a number of concerns about spinning out of the NHS and these concerns are not uncommon – they have also been raised at the other pathfinder organisations as well as by staff at social enterprise organisations that provide NHS care pre-spin out.***

# 6 Commercial

## 6..1 Introduction

This section of the report describes the commercial cost, benefits and risks associated with spinning out services into a public service mutual.

## 6..2 Growth opportunities

A successful public sector mutual might bring with it significant commercial benefits from growth opportunities, these might come about as a result of, amongst other things:

- The mutual form being a differentiator to commissioners and other customers,
- The structure of the organisation becoming leaner, more fleet of foot and able to respond quickly to market opportunities, or
- People within the organisation being more engaged and motivated to develop opportunities to grow the business.

Only the first of these points actually requires an external structure to deliver the benefit; it is possible that the other two might be achieved in the existing form of FT, if changes are made to replicate a leaner structure and increase employee engagement.

## 6..3 Mutual as a unique selling point (USP)

Testimony from existing mutuals in the health sector indicate that their status as a public service mutual has been a USP for commissioners wanting to commission some services outside the NHS, but not to a "for-profit" corporate where the main aim would be maximising shareholder value. The extent to which this would be the case for acute services has not been determined.

## 6..4 Speed of response to market opportunities

The expectation is that a public service mutual would be freed from certain elements of bureaucracy of the NHS, which would allow them to build a flatter hierarchy that could respond more quickly to growth opportunities.

However, the Trust has identified that many aspects of the NHS framework would remain in place in respect of a public service mutual; the organisation would still require a licence to operate from Monitor, and that would have the same or very similar conditions attached to it. In addition, it would be subject to Monitor's risk assessment framework for independent providers [which is very similar in its reporting requirements]. It is therefore not clear how much leaner the organisation could become and remain in compliance with Monitor's requirements.

It is likely to be the case that there was flexibility within the current FT arrangement to restructure the organisation to make it more commercial and effective in its focus on growth opportunities, which may mean that a mutual organisational form was not required.

### 6..5 Staff engagement leading to growth

There is evidence to suggest that companies with high levels of staff engagement see higher levels of growth of operating income than companies with low levels of employee engagement.

As it is believed the mutual model fosters increased employee engagement, it is possible this would lead to income growth, however it may be possible to achieve similar results through increased employee engagement within the FT model.

### 6..6 Commercial risks

The ultimate commercial risk is that a public service mutual is a corporate entity that is outside the public sector and therefore is a stand-alone entity, responsible for its own success or failure. Failure of the business could result in insolvency of the company, the business ceasing to trade, redundancy of staff and scrutiny of directors' actions.

It should be noted however that directors of Foundation Trusts are also subject to the Company Directors' Disqualification Act 1986, which sets out the basis for review the conduct of directors in respect of breaches of their fiduciary duties.

Therefore, consideration of the commercial risks for the mutual would need to be considered more fully in the context of the risk of commercial failure

### 6..7 Risk of loss of business

As an independent provider the public service mutual is exposed to the risk of loss of business without access to any safety net of the NHS/Department of Health.

TUPE would continue to apply to staff when services transfer, however the organisation as a whole may become unsustainable if a significant portion of its business is lost.

When negotiating contracts this risk would need to be mitigated through seeking to include contract terms, to balance risk such as notice periods, transition periods and payments to cover transition costs.

The organisation could reduce this risk of failure by diversifying to increase its portfolio of contracts so that it was not wholly reliant on one or two large contracts.

### 6..8 Contracting with commissioners

As an independent provider, a public service mutual is not required to adopt the NHS standard contract, however it is likely that commissioners would want similar arrangements in place, and it would be for the mutual to negotiate a contract that reflects appropriate risk share and gain share arrangements. For example, a public service mutual would want to secure a longer term contract to provide greater financial security and to allow the mutual to raise capital, form strategic partnerships and reduce other costs by entering into longer term agreements. Amongst other things, terms dealing with the following should be considered in addition to pricing, Key Performance Indicators quality and performance metrics and efficiencies:

- Contract length, lock in periods and break clauses
- Exit route and notice periods
- Liability caps

- Dispute resolution
- Transition arrangements
- Access to NHS patient data

6..9 **Procurement of services**

The new public service mutual would be required to establish new arms-length contracting arrangements with suppliers who may previously have been internal providers. In particular, this may impact on back office or shared services that are currently provided by other parts of the NHS.

In negotiating contracts with suppliers, similar consideration would need to be given to the issues listed above for contracts with commissioners, and supplier contracts would seek to mirror their terms, (for example a supply contract might run for a similar period to the commissioning contract so that continuity of supply can be assured, and there is no period of excess supply at the end).

It is assumed that the mutual would still have access to the NHS procurement scheme, as is the case in other public service mutuals in the health sector, and could continue to benefit from economies of scale provided. However it should be noted that as a Foundation Trust the Trust currently has the ability to shop around for services outside of the NHS procurement scheme, so the benefit of this is limited.

***Key messages:***

- ***Research shows that spinning out of the NHS is likely to make an organisation leaner, more flexible and more innovative which brings competitive advantage.***
- ***However, spinning out of the NHS would also bring greater commercial risk. The organisation would need to be financially independent and could not seek financial support from the Department of Health.***

# 7 Financial Option Appraisal

## 7..1 Introduction

This section of the report describes the financial costs and benefits of each option. The financial appraisal should compare the financial benefits of becoming a public service mutual with the financial costs. Given the short timeframe for the project, these financial benefits and costs have not all been fully tested as the evidence as to the extent that they can be attributable to the public service mutual form is uncertain. Where indicative numbers have been obtained, they are included to give some context as to the size of the potential impact of the benefit or risk. It should also be noted that in many respects the financial costs and benefits for options 2 and 3 would be the same as neither would require a change in legal form. Therefore, the financial appraisal largely focuses on the difference in financial benefits and costs between a FT and a PSM.

## 7..2 What are the potential financial benefits?

The table below summarises the potential financial benefits.

| **Financial benefits** | **Commentary** |
|---|---|
| New services | Increased staff engagement and flatter hierarchy may lead to income growth. Evidence from case studies found companies with higher staff engagement achieve increased operating income compared to companies with low staff engagement seeing a reduction in income. Further work would be required by the Trust to analyse the market and to model the potential scope for income growth as a next step after the conclusion of the project. |
| New markets (NHS) | The USP of a “mutual” organisation may provide an opportunity to compete successfully for business both within and without the local region.<br><br>For example, for commissioners wanting to commission from outside the NHS, but with an aversion to “for-profit” organisations, a public service mutual organisation provides a third alternative. |
| New markets (private) | Increased staff engagement and flatter hierarchy may lead to income growth. Evidence from case studies found companies with higher staff engagement achieve increased operating income compared to companies with low staff engagement seeing a reduction in income. Further work would be required by the Trust to analyse the market and to model the potential scope for income growth as a next step after the conclusion of the project. |

| | |
|---|---|
| Productivity improvements | Studies have shown a link between levels of staff engagement and absenteeism. Research found that highly engaged employees took 2.7 days sickness compared to 6.2 days for disengaged employees. For Liverpool Heart and Chest, the Trust believes that higher productivity could generate savings between £0.5 million and £1.2 million predominately through lower use of bank and agency staff. |
| Non-pay cost savings | Anecdotal evidence that increased employee engagement leads to increased profitability, for example through reduced wastage. For Liverpool Heart and Chest, the Trust believe there is scope to achieve recurrent non-pay cost savings of between £0.5 million to £1 million if staff engagement could be increased to around 90%. |
| Tax benefits | Potential benefit (charity only) to secure zero-rating on purchase (by a charity) of certain other goods and services, e.g. drugs and medical, laboratory and sterilising equipment used for medical diagnosis or treatment. This could result in a recurrent £4 million VAT saving for the Trust. |
| Pensions benefits | As set out above in section 4, the potential to reduce pension costs is dependent on the appetite of the organisation to create a “two-tier” workforce. The potential benefit has been modelled at a high level. However, the Trust has decided that it would not want to create a “two-tier” workforce so has decided not to include the potential financial benefit in the research report. |

7..3 **What are the potential financial costs?**

The table below summarises the potential financial costs.

| **Financial costs** | **Commentary** |
|---|---|
| Increased cost of capital | A mutual may present a risk profile that results in higher funding costs than currently charged. Evidence suggests that the cost of capital is likely to be higher for independent providers than foundation trusts. This is because foundation trusts can access public sources of capital which are not necessarily risk reflective.<br><br>Access to capital is also likely to be more difficult for a public service mutual as the capital markets are not as familiar with this sector and therefore less willing to lend. However, new sources of capital are being developed which the new entity could access such as Big Society Capital, which was set up in 2012 to develop the market for social investment.<br><br>Further work is required to establish the likely range of the cost of working capital. However, our research indicates that it is quite likely that the cost of capital will be higher than currently available to the Trust and somewhere in the region of 6% to 12%. |
| Increased cost of insurance | As discussed in section 8 a risk exists that the public service mutual may need to seek alternative insurance provision which may incur additional administration and potentially cost up to £150,000 more. Equally, the alternative insurance provision may prove to be cheaper by up to £90,000 depending upon the Trust's claims profile. |
| Increased directors' pay | Directors might demand additional remuneration to reflect the additional risks attached to becoming a corporate director (relating to directors duties and liabilities). However, for the purpose of this research, it has been decided that overall director pay would not increase. |
| Staff incentive payments | The organisation may choose to pay staff additional payments, linked to performance. However, it has been decided that any increase in pay would not exceed the additional contribution from staff, i.e. "something for something". Therefore, the overall impact on profitability would remain neutral. |
| VAT and Tax impacts | These are considered in the next section of the report |
| One off transition costs | There would be significant costs associated with developing the business case up to implementing the move to a public service mutual. The period from decision until ultimate implementation would be likely to span a number of years, and therefore the associated costs would need to be |

| | |
|---|---|
| | thoroughly assessed and refined through the business case approval process.<br>Costs would include:<br>▪ Legal and professional costs between £0.5 - £0.6 million<br>Costs of backfilling internal transition project team of between £0.4 - £0.5 million |

## 7..4 What are the potential tax impacts?

### 7..4.1 *VAT Implications of mutualisation*

The mutualisation of the FT (either as a CIC or Charitable entity) would result in the loss of s41 (to the Value Added Tax Act 1994) status, which currently allows the FT to recover VAT incurred under Contracted-Out Services rules. The expected loss to VAT recovery for the new entity would be in the region of £1.5 million to £2 million per annum. This loss could be mitigated if enabling legislation could be implemented to either expand s41 or add a further section to s33 (i.e. s33D) to allow the new entity to operate on a similar footing to NHS Trusts, Local Authorities and Hospices etc. This would not be a straight forward process nor could a successful outcome be guaranteed, although we are aware that the Cabinet Office is currently exploring options in this area.

Moreover if the new entity became a charity, the new entity could benefit from zero-rating relief on the purchase of certain goods and services (e.g. drugs and medical equipment used in diagnosis or treatment). The potential VAT benefit of zero-rating is estimated to be in the region of £4 million per annum, based on current spending levels. Again, it is the Trust's expectation that enabling legislation would need to be bought into effect to allow this to happen. Legislative changes are likely to take a significant time to bring into effect.

### 7..4.2 *The transfer of the business and assets*

For VAT purposes, the transfer of the business and assets (into either a CIC or Charity) would be outside the scope of VAT (i.e. no VAT would be chargeable on the consideration) provided it satisfied the conditions of a Transfer of a Going Concern ('TOGC') under s49 of the VATA 1994 or fall within the provisions of a Statutory Order.

If the conditions could not be satisfied then VAT would be likely to be due on the value of the assets transferred at the standard rate (i.e. 20%) which is believed would be approximately £13.95 million. The VAT then incurred by the new entity on the transfer of assets (assuming no TOGC) would be regarded as an overhead of the business and only be recoverable to the extent the new entity made taxable supplies (or was eligible to recover such VAT under a newly created s33D, where appropriate).

### 7..4.3 *VAT treatment of supplies made after the mutualisation*

The VAT liability of supplies made following the mutualisation of the FT (either as a CIC or Charity) would be dependent on the nature of the goods and/or services being supplied. It would be expected that a majority of the services to be provided by the new

entity would comprise healthcare and would qualify for the VAT exemption (under Group 7 to Schedule 9 of the VATA 1994). To the extent the FT previously made taxable supplies (e.g. catering and car parking etc), the VAT liability of these goods and services would remain the same in the new entity. The Trust would expect the new entity to be heavily 'partially exempt' for VAT purposes

Where customers of the new entity incur VAT on supplies received (from the new entity), they may be blocked from recovering such VAT where they are not VAT registered (e.g. consumers) or engaged in a exempt or non-business activities (e.g. NHS Trusts or Universities etc). As the new entity would fall outside of the NHS divisional VAT registration it would be obligated to charge VAT to other NHS organisations under the normal VAT rules.

### 7..4.4 *VAT recovery status after mutualisation*

As noted above, it would be expected the new entity (be it a CIC of Charity) to be heavily 'partially exempt' for VAT purposes. As a result the new entity would be` unlikely to be eligible for significant VAT recovery under the normal rules (i.e. any VAT incurred on costs that is directly or indirect related to VAT exempt supplies would not be eligible for recovery). Aside from increasing its level of taxable supplies made, the only option to mitigate this additional VAT cost would be either the extension of s41 or the addition of s33D as noted above. As such, without enabling legislation additional VAT costs would likely be prohibitive.

### 7..4.5 *Corporation Tax implications of mutualisation and the asset transfer*

Even if established on a not for profit basis, a CIC, would introduce a corporation tax cost on an ongoing basis. In addition, the corporation tax impact for the CIC/social enterprise as a result of the initial transfer of assets would also need to be considered (including whether goodwill has been transferred, whether allowances available for the capital assets transferred and what the impact on the ongoing corporation tax cost is as a result). As such, enabling legislation would need to be considered in order to negate any corporation tax charges introduced as a result of 'mutualisation'.

Alternatively a charitable entity could be established. This would be able to claim exemption from corporation tax in relation to its primary purpose (charitable) activities. However, other activities such as commercial trading would be bought within the charge to corporation tax.

### 7..4.6 *Stamp Duty Land Tax implications of mutualisation and the asset transfer*

Stamp Duty Land Tax (SDLT) is likely to apply to a CIC unless enabling legislation provides for the new entity to fall within an existing or new exemption. SDLT charity relief should apply to a charitable entity which means that SLDT should not be a cost to the new entity in relation to any land transactions (to the extent the relief applies).

## 7..5 Summary of financial costs and benefits

It is recognised that given the tight timeframe for the development of the options the capital and revenue costs can only be indicative. Extensive due diligence would be required to robustly test the assumptions made during this research project.

Indicative non-recurrent and recurrent revenue costs and benefits have been estimated for each of the three options and are shown in the table below.

Appendix 3 includes a breakdown of the financial analysis below.

**Non-recurrent costs**

| **Option** | **Indicative one off revenue costs** | | |
|---|---|---|---|
| | **Best case (£'000)** | **Expected case (£'000)** | **Worst case (£'000)** |
| Option 1 - Do nothing | 0 | 0 | 0 |
| Option 2 - Implement plan to better engage and empower staff within the current FT model | 200 | 225 | 250 |
| Option 3 - Implement plan to better engage and empower staff but also seek legislative changes to FT model which will help to improve staff empowerment | 200 | 225 | 250 |
| Option 4 - Implement plan to better engage and empower staff but also further explore an employee owned organisation to improve staff empowerment | 900 | 1,000 | 15,050 |

It should be noted that the worst case scenario under Option 4 assumes that SDLT is applied to the transfer of new assets to the new entity.

**Recurrent revenue costs**

| **Option** | **Indicative recurrent revenue costs** | | |
|---|---|---|---|
| | **Best case (£'000)** | **Expected case (£'000)** | **Worst case (£'000)** |
| Option 1 - Do nothing | 0 | 0 | 0 |
| Option 2 - Implement plan to better engage and empower staff | 0 | 0 | 0 |

| | | | |
|---|---|---|---|
| within the current FT model | | | |
| Option 3 - Implement plan to better engage and empower staff but also seek legislative changes to FT model which will help to improve staff empowerment | 0 | 0 | 0 |
| Option 4 - Implement plan to better engage and empower staff but also further explore an employee owned organisation to improve staff empowerment | 0 | 1,500 | 2,150 |

It should be noted that the best case scenario under Option 4 assumes that VAT legislation is changed to extend the VAT refund on contracted out services to public service mutual that provide NHS care.

**Recurrent revenue benefits**

| **Option** | **Indicative recurrent revenue costs** | | |
|---|---|---|---|
| | **Best case (£'000)** | **Expected case (£'000)** | **Worst case (£'000)** |
| Option 1 - Do nothing | 0 | 0 | 0 |
| Option 2 - Implement plan to better engage and empower staff within the current FT model | 1,100 | 800 | 500 |
| Option 3 - Implement plan to better engage and empower staff but also seek legislative changes to FT model which will help to improve staff empowerment | 1,650 | 1,200 | 750 |
| Option 4 - Implement plan to better engage and empower staff but also further explore an employee owned | 6,290 | 1,645 | 1,000 |

| | | | |
|---|---|---|---|
| organisation to improve staff empowerment | | | |

It should be noted that the best case scenario under Option 4 assumes that the new entity is a charity which qualifies for zero-rating relief on the purchase of certain goods and services.

### 7..6 What would be the expected net present value for each option?

To support the scoring of the financial benefit criteria in the options appraisal, the Trust has calculated the Net Present Value of each option using the financial costs and benefits identified during the research project. The Net Present Value is a cost benefit analysis which calculates the economic costs and benefits for each year covered by the proposal and then summed to produce a net figure for each year. Each of these annual net values is then discounted (using the suggested 3.5% in the Treasury's Green Book) and the results are summed to give a Net Present Value (or NPV). This NPV is the basis on which value for money is assessed.

Typically, the option with the highest NPV is generally taken to be the preferred option. There may however be decisive but unquantifiable costs or benefits which although impossible to quantify are sufficient to override a simple highest Value for Money result. This is why the Trust agreed upon and weighted a range of non-financial evaluation criteria which were used to appraise each option during the options appraisal workshop.

It should be noted that whilst the expected cash flows for all options have been discounted at 3.5% in accordance with the HM Treasury's Green Book, this does not take into account that the cost of capital incurred by a public service mutual (Option 4) is likely to be higher. The Trust should be aware that this would have the impact of reducing the expected net present values calculated for option 4.

In addition, there is a broad assumption that all four options in the short list would be affordable to the organisation but this would need to be confirmed in more detail after the completion of this research project and costs became more accurate.

The indicative capital and revenue costs shown in Section 7 have been used to calculate the Net Present Value (NPV) of each option over a 30 year life using discounted cash flow techniques in accordance with HM Treasury guidance. The results from this are shown in the table below.

| **Option** | **Best case (£'000)** | **Expected case (£'000)** | **Worst case (£'000)** |
|---|---|---|---|
| 1. Do nothing | 0 | 0 | 0 |
| 2. Improve staff engagement as a FT | 18,580 | 13,434 | 8,289 |
| 3. Improve staff engagement as a FT Plus | 27,968 | 20,262 | 12,556 |
| 4. Public service mutual | 106,483 | 1,492 | -33,734 |

The table shows that Option 3 has the highest NPV over 30 years in the expected case. It also shows that whilst Option 4 has the greatest potential financial benefit in the best case scenario, it also has the largest difference between the NPV returns of the best and worst case scenarios which indicates that it is the option which would present the highest risk in terms of financial return.

***Key messages:***

- ***The potential financial benefits may be greater if the Trust spins out of the NHS. In the best case scenario, it has the highest Net Present Value.***
- ***However, the financial costs and risks are also higher. For example, spinning out of the NHS may result in a loss of s41 status which currently allows the Trust to recover VAT of between £1.5 million to £2 million on contracted out services. However, the Department of Health is reviewing VAT legislation would may allow a public service mutual that provides NHS care to retain s41 status. Without this VAT refund, the financial risks are felt to outweigh the financial benefits.***
- ***In the expected case scenario, seeking to become an enhanced FT has the greatest financial benefit (or Net Present Value).***

## 8 Governance, Legal and Management Option Appraisal

### 8..1 Introduction

This section of the report describes the key costs, benefits and risks associated with each option from a legal and governance perspective.

### 8..2 What legal form options would be available?

The legal structure of a FT is a public benefit corporation which is a body corporate constituted in accordance with Schedule 7 of the NHS Act 2006. If the organisation remains as a FT or become a FT Plus, this is the only legal structure available.

If the Trust chose to spin out services into a public service mutual then a number of legal structures are available. The long list of options include:

- Company limited by shares or by guarantee
- Limited liability partnership
- Social enterprise
- Community Interest Company (a regulated form of social enterprise)
- Industrial & Provident Society
- Co-operative
- Charity
- Joint venture

The Steering Group considered a paper which described the key features of each legal structure and the associated costs and benefits. All but three of the options – social enterprise, community interest company and charity – were eliminated by the Steering Group for the reasons set out below.

| Option | Rationale |
|---|---|
| Company limited by shares | Although this model may create a strong sense of ownership amongst staff as co-owners of the organisation, the ability to distribute profits to shareholders in the form of dividends may create a perverse incentive to maximise shareholder value which could come into conflict with NHS values and the Trust's current vision and strategic objectives. Whilst this option was ruled out, it was acknowledged this form can be used as the basis for a social enterprises model which would have community purpose embedded into its legal constitution. |
| Limited liability partnership | May be attractive but only if the Trust chose to partner with other local organisations to provide NHS care. On the basis, that none of the three shortlisted options involve this, the option was ruled out. |
| Industrial & Provident Society | The lack of tax advantages makes this option unattractive |

| | |
|---|---|
| Cooperative | This model may be attractive if the Trust preferred to better engage and empower patients rather than staff. In addition, the lack of tax advantages makes this option unattractive |
| Joint venture | May be attractive but only if the Trust chose to partner with other local organisations to provide NHS care. On the basis, that none of the three shortlisted options involve this, the option was ruled out. |

8..3 **What are the features of a social enterprise model?**

Social enterprises can take many different forms but essentially the economic features are identical, these are essentially;

- Continuous activity of the production and/or sale of goods and services (rather than predominantly advisory or grant-giving functions).
- A high level of autonomy: social enterprises are created voluntarily by groups of citizens and are managed by them, and not directly or indirectly by public authorities or private companies, even if they may benefit from grants and donations. Their shareholders have the right to participate ('voice') and to leave the organisation ('exit').
- A significant economic risk: the financial viability of social enterprises depends on the efforts of their members, who have the responsibility of ensuring adequate financial resources, unlike most public institutions.
- Social enterprises' activities require a minimum number of paid workers, although, like traditional non-profit organisations, social enterprises may combine financial and non-financial resources, voluntary and paid work.

In addition, there are a number of social criteria that must be adopted as follows;

- An explicit aim of community benefit: one of the principal aims of social enterprises is to serve the community or a specific group of people. To the same end, they also promote a sense of social responsibility at local level.
- Citizen initiative: social enterprises are the result of collective dynamics involving people belonging to a community or to a group that shares a certain need or aim. They must maintain this dimension in one form or another.
- Decision making not based on capital ownership: this generally means the principle of 'one member, one vote', or at least a voting power not based on capital shares. Although capital owners in social enterprises play an important role, decision-making rights are shared with other shareholders.
- Participatory character, involving those affected by the activity: the users of social enterprises' services are represented and participate in their structures. In many cases one of the objectives is to strengthen democracy at local level through economic activity.
- Limited distribution of profit: social enterprises include organisations that totally prohibit profit distribution as well as organisations such as co-operatives, which may distribute their profit only to a limited degree, thus avoiding profit maximising behaviour.

A social enterprise is not a legal entity itself and would need to register with Companies House as either a company limited by shares or company limited by guarantee or an industrial and provident society. When registering with Companies House, there would be the need to provide additional documents, including a community interest statement

describing the social purpose. As with a limited company, there are two governing documents – Memorandum of Association and Articles of Association.

Additionally, the community interest we would wish to benefit must be identified, as must the activities to be carried out and how they would benefit the community. Unlike CICs, other forms of social enterprise are not subject to dual regulation – by Companies House and the CIC Regulator

Social enterprises can qualify for charitable status. Social enterprises have a two-tier management structure, as per a company and Directors' remuneration packages may be subject to openness and transparency.

Generally, as companies they pay corporation tax and must make an annual return to HM Revenue & Customs (HMRC). A company limited by guarantee can make a gift aid payment and receive a tax deduction in respect of a payment to a charity. The nature of the company's activities must be considered from a VAT perspective especially if the company is involved in an exempt activity (due to irrecoverable VAT) or if customers are unable to recover VAT charged which may impact pricing. Tax and VAT systems and processes would need to be established.

8..4 **What are the advantages and disadvantages of the social enterprise model?**

The advantages are as follows:

- Run for the benefit of the members, i.e. employees and/or the community.
- Surpluses re-invested in the organisation/community.
- Asset lock so assets cannot be sold off for private gain
- Lighter touch regulation compared to Monitor regime
- Capable of making a gift aid to a charity.

The disadvantages are as follows:

- Potential limited ability to raise finance as awareness of CICs amongst lenders is still low.
- Less flexible.
- Cannot distribute profits although can make a gift aid donation to a charity.

8..5 **What are the features of a community interest company?**

A CIC is a regulated form of social enterprise. CICs combine the features of the conventional company form with those normally associated with a charitable organisation. The main features include: the requirement to satisfy a 'community interest' test; profit distribution is not permitted (the model does allow a dividend to be paid to investors, but the rate is tightly controlled); there is a cap on investment returns; limits on investor control and stakeholder influence; and a lock on assets to ensure they are held for community benefit if the company is wound up. This means that the assets and profits must be retained within the CIC and used solely for community benefit, or transferred to another organisation that itself has an asset lock or similar restrictions. CICs are frequently used as a model for social enterprises.

To register as a CIC it is required to register as either a company limited by shares or a company limited by guarantee. When registering the CIC with Companies House, it would

needed to provide additional documents, including a community interest statement describing your social purpose. The CIC Regulator would approve the application if the statement passes the community interest test.

As with a limited company, there are two governing documents – Memorandum of Association and Articles of Association.

Additionally, the community interest to be benefited must be identified, as must the activities to be carried out and how they would benefit the community.

CICs are subject to dual regulation – by Companies House and the CIC Regulator (but are perceived to have more flexibility and less regulation than a charity).

CICs cannot qualify for charitable status. CICs have a two-tier management structure, as per a company and Directors' remuneration packages may be subject to scrutiny by the CIC Regulator

In addition to an annual report, annual accounts and a directors report, there is a duty to produce an annual community interest company report detailing salaries, assets transferred and a description of how the CIC has benefited the community.

CICs must also publish an annual social report explaining how it is serving a specified community of interest, or locality, to the CIC Regulator.

There are no special tax reliefs attaching to a CIC, and an assessment of the Corporation Tax, VAT and Stamp Duty Land Tax liabilities would need to be made as per companies limited by shares or guarantee and Limited Liability Partnerships (LLP). CICs can make gift aid donations to charities.

### 8..6 What are the advantages and disadvantages of a community interest company?

The advantages and disadvantages of a community interest company are similar to a social enterprise. The key difference is the additional regulation which the organisation would be subject to but this is relatively light touch.

### 8..7 What are the features of a charity?

Charitable status is available to all organisations which have exclusively charitable purposes and activities and providing certain tests are passed. The legal requirement is that all charities must have a 'public benefit', identifiable benefits and defined qualifying charitable purposes.

To become a charity:

- A governing document needs to be drawn up, which ensures that the purposes of the trust or company are charitable and benefit the public (model documentation is available on the Charity Commission website). The precise model documentation would depend upon whether a simple trust is to be formed or a charitable company.
- A Charity Commission application form, with declaration completed by trustees/directors, needs to be completed, including any supporting documentation. Since 2010 it is be possible to set up a charitable incorporated organisation. This corporate structure is designed specifically for charities. It would permit charities to be incorporated but without being registered with and regulated by Companies House as well as the Charity Commission. This would need further investigation.

A charity may take two forms. The first is a so-called trust, which is not a strict legal entity and acts through its trustees; the second is a company, which is a legal entity and acts through its directors. Once the decision as to the legal status of the charity has been made, trusts or companies can then, if necessary, apply to register their charitable status with the Charity Commission. Companies would also need to register with Companies House. Organisations with charitable status are regulated by the Charity Commission.

A charity has preferential tax status: it is exempt from Corporation Tax on its primary purpose activities and it can access certain VAT and Stamp Duty Land Tax reliefs. Other tax considerations would be similar to companies limited by shares or guarantee and LLPs.

8..8 **What are the advantages and disadvantages of a charity?**

The advantages are as follows:

- Significant tax advantages of charity status which would realise cost savings

The disadvantages are as follows:

- Complex regulatory environment. Although there are clear benefits to setting up a charity this is also a highly regulated area, with strict governance requirements. Setting up a charity is considerably more complex than setting up, for example, a company limited by guarantee without charitable status.
- Risks vest with the Trustees

8..9 **If the Trust became an employee owned organisation, what options would be available for employee ownership?**

Employee ownership is not an option under the FT model. No one is the strictest sense owns a foundation although the members of a FT have rights of control via the Council of Governors. However, as this is through legislation rather than direct share ownership, in practice there is not a great sense of “ownership” or “control” by members. In reality, the body that acts most like a shareholder in the current FT regime is Monitor, the independent regulator, as that is who most trust boards feel held to account by rather than governors or members. The advantage of this model is that FT have a failure regime and Monitor can provide turnaround support when required. The drawback to this model is that it undermines efforts to empower staff as they have little influence or power. In addition, there is a great regulatory burden placed on the Trust by Monitor which comes with a significant overhead cost which employee owned organisations may not have.

For the purpose of simplification, we have only considered options for employee ownership assuming the legal structure is a company limited by shares. The options available are as follows:

| **Employee ownership options available** | **FT** | **FT Plus** | **Public Service Mutual** |
|---|---|---|---|
| Indirect - Employee trust | No | No | Yes |
| Direct - Individual share ownership | No | No | Yes |
| Combined trust & share ownership | No | No | Yes |

The most common method of employee ownership within existing public service mutual that provide NHS care is direct employee ownership, e.g. one £1 share offered to each employee. This is the method used by City Healthcare Partnership and Locala.

Central Surrey Health (CSH), which was the first public service mutual to transfer out of the NHS in 2006, has set up an employee trust. CSH's shares are held by four co-owner Guardian Shareholders, whose primary roles are to vote on behalf of their fellow co-owners at Annual General Meetings. They are accountable to CSH 's Guardian Trust, a group of six Trustee Directors who ensure the Guardian Shareholders act in the best interests of patients, co-owners and CSH .

The key features of each employee ownership options are described below.

**Employee Trust**

A common solution is for the shares to be first bought into a "warehouse" and subsequently held in trust for the long-term benefit of employees.

This would require the establishment of an employee trust and to fund it to make the purchase of shares. A discrete pool of shares sits in the trust, held under a legal duty to apply the benefit of the shares for employees, either by transfer to employees over time or long-term retention in the trust.

In its simplest form, establishing a trust can be accomplished in a few days and requires:

- The creation of a trust deed. This can take a standard form (although this deed may need tailoring if there are particular requirements for how the trust would operate).
- The formation or purchase of a shelf company to act as trustee. The shelf company must have at least one director, although individual trustees are an alternative.
- Notifying HMRC of the trust's creation.
- Opening a bank account for the trust.

The best known example of an employee trust outside of the NHS is the John Lewis Partnership.

There are two types of employee trust:

- General employee trust – shares are held for employees and possibly their dependents and former employees – the beneficiaries. The trust is discretionary allowing the trustees wide scope in deciding how benefit should be allocated to the beneficiaries.

- Trust used to hold shares under a Share Incentive Plan (SIP) – A SIP based trust has a more specific purpose of allocating shares to named employees and holding them in their names for a period (normally 5 years) after which they can be released. Latter point is problematic in that it can create complexity and cause instability in the ownership structure. However, eemployees can benefit from relief against income tax and National Insurance (NI) by acquiring shares in this way. The organisation also saves employer NI on the value of any shares acquired.

Starting a general employee trust is simple and cost effective and offers more flexibility. Setting up a SIP requires more work and is less flexible but has tax advantages.

Employee trusts must have one or more trustees who have a legal duty to hold the Trust's assets for the purposes laid down in the trust deed. Trustees may be individuals or a single corporate trustee whose directors perform the role of trustees.

The trust may have an important role in ensuring that the organisation's board is accountable to the shareholders. Therefore, you shouldn't just appoint trustees from the board of directors as this may create a conflict of interests. Trustees could include:

- Employees
- Independent individuals with business experience
- Non-executive directors from the board of directors
- Executive directors

The last two categories should comprise a minority of the total trustee board.

Advantages of an employee trust are:

- Employees can be rewarded for success, e.g. performance related rewards, but unlikely for a NHS care provider
- No shares are held by individual employees which is beneficial because there is no pressure on the organisation to provide a financial underpin to ensure that sellers are always able to sell – although financial pressure is unlikely as total share capital is likely to be low, e.g. £1 per employee
- It can create a stronger focus on the long term as free of pressure to sell shares to realise investment

Disadvantages of an employee trust are:

- No personal shareholdings with no scope for tax-efficient performance based rewards
- Employees are not able to make capital gains on shareholding

**Individual share ownership**

There are typically three ways in which employees can become direct shareholders:

- Buying shares – they can obtain relief against income tax and NI as the share is purchased from their pre-tax income
- Being given shares free of charge – employees acquire shares without risking personal savings. Free shares can be awarded tax free through a SIP or otherwise would have to pay income tax and NI on the value of the shares. Tax advantages likely to be minimal in a public service mutual
- Share options – Provide an option to acquire shares through a Save As You Earn (SAYE) scheme although unlikely in a public service mutual.

Advantages of individual share ownership:

- Direct share ownership is the most straightforward and powerful way of creating a feeling of co-ownership among employees
- Strong positive connection between direct share ownership and performance improvement if staff are incentivised in the most right way
- Employees can share in capital growth although unlikely in a public service mutual
- Cost to the organisation of financing employee share ownership may be set off against corporation tax – again likely to be minimal in a public service mutual context.

Disadvantages of individual share ownership:

- Potential pressure on company to provide financial underpin to ensure sellers are always able to sell. However, likely to be minimal if only one share is offered to each employee.
- May require wider consultation / votes to be cast on any key decisions set out in the constitution.

**Combined trust and share ownership**

Combined trust and individual share ownership is possible. Initially, employees may hold no shares directly and all employee ownership is through the employees' trust. Over time, the trust may transfer shares to individual employees, but always retaining a minimum percentage of shares in long-term trust ownership. This may combine the best of both worlds but does not fully eliminate the disadvantages inherent in each option.

**What would be the cost, benefits and risks associated with employee elected directors of the board?**

Evidence suggests that employee ownership does not automatically lead to greater participation in the running of the organisation. The key benefit of employee elected directors on the board is that it is a formal way for giving co-owners a greater say in the running of the organisation.

The disadvantage of employee elected directors is that equipping them for the task can be challenging as they may not have the requisite skills, knowledge and capacity to effectively fulfil the role.

It would be important that they understand the time that needs devoting to the role. They are likely to need to attend training courses in-house or externally provided. They may also require a mentor who can offer to talk them through any issues which they need to understand. All of this would come at a cost to the organisation. Investing in the elected directors would be significantly more important than it is for Council of Governors within a FT.

8..10 **If the Trust became a public service mutual, what could the role and composition of the Board look like?**

The key difference between a FT board and a potential board of a public service mutual is that it may include elected directors who represent the interests of shareholders and/or staff. The other variables to consider are the number of directors on the Board, the balance between the three different types of director and the skills that may want your non-executive directors to possess, e.g. greater private sector / commercial experience.

| **Board composition** | **FT** | **Public Service Mutual** |
|---|---|---|
| Non-executive directors | Yes | Yes |
| Executive directors | Yes | Yes |
| Elected directors | No | Yes |

In the FT model, the Council of Governors appoint directors to decide on strategy and managers to make day-to-day decisions and guide and supervise the activity of the employees in pursuit of this strategy.

In an employee owned organisation, the same processes occur, although in this case the employees are also shareholders and therefore have rights and responsibilities that come with that role. At the same time the directors would also usually be employees and also shareholders so the roles overlap. Whilst the directors would still run the business day to day, in an employee ownership structure, there are normally formal processes and structures in place to ensure that they are held accountable to the employee owners.

The employee 'voice' is extremely important in employee owned organisations and is normally represented in a formal way, such as through the Employee Benefits Trust trustees (if there is an EBT), via Employee Forums or Councils and through high profile information sharing and greater transparency, employee involvement and increased levels of trust. However, it is always important that this is balanced with the need to have effective decision making within the organisation

Board structures of employee owned organisations that provide NHS care do slightly differ from one another but in general they have a board of directors (consisting of non-executive directors and executive directors) which is accountable to some form of employee council. The employee council is similar to the Council of Governors in the FT model. However, a key difference is that it is mostly made up of employees rather than other stakeholders from other parties but also that they have an ownership stake in the organisation which may make their participating more meaningful.

8..11 **If the Trust became a public service mutual, what could the management team look like?**

The role and composition of the management team would not fundamentally differ if the Trust became a public service mutual. Any changes to the management team are likely to apply to a FT as it would a public service mutual.

8..12 **How would regulation differ under each option?**

As a foundation trust, the Trust would remain subject to regulation by multiple bodies and external agencies, most notably Monitor and the Care Quality Commission (CQC). The advantage of maintaining the status quo from a regulatory perspective is that Monitor do provide a safety net in the event of financial distress. For example, Monitor may direct Trusts to appoint a turnaround director, hire external advisors to provide expert support or help the Trust to secure financial support in the form of Public Dividend Capital or loans from the Department of Health. This might be felt to be burdensome by the Trust at the

time but it does provide support in times of distress which would otherwise not be available to the Trust if it left the NHS to form a public service mutual.

However, the status quo also brings disadvantages from a regulatory perspective. This key disadvantages identified include:

- The need to account for performance to Monitor and the CQC is burdensome and costly. A public service mutual is likely to be able to have lower management costs because of the lighter regulation regime.
- Top-down intervention by regulators has a disempowering effect on organisations which therefore may limit the Trust's ability to engage and empower staff.
- The need for regulatory approval and management's focus on achieving top-down targets may stifle or slow down innovation which may help to improve patient care.

The other option which the Trust is considering is FT Plus. Under this option, the Trust would likely remain subject to regulation by multiple bodies including Monitor and the CQC. However, it may be possible as part of this programme for the Trust to seek changes in the way that Monitor acts as a regulator to mitigate the disadvantages set out above. This might include seeking a move away from directive regulation model to a more facilitative model. For example, regulators could intervene in a more supportive way which would encourage and model the kind of leadership behaviours that encourage rather than hinder staff engagement and empowerment.

The final option is to become a public service mutual. A public service mutual is likely to subject to regulation by a number of bodies including Monitor and CQC. However, it is believed that it would be subject to less regulation than a foundation trust overall. The key points are set out below:

- There would be no change in the requirement to register as a provider of health care with the CQC and would still be subject to their inspection regime.
- The public service mutual would need to apply for an independent provider license from Monitor.
- To be subject to Monitor's Risk Assessment Framework, an independent provider must be designated as a providing a "Commissioner Requested Service" (CRS). This would be the case for services currently provided by Liverpool Heart & Chest Hospital NHS Foundation Trust and therefore we believe the public service mutual will still be subject to some Monitor regulation.
- With CRS status, the public service mutual would need to meet Continuity of Service Licence Conditions 3, 4 and 7 (suitable corporate governance, no undue influence or financial risk from other group members, sufficient resources to provide the service.
- It would also be subject to the following checks on risk:
  - Liquidity
  - Capital servicing facility
  - Assessment of financial data e.g. current and forecast income & expenditure, balance sheet and cash flow.
  - Where applicable - Debt maturity profiles and banking profiles, annual reports and accounts and other information e.g. planned transactions.
- The public service mutual would be given a risk rating of 1-4 based on the above.

- Depending on the risk rating and the financial size of the service being provided there would be monthly, quarterly, six monthly or annual monitoring.
- Providers would also be expected to exception report e.g. material financial events, CQC warnings
- The public service mutual might be subject to some new regulation depending on the legal form chosen which has already been covered earlier in Section 8. However, this is not expected to be onerous.

Whilst a public service mutual that provides commissioner requested services would be subject to Monitor regulation under its Risk Assessment Framework, it would be less than that currently faced by foundation trusts. The clear advantages of less regulation is as follows:

- It would allow the new entity to reduce its management costs to reflect that less time and resource were required reporting upwards to regulators.
- It would be less likely to suffer top-down, directive intervention from Monitor which would assist in efforts to improve staff engagement and empowerment; and
- A public service mutual would have greater freedom to innovate because it would be less likely to need to seek regulatory approval

However, the price of being freed from some of the regulatory burden faced by foundation trusts, is that it would be a standalone entity, responsible for its own success or failure. Failure of the business could result in the insolvency of the public service mutual in the event of financial distress. A public service mutual would not be able to depend upon the financial support that Monitor and the Department of Health can and often do provide to financially distressed foundation trusts.

8..13 **If the Trust became a public service mutual, how would the Trust's membership of the NHS Litigation Authority's Clinical Negligence Scheme for Trusts be impacted?**

If the Trust remains as a FT, the Trust would be entitled to maintain its membership of the NHS Litigation Authority's Clinical Negligence Scheme for Trusts (CNST). However, the Trust may still wish to consider alternative insurance provision especially in light of increasing significantly increased annual premiums. Some foundation trusts have already started to explore the costs, benefits and risks of switching their clinical negligence insurance to a private sector provider as a way of seeking to reduce their insurance costs.

It is possible for an NHS organisation which spins out into a public service mutual to retain access to CNST. However, we understand that public service mutual are currently unable to access some of the NHS Litigation Authority's (NHSLA) schemes. Therefore, a risk exists that the public service mutual may need to seek alternative insurance provision which may incur additional administration and potentially more cost. Equally, as previously mentioned, the alternative insurance provision may prove to be cheaper depending upon the Trust's claims profile.

The types of insurance which the Trust might not be able to access through the NHS Litigation Authority includes employers and public liability insurance, combined liability insurance, and executive risk insurance.

Based on current data, insurance costs to a social enterprise is around £30,000-£50,000 per £10million turnover. Based on current turnover, the insurance costs of the public service mutual are estimated to be between £345,000 and £575,000. This compares to the CNST cost of £436,000 in financial year 2013/14.

The key message is that uncertainty exists around the ability to retain membership to CNST and NHSLA schemes if we became a public service mutual. There is also uncertainty as to whether the cost of replacing this with commercial schemes would be a cost pressure or cost saving. If the Trust Board decided to spin out any services, it would need to consider its insurance provision as part of its due diligence.

***Key messages:***

- ***Three main legal structures were considered which could be used to create a public service mutual – social enterprise, community interest company and charity. Most existing public service mutual organisations that provide NHS care have used the community interest company legal structure.***
- ***Three options exist for employee ownership – the most common method used by social enterprises that provide NHS care is direct share ownership, e.g. £1 share financed by the organisation and given to each employee.***
- ***There is a view that co-ownership is the most effective way of embedding staff engagement and empowerment into the culture and governance of an organisation.***
- ***A public service mutual would be subject to regulation from both Monitor and the Care Quality Commission. However, the extent of regulation by Monitor is likely to be significantly less which could help to reduce management costs and more crucially help to improve staff engagement further than could otherwise be done as a foundation trust.***
- ***A PSM would be able to maintain its membership to CNST. However, it may not have access to all of the NHS Litigation Authority's schemes and may therefore need to find alternative insurance provision. Dialogue with commercial insurers is required to determine if this would or would not be more expensive.***

# 9 Feedback from other pathfinders

## 9..1 Introduction

This section of the report describes the findings reported by the other pathfinder organisations.

## 9..2 Who are the other pathfinder organisations?

There were nine NHS organisations which applied to become pathfinders for this Cabinet Office sponsored programme. They were as follows:

- Liverpool Heart and Chest Hospital NHS Foundation Trust (Specialist Trust)
- Cheshire and Wirral Partnership NHS Foundation Trust (Mental Health Trust)
- Tameside Hospital NHS Foundation Trust (Acute Trust)
- Norfolk and Norwich University Hospitals NHS Foundation Trust (Acute Trust)
- Oxleas NHS Foundation Trust (Mental Health Trust)
- Surrey and Sussex Healthcare NHS Trust (Acute Trust)
- Moorfields Eye Hospital NHS Foundation Trust (Specialist Trust)
- Norfolk and Suffolk NHS Foundation Trust (Mental health Trust)
- University Hospitals of Leicester NHS Trust (Acute Trust)

Of the above, two organisations have since dropped out of the programme – Norfolk and Norwich University Hospitals NHS Foundation Trust and Norfolk and Suffolk NHS Foundation Trust. Despite press reports to the contrary, the main reason that they have both dropped out of the programme was because both organisations are under review by Monitor because of financial, operational and quality performance concerns. Resolving those concerns whilst going through the annual planning process was too significant a burden on management capacity which meant they could not devote sufficient time to a research project before the end of this financial year.

## 9..3 What are the common findings being reported by the other pathfinders so far?

There are four common areas which the pathfinder organisations are reporting at this early stage:

- Staff and union representatives that have been engaged by the pathfinder organisations have generally been resistant to the idea of spinning out services into a public service mutual. Their views are generally based on preconceptions of what mutualisation is. Understandably they are concerned about job security and the terms and conditions of their employment. However, perhaps more importantly, it is because many do not see a pressing need for change. The majority of existing public service mutuals – in different ways - were set up to respond to a sense of urgent need – or crisis – which they used to drive change. For example, the level of competition that existed for a niche service meant that employees wanted to spin out into an employee-owned business rather than be acquired by another large NHS provider. In the current Programme, many of the pathfinder organisations – including Liverpool Heart and Chest Hospital NHS Foundation Trust – do not face an imminent crisis to upset the status quo.

- Management capacity is limited due to competing pressures, e.g. annual planning, and the timetable for the programme has hindered the ability of pathfinders to properly assess the high level costs, benefits and risks of their respective options

- The greater the scale of services that would be transferred into a public service mutual, the greater the complexity. Only those trusts that are only considering transferring relatively small services (for example, services with less than 50 staff) into a public service mutual appear to be seriously committed to spinning out services in the short-to-medium term at this stage.

- Five out of the seven remaining pathfinders have expressed an interest in contributing to the debate as to how legislation could be changed to improve the current FT model so organisations can better engage and empower staff. There are two areas where pathfinders believe legislation could change. Firstly, the composition and role of the Council of Governors. At the moment, legislation states that staff governors must be in the minority. However, there is a growing consensus that it would help to empower staff if staff governors proportion could at least be increased to give staff a stronger voice in the Council of Governors. Secondly, the role of Monitor, as the independent regulator of NHS Foundation Trust. Although foundation trusts are legally controlled by the members and one of the duties of the Council of Governors is to hold the Trust Board to account, the reality is that trust boards feel more held to account by Monitor. There is a growing consensus that the role of Monitor and the way in which it regulates foundation trusts would need to change so that the governors' role could increase in importance.

***Key messages:***

- ***All pathfinders have encountered staff resistance to the idea of mutualisation. However, some of these concerns are largely based on preconceptions.***

- ***Small is beautiful. Spinning out service lines at a small scale is more likely in the short-to-medium term rather than whole trust spin outs because of the financial risks which emerge for larger providers.***

- ***There is a lot of interest in changing and improving the FT model between the pathfinder organisations. Recommendations for regulators and central government will be made as part of this project.***

# 10 Recommendations

## 10..1 Introduction

This section of the report outlines the key recommendations for the Trust, local partners, regulators and central government.

## 10..2 Recommendations for the Trust

Given the strength of evidence which shows that there is a positive correlation between staff engagement and patient outcomes, the overarching recommendation from the options appraisal is that the Trust needs to dedicate greater time, attention and resources to considerably improve staff engagement. It is a subject that should demand regular discussion and reflection at all levels of the organisation, including the Trust Board. The Trust should seek to embed staff engagement into the culture of the organisation so that it is resilient to changes in the management team. In addition, in conjunction with the other pathfinder organisations, the Trust could seek legislative and regulatory changes which will also help to empower staff to have a greater say in the running of the organisation.

To achieve the overarching recommendation, a number of potential actions have been developed under nine improvement themes which are as follows.

1. *Highly visible, supportive and inclusive leadership style with open lines of communication with management team*

| **Recommendation** | **Deadline** |
|---|---|
| Undertake a review of the effectiveness of the various staff communication channels currently in place at the Trust. This review should involve seeking views of staff. Consider making changes for channels which are considered to be ineffective. Generally, face-to-face communications whilst the most resource intensive are by far the most effective. Consider use of social media to engage different staff demographics. | *June 2015* |
| Advertise Board walk rounds so staff are aware of when they are taking place and to encourage staff to engage with board members – balance this with unannounced 'drop ins', which can help promote quality and safety, especially if out of hours. | *June 2015* |
| Promote use of existing and new informal communication channels between staff and management, e.g. Ask The Executive | *June 2015* |
| Professionalise leadership and management - Provide training to improve the standard of performance management, coaching and mentoring throughout the organisation | *December 2015* |

| | |
|---|---|
| Consider greater use of the NHS Leadership Academy core programmes, to professionalise leaders and managers, and to build networks across the NHS. | *December 2015* |
| Ensure senior managers and other leaders are fully aware of the need to keep engaging people in their teams, i.e. make it one of their objectives and measure it through feedback. | *June 2015* |
| Undertake a review to understand the leadership style that is most prevalent across the organisation, and where this needs to change. Utilise the Healthcare leadership Model 360 appraisal to do this (available on the NHS Leadership Academy website) | *December 2015* |
| Participate in Listening into Action | *April 2015* |

*2. Involve staff in developing strategic direction and service transformation*

| **Recommendation** | **Deadline** |
|---|---|
| Engage staff early when developing strategy to ensure that a compelling and shared strategic direction is set. Engage patients, and the wider community in this too – a truly collaborative approach. | *April 2015* |
| Consider use of technology to obtain staff views on strategic direction, e.g. crowdsourcing, and to share ideas and knowledge | *June 2015* |
| Staff & patient-led service improvement - empower staff to propose and lead service change / establish continuous quality improvement system | *April 2015* |
| Invest in training for staff to develop their skills and expertise to develop, test and implement service change | *October 2015* |
| Establish regular, formal meetings where attendance is strongly encouraged, or even mandatory, to review or develop business plans, and staff are encouraged to raise issues and provide feedback on decisions which may impact the services they provide. This could be single team meetings to larger divisional meetings. Consider use of innovative methods such as appreciative inquiry summits, accelerated solutions events, world cafes and other whole system engagement events. | *December 2015* |

| | |
|---|---|
| Subject to meeting certain standards of governance, devolve autonomy to divisions and/or directorates to empower managers and give staff more of an influence over their environment | *June 2015* |
| Promote innovation stories regularly | *June 2015* |

*3. Employee representation forums (e.g. Council of Governors, Staff Partnership Forums, Listening in Action, Roadshows)*

| **Recommendation** | **Deadline** |
|---|---|
| Considering establishing a Workforce Committee to provide assurance to the Board on the approaches and developmental interventions that support moving the Trust and its employees towards the vision to be the Best | *July 2015* |
| Consider increasing number of staff governors to the greatest extent possible under current legislation on the Council of Governors to increase staff voice | *July 2015* |
| Establish an Employee Forum which is attended by elected representatives from each part of the organisation which allow staff to formally raise issues about the workplace. | *October 2015* |

*4. Regular feedback from employees (e.g. Listening in Action, staff survey)*

| **Recommendation** | **Deadline** |
|---|---|
| Ensure 360 feedback is sought and provided for all senior leaders and managers within the Trust to ensure staff are able to provide feedback on their senior reports. Ensure this feedback is taken into account during appraisals and promotion interviews. Consider using Healthcare Leadership 360 to do this. | *December 2015* |
| Promote use of system where staff are able to quickly able to raise concerns | *June 2015* |
| Ensure results of the NHS staff survey are widely promoted | *June 2015* |

| | |
|---|---|
| Ask managers to engage staff to understand the reasons behind any areas in the staff survey where the Trust has not performed as well as it wants to and develop action plans to tackle the root cause of any dissatisfaction | *June 2015* |
| Widely promote actions taken in response to the NHS staff survey, i.e. "You said, We acted" to demonstrate that management is listening to staff, e.g. Listening into Action | *April 2015* |

*5. CSR activities (e.g. Access to Medicine, apprenticeships)*

| **Recommendation** | **Deadline** |
|---|---|
| Develop Corporate Social Responsibility Strategy in consultation with staff. Encourage staff to suggest ideas for CSR activities | *October 2015* |
| Find best way of promoting CSR opportunities and activities undertaken through staff communication channels | *October 2015* |

*6. Staff conferences / AGM*

| **Recommendation** | **Deadline** |
|---|---|
| Build on Staff Achievement Event to organise iconic events such as an annual staff conference to communicate strategic direction, encourage staff engagement, share ideas and celebrate success. | *December 2015* |

*7. Organisational development programme to equip governors so they can more effectively hold to account*

| **Recommendation** | **Deadline** |
|---|---|
| Invest more in induction and ongoing training provided to staff and other governors to properly equip themselves for the role so that they can more effectively hold the Trust Board to account. | *October 2015* |

*8. Sharing of strategic information with staff*

| **Recommendation** | **Deadline** |
|---|---|
| Consider ways in which strategic information is shared. As part of this, consider embracing new technology (e.g. video casts, podcasts, blogs, text messaging and social networking). | *December 2015* |
| Be open and transparent in sharing information, including both good and bad news. | *June 2015* |

*9. Non-financial rewards and recognition*

| **Recommendation** | **Deadline** |
|---|---|
| Encourage managers to regularly show appreciation of good work and hard effort | *April 2015* |
| Review rites and rituals to celebrate success and reinforce good practice | *October 2015* |
| Ensure staff objectives at a minimum cover financial targets (e.g. cost improvement targets) and innovation as well as quality and values | *June 2015* |
| Promote existing recognition schemes, e.g. Best of the Best / Employee of the Month, which allows staff to nominate colleagues who have 'gone the extra mile' to deliver or improve the quality of patient care which may have financial or non-financial rewards if approved by managers. | *April 2015* |

10..3 **Recommendations for local health economy partners**

*Commissioner support*

Encourage commissioners to support the introduction of alternative providers, such as public service mutuals, where it can improve the care patients receive. For example, the creation of a public service mutual may provide an opportunity to deliver better integrated care by bringing together services currently provided across a range of organisations. Without commissioner support, a public service mutual would not get off the ground.

As part of the Healthy Liverpool Programme, which is aiming to design a new health and social care system to transform the health in Liverpool, commissioners should work with local providers to consider where with the system the creation of public service mutuals could help to deliver improvement in the care that patients receive.

## 10..4 Recommendations for Monitor

*Changing regulatory behaviour*

The directive, interventional way in which Monitor regulates foundation trusts could bes felt to have a disempowering impact on a foundation trust and their Council of Governors. Although the Council of Governors have a duty to hold Trust Board to account, in practice it is Monitor to whom the Trust Board feel most accountable to. As a result, the power and influence of the Council of Governor on the Trust Board could be considerably undermined as management focus their time on upward reporting to Monitor and other regulators. This issue combined with the fact that legislation requires staff governors to be in the minority within the Council of Governors means that the staff voice in how the foundation trust is run is very low. In addition, it may also have the effect of stifling innovation within foundation trusts as fear of regulatory action creates risk adverse leadership behaviours.

Regulators should review whether to change the way in which they regulate if they agree with the evidence that shows that improved staff engagement will help to improve the quality of care that patients receive. We fully endorse the recommendation already made in the 2014 report *Improving NHS Care by Engaging Staff and Devolving Decision-Making: Report of the Review of Staff Engagement and Empowerment in the NHS* (Ham, 2014) which encourages regulators to role model the types of leadership behaviours that deliver better staff engagement. This might include:

- Moving away from top-down intervention to make required changes in favour of a more facilitative and supportive regulatory style particularly in times of financial distress;
- Granting more autonomy to foundation trusts to provide freedom to innovate without the need for regulatory approval.
- Supporting organisations to improve staff engagement rather than measuring performance against external targets;

## 10..5 Recommendations for HM Revenue & Customs (HMRC), Department of Health (DH) and the Cabinet Office

*VAT refund on contracted out services*

Existing VAT rules allow public sector providers to reclaim VAT on some contracted out services. At Liverpool Heart & Chest NHS Foundation this VAT refund in the region of £1.5 million to £2 million per annum which equates to 1.8% of total revenue. Currently if the Trust span out its services into a public service mutual it would lose its s41 status, which currently allows the trust to recover VAT on contracted out services.

The loss of this VAT refund could potentially eliminate the financial benefit that could be gained through productivity improvements in a public service mutual. It would also give public sector provides a cost advantage over the public service mutual as it could offer services at a lower cost than they would otherwise have faced.

This loss could be mitigated if enabling legislation could be implemented to either expand s41 or add a further section to s33 (i.e. s33D) to allow the new entity to operate on a similar footing to NHS Trusts, Local Authorities and Hospices, etc. The Trust recommends that central government review whether to extend the VAT refund on

contracted out services to public service mutual that provide NHS care to remove this cost distortion and significant barrier to implementation.

*Flexibility over composition of Council of Governors*

Statutory guidance requires that there must be a majority of public governors on the composition of the Council of Governors. Conversely this means that staff governors must be a minority which may potentially have a disempowering impact on staff in their ability to have a say in the running of the organisation.

Regulators should consider whether it would be possible to provide flexibility over the composition of the Council of Governors by removing the minimum requirement that public governors must be in the majority. This would allow organisations to increase the number of staff governors to increase their power and influence where it is felt it would help to improve staff engagement and empowerment.

*Cost of and access to capital*

The cost of capital is likely to be higher for a public service mutual than a public sector provider. For example, a foundation trust can access capital from the Independent Trust Financing Facility at a low rate which is not necessarily reflective of the risk faced by the organisation. A public service mutual would not currently have the same access to capital as a foundation trust and would only be able to secure capital at a commercial rate which would reflect their level of risk. As a result, the cost of capital is likely to be higher for a public service mutual than a foundation trust. This means that public service providers have a cost advantage that would act as a barrier for a public service mutual to spin out of a foundation trust.

Whilst new sources of capital have been recently developed such as Big Society Capital which have helped to improve access to capital for public service mutuals, it is believed that further work is required to improve access to capital and financial support for public service mutuals that provide NHS care to remove this cost distortion.

*Indemnity for clinical negligence*

The NHS Litigation Authority currently provides a Clinical Negligence Scheme for Trusts. The scheme is often available to members at a lower cost than commercial insurance schemes. Whilst it is possible for a public service mutual to retain access to Clinical Negligence Scheme for Trusts, we understand that a public service mutual may not currently be able access some of the NHS Litigation Authority's schemes. The types of insurance which a public service mutual may not be able to access through the NHS Litigation Authority includes employers and public liability insurance, combined liability insurance, and executive risk insurance. Therefore, a risk exists that the public service mutual may need to seek commercial insurance provision which may incur additional administration and potentially more cost.

Based on current data, insurance costs to a social enterprise is around £30,000-£50,000 per £10million turnover. Based on current turnover, the insurance costs of the public service mutual are estimated to be between £345,000 and £575,000. This compares to the CNST cost of £436,000 in financial year 2013/14. Whilst this is not considered to be a major barrier to implementation, the Trust recommends that the Department of Health work with the NHS Litigation Authority to review whether to extend access to all schemes to public service mutuals that provide NHS care.

*Improve evidence base to make the case for mutualisation*

There was limited data publically available during the project that provided adequate evidence over the benefits, such as improved staff engagement and productivity gains, which could be achieved through mutualisation. Although attempts were made to obtain data from other bodies, it was impossible to obtain a comprehensive set of data which proved the benefits that could be achieved. As a result, it is natural that a degree of scepticism exists that the benefits of mutualisation outweigh the potential and very real risks which do exist.

For public service mutuals that provide NHS care, it would help to make the case for mutualisation if data could be made publically available which evidences the improvement made by these organisations since they span out of the NHS on the following metrics:

- Staff engagement and/or job satisfaction;
- Staff turnover;
- Sickness absence;
- Highest paid director to average pay ratio; and
- Financial metrics such as productivity increase, income growth, operating profit margin.

# 11 Transition Plan

## 11..1 Introduction

This section should describes the timeline for implementation, the potential barriers to implementation and the key risks as move forward.

## 11..2 Why does the Trust need a transition plan and what does good transition planning look like?

Given the strength of evidence that improved staff engagement leads to improved patient outcomes, the Trust needs to ensure that it starts work to improve staff engagement from day one. In order to do this it is needed to ensure the development of a plan to create the necessary infrastructure and governance arrangements.

A good transition plan includes clear, specific actions which have a clear timeline for delivery and an appropriate owner for each action. Each action should be RAG rated according to progress against the agreed timescales. In addition actions should be prioritised.

## 11..3 What is the Trust's timeline and milestones for implementation?

With regards to the recommendations for the Trust, the Trust will further develop the recommendations outlined in Section 10 into a comprehensive action plan.

The Trust will aim to implement all recommendations within the next two years but will also develop and take forward a 100 day plan which contains of the high priority, quick win actions that can be implemented early in 2015-16 financial year.

## 11..4 Outline of key barriers to implementation for a public service mutual

The key barriers to implementation for a public service mutual are set out below.

*Staff resistance to change*

Currently, the majority of staff at the Trust are strongly opposed to the idea of spinning out of the NHS into a public service mutual. This is the most significant non-financial barrier to implementation. Before a public service mutual could be established, management would need to overcome this resistance to change and gain the buy-in of the majority of staff.

To do this, management would need to develop and outline a strong and compelling case for doing so. In particular, management would need to highlight the benefits of creating a public service mutual for staff. In addition, the Trust would need to have a compelling reason of a mutual being the best way forward for the organisation (i.e. form follows function) before doing anything different. The benefits for both staff and the organisation would need to be supported by strong and compelling evidence which in part would be dependent on existing public service mutuals that provide NHS care providing that data. It is unlikely that this could all be achieved quickly and it would be likely to need a well-structured and sustained programme of staff engagement over a number of years. However, this project has found that ideally this type of change would need to be led by staff (i.e. bottom-up) rather than management (i.e. top-down).

*Loss of VAT refund on contracted out services*

The loss of VAT refund on contracted out services in the region of £1.5 million to £2 million per annum is the most significant financial barrier to implementation for a public service mutual.

To make a public service mutual financially attractive for a specialist acute provider such as Liverpool Heart & Chest Hospital NHS Foundation Trust, central government would need to agree to extend the VAT refund on contracted out services to a public service mutual.

*Cost of and access to capital*

The higher cost of capital for a public service mutual is another financial barrier to implementation.

Either the cost of capital for public sector providers would need to increase to reflect the risk profile of each organisation to remove the cost distortion or greater access to more affordable capital would need to be offered to independent providers.

*VAT on assets*

If a public service mutual was being established and in the unlikely event that the transfer of the business and assets into a public service mutual did not satisfy the conditions of a Transfer of a Going Concern (TOGC) or fall within the provisions of a Statutory Order, a new entity would be likely to incur a VAT charge on the value of the assets transferred at the standard rate (20%) which for Liverpool Heart & Chest Hospital we believe would be in the region of £13.95 million. If this was the case, this would act as a very significant financial barrier as it would be unlikely that the new entity would be able to afford the VAT liability.

The creation of a public service mutual would therefore be dependent on the transfer of the business and assets being considered a TOGC.

*Commissioner buy-in*

If commissioners choose not to support organisations in spinning out services out of the NHS and into employee owned organisations then this would prevent the creation of a public service mutual. The ongoing Healthy Liverpool Programme means that any significant change in the provider landscape would be unlikely until this programme has reached a conclusion.

A public service mutual would therefore be dependent on commissioner support following the conclusion of the Healthy Liverpool Programme.

*Indemnity against clinical negligence*

Another potential albeit less significant financial barrier is the cost of insurance. As a public service mutual cannot currently access all of the NHS Litigation Authority's schemes, it would need to seek insurance from the commercial market which is likely to be more

expensive. The types of insurance which a public service mutual may not be able to access through the NHS Litigation Authority includes employers and public liability insurance, combined liability insurance, and executive risk insurance.

The NHS Litigation Authority has recently changed its pricing of risk which has had the effect of increasing premiums for most NHS providers. Ideally, the NHS Litigation Authority could open access to all of its schemes to independent providers of NHS care. However, even if not, the increased insurance costs is unlikely by itself to act as barrier to implementation.

### 11..5 Outlines of key barriers to implementation for the preferred option

The key barriers to implementation for the preferred option are set out below.

*Potential regulatory intervention*

If, for whatever reason, Monitor or the Care Quality Commission chose to intervene this would have a disempowering effect on management as well as staff in how the organisation is run. This could therefore undermine the Trust's efforts to dedicate greater time, attention and resources to improve staff engagement and empowerment.

If, for whatever reason, the Trust faced financial difficulties or concerns about the safety and quality of care, the Trust's plans to improve staff engagement would be dependent on regulators responding in a more supportive way.

*Legislation*

Current legislation prevents staff governors being in a majority within the Council of Governors. To help engage and empower staff, the Trust would like to increase the number of staff governors sitting on the Council of Governors. The extent to which it can do is dependent upon central government changing the existing legislation to remove the minimum requirement that public governors must be in a majority to provide greater flexibility on the composition of governors.

### 11..6 What project support, capability and capacity does the Trust need to deliver its plans?

Although the transition plan is significantly less complex than would be required to create a public service mutual, it is likely that a dedicated project team would still be required to further develop and implement the transition plan. Management capacity given existing priorities is limited which may act a barrier to implementation.

To address this, management could backfill management posts and seek additional capacity from external advisors. This would result in one-off transition costs in the region of £225,000.

If the Trust were ever to consider establishing a public service mutual, a dedicated project team would also be required. However, in this case, the costs of backfilling management posts and external advisors would be likely to result in significant, one-off transition costs in the region of £1 million which could in turn act as a financial barrier if no additional funding could be found to pay for these costs.

11..7 **What are the key risks of moving to the next stage?**

The key risk for taking forward the preferred option which will be added to the Trust's risk register is:

- Failure to improve and embed staff engagement within the culture of the Trust that is resilient to changes in the management team. This may happen because either management are unable to devote sufficient time, attention or resources to implementing the transition plan; an inability to change the composition of governors due to a lack of change in legislation; or because of a lack of change in regulatory behaviour the supports rather inhibits staff engagement. If staff engagement does not improve, the Trust might not achieve the improvements in quality of care or the productivity gains that the Trust is targeting.

The key risks in creating a public service mutual would be as follows:

- The new entity is not financially or commercially sustainable. This could be because the additional costs, such as VAT, insurance or cost of capital, may exceed the productivity gains or income growth achieved or because the Trust is unable to agree a commercially viable contract with commissioners. This could result in the new entity becoming insolvent.
- Staff resistance to spinning out of the NHS mean hinder rather than improve staff engagement. This might be because the change is only desired by and is being led by management rather than staff. This could result in the Trust being unable to recruit and retain staff who want to work for a NHS provider. This risk is heightened by the fact that the Trust is situated in a competitive NHS job market with staff able to switch to a NHS employer with relative ease.

**Appendix 1: Mutuals in Health Pathfinder Project Steering Group Terms of Reference**

| | |
|---|---|
| **Authors Name & Title: Dr Margarita Perez-Casal, Head of Research & Innovation** | |
| **Scope: Trust Wide** | **Classification: ToR** |
| **Replaces: new** | |
| **To be read in conjunction with the following documents:** | |
| **Document for public display? Yes/No** | |

| | | |
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| **Authorised by:** | **Authorisation Date:** | |
| **After this document is withdrawn from use it must be kept in an archive for 10 years.** | | |
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| **Officer responsible for archive: Document Control Administrator** | | |

## 1. Constitution and Remit

The Mutuals in Health Pathfinder Programme is a research project to test the benefits, risks, opportunities and barriers of a healthcare mutual model. The Trust has been chosen to be one of nine pilot sites for this research. The purpose of the programme is to provide evidence to guide the new options for providers of NHS care alongside the recommendations from the Dalton Review.

The Executive team have identified a project team. The Project Lead will be the Head of Research and Innovation; the Executive Sponsor will be the Director of Strategy and Organisational Development; the clinical lead will be the Clinical Lead for Research and Innovation.

The Pathfinder Project Steering Group will provide support to the Project Team in the decision-making throughout the length of the project.

This Steering Group will decide on its future based on the lifespan of the Project. The Pathfinder Mutual in Healthcare Programme is to conclude by 31st March 2015; recommendations in the final report will indicate the longevity of this group.

## 2. Authority

This is a steering group with delegated authority from the Trust's Chief Executive Officer

## 3. Objectives and Duties

1. Approve project initiation document for mutuality research project
2. Define and agree the Trust's vision and long list of options for mutuality.
3. Define and agree critical success factors and benefit criteria for assessing the long list of options for mutuality
4. Exploring feasibility of mutuality for the Trust by looking at all benefits, risks, barriers and opportunities
5. Identify the most suitable model for mutuality, either applied to the whole Trust, a service line spin out or taking the Foundation Trust model to full capability within its legal framework
6. Advise on best tools for stakeholder engagement to capture views and opinions accurately
7. Ensure that staff and members involvement in the process is captured accordingly and is reflected in the outcome
8. Support the Project Team ensuring the project is delivered to time and to the right quality
9. Review draft Outline Business Case including an overview of most suitable option and the case for change

## 4. Integration

The Pathfinder Project Steering Group will include the Project Team and will report to the Trust Executive Team via the project Executive sponsor.

## 5. Membership

There will be two subgroups of the steering group, a strategic group and an operational group.

The strategic group will include:

Chair - Director of Strategy and OD – Executive Sponsor

Deputy Chair- Head of Research & Innovation-Pathfinder Project Lead

Clinical Lead for Research & Innovation

Non-Executive Director

Director of Research & Informatics

General Manager

Staff rep Council of Governors x 2

The operational group will include:

Director of Finance

Head of Management Accounts

Trust Secretary

Head of Human Resources

Lead for Organisational Development

Director of Nursing

Deputy Medical Director

Communications Manager

Other staff representatives can be invited to attend the meetings on an *ad hoc* basis.

## 6. Attendance

Members are expected to attend at least 75% of meetings.

## 7. Quorum and Frequency

The Strategic Group will meet monthly until the end of the Project.
The Operational Groups will meet fortnightly until the end of the Project.
It will be considerate quorate when the Chair/ Deputy Chair, and 50% of members are present.

## 8. Reporting

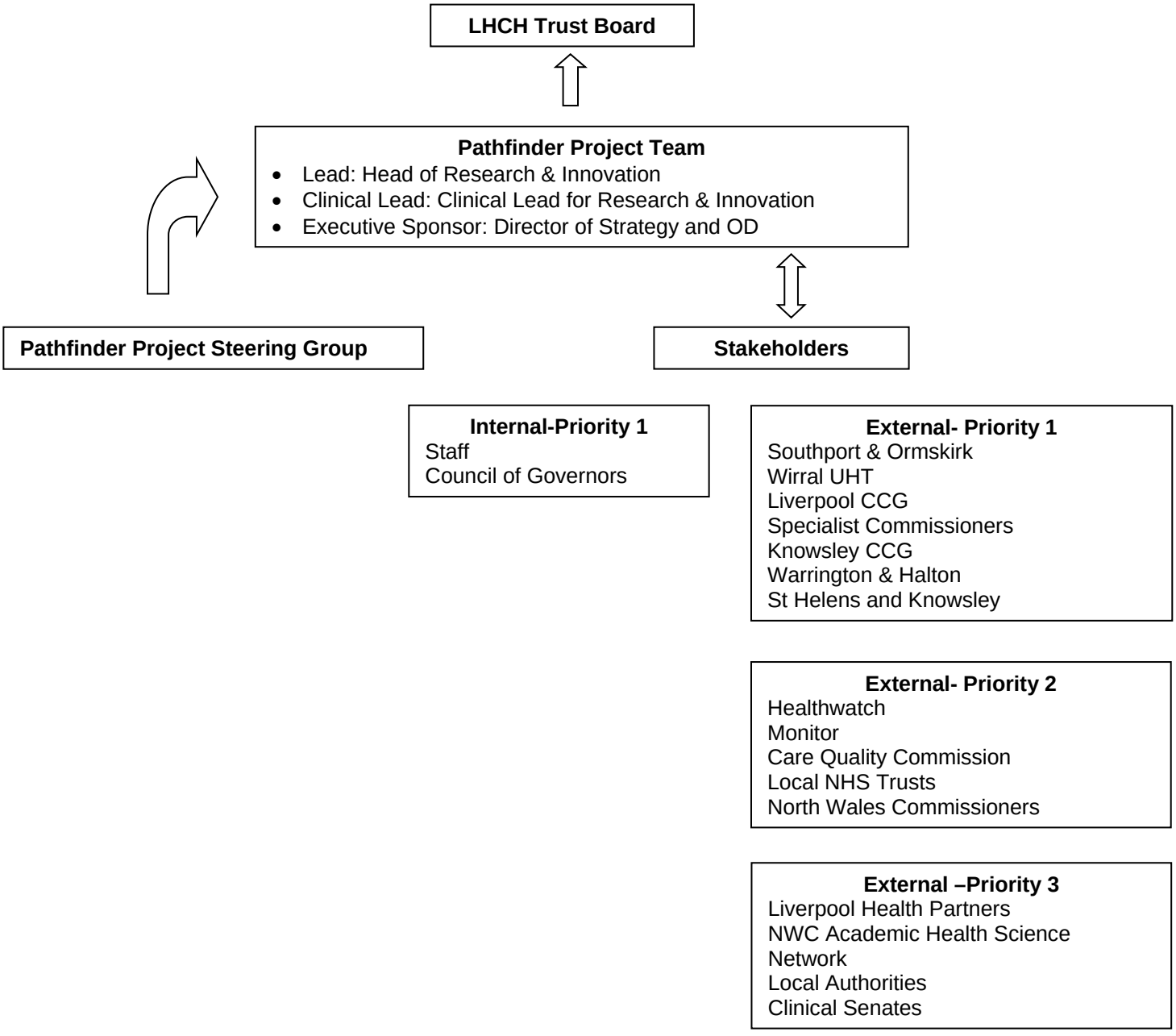
The Pathfinder Project Steering Group will report to the Pathfinder Project team; this will report to the Trust Board.

## 9. Conduct of Committee Meetings

Meetings will consist of:

- Action Log
- Minutes
- Stakeholder engagement progress
- Progress report
- AOB

**10. Governance Framework Pathfinder Mutual Project**



# Appendix 2

High Level Summary of Costs, Benefits and Risks

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Growth opportunities – new services** | Increased staff engagement and flatter hierarchy may lead to increased growth. Evidence from case studies found companies with higher staff engagement achieve increased operating income (+19%) compared to companies with low staff engagement seeing a reduction in income (-37%). | May be able to increase staff engagement and hierarchy to achieve similar results but greater dependency on management to engage and empower staff. |
| **Growth opportunities– new customers/markets** | USP of "mutual" organisation may provide opportunity to compete successfully for business both within and without the local region.<br>For example, for commissioners wanting to commission from outside the NHS, but with an aversion to "for-profit" organisations, a public service mutual organisation provides a third alternative. | No change |
| **Productivity improvements** | Studies have shown link between levels of staff engagement and absenteeism. Research found that highly engaged employees took 2.7 days sickness compared to 6.2 days for disengaged employees. | May be able to increase staff engagement and hierarchy to achieve similar results. |
| **Non-pay cost reductions** | Anecdotal evidence that increased employee engagement leads to increased profitability, for example through reduced wastage. | May be able to increase staff engagement and hierarchy to achieve similar results. |
| **Tax benefits** | Potential benefit (**charity only**) to secure zero-rating on purchase (by a charity) of certain other goods and services, e.g. drugs and medical, laboratory and sterilising equipment used for medical diagnosis or treatment. The potential VAT benefit is estimated to be in the region of £4m. | No change |
| **Asset considerations** | Assets would be held by the mutual, but likely to be ring-fenced. | No change |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Increased cost of finance** | A mutual may present a risk profile that results in higher funding costs than currently charged. Further work is required to establish the range of the cost of working capital. | No change |
| **Increased cost of insurance** | It is possible for an NHS organisation which spins out into a public service mutual to retain access to CNST. However, we understand that public service mutual are currently unable to access some of the NHS Litigation Authority's schemes. Therefore, a risk exists that the public service mutual may need to seek alternative insurance provision which may incur additional administration and potentially more cost. Equally, as previously mentioned, the alternative insurance provision may prove to be cheaper depending upon the Trust's claims profile.<br><br>The types of insurance which you might not be able to access through the NHS Litigation Authority includes employers and public liability insurance, combined liability insurance, and executive risk insurance.<br><br>Based on current data, insurance costs to a social enterprise is around £30,000-£50,000 per £10million turnover. Based on current turnover, we estimate that that the insurance costs of the public service mutual to be between £345,000 and £575,000. This compares to your CNST cost of £436,000 in financial year 2013/14. ? | No change |
| **Increase to directors' pay?** | Directors may demand additional remuneration to reflect the additional risks attached to becoming a corporate director (relating to directors duties and liabilities). | No change |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Increase to staff costs – performance related bonuses** | The organisation may chose to pay staff additional payments, linked to performance. However, it would be assumed that this would not exceed the additional contribution, so would not reduce profitability overall. | It is possible that similar scheme could be introduced under existing FT rules |
| **One off transition costs** | Transition costs will include:<br>▪ Legal/HR<br>▪ Professional<br>▪ Internal transition project team to backfill | No change |
| **Asset considerations** | To be confirmed – Insurance of assets in mutual compared to within FT<br>? | No change |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **VAT** | **Community Interest Company ('CIC')**<br>Risk will be the loss of s41 status for VAT purposes – new entity no longer entitled to recover VAT under the Contracted-Out Service rules. The expected VAT loss will be in the region of £1.5m to £2m per annum. ↓<br><br>Mitigation strategy - consider scope for implementing enabling legislation, e.g. extension to s41 to enable the new entity to operate on a similar VAT footing to the FT (as is) or the addition of a s33D (to the VATA) to enable the new entity to operate on a similar VAT footing to Local Authorities, Academies, Museums & Galleries etc. This would not be a straight forward process nor can a successful outcome be guaranteed. It should also be noted that enabling legislation may take some time to bring into effect. ↔<br><br>**Charity**<br>Same risk as per CIC above with the expected VAT loss will be in the region of £1.5m to £2m. ↓<br><br>Same mitigation strategy as per CIC above ↔<br><br>Additional potential benefit – opportunities to secure zero-rating on purchase (by a charity) of certain other goods and services, e.g. drugs and medical, laboratory and sterilising equipment used for medical diagnosis or treatment. The potential VAT benefit is estimated to be in the region of £4m. ↑ | No change ↔ |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Corporation Tax & Stamp Duty Land Tax** | **Community Interest Company ('CIC')**<br>Even if established on a not for profit basis, a CIC, will introduce a corporation tax cost on an ongoing basis. In addition, the corporation tax impact for the CIC/social enterprise as a result of the initial transfer of assets would also need to be considered (including whether goodwill has been transferred, whether allowances available for the capital assets transferred and what the impact on the ongoing corporation tax cost is as a result). As such, enabling legislation will need to be considered in order to negate any corporation tax charges introduced as a result of 'mutualisation'.<br><br>SDLT is likely to apply unless enabling legislation provides for the new entity to fall within an existing or new exemption.<br><br>**Charity**<br>Alternatively a charitable entity could be established. This would be able to claim exemption from corporation tax in relation to its primary purpose (charitable) activities. However, other activities such as commercial trading would be bought within the charge to corporation tax.<br><br>SDLT charity relief should apply to a charitable entity which means that SLDT should not be a cost to the new entity in relation to any land transactions (to the extent the relief applies). | No Change |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Pension considerations** | Three options:<br>1. Stay as NHS Approved Employer (assume equivalent to higher cost scheme)<br>2. Transferring staff in NHS Pension Scheme, new recruits in lower cost scheme<br>3. Transferring staff in NHS Pension Scheme, new recruits in higher cost scheme | No change |
| **Staff engagement and empowerment** | Mutual model gives staff bigger say in use of surplus, appointment of Board, strategy and direction. This could lead to greater engagement, as well as a mandate to the Board to ensure engagement happens, as opposed to being seen as an optional extra. | Changes could be made within existing model to better engage and empower but without mutualisation these may well not be realised by management and/or staff. With this option, you need to continue to work hard to engage staff, and this may not be perceived by the Board as a key focus of their role. However, we know from the evidence that greater staff engagement leads to better patient care (West, 2012). Therefore, this and subsequent Boards should see staff engagement as a key part of their role.<br>The ability to empower staff is likely to be undermined by more the influential independent regulator, Monitor |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Reward and recognition of staff** | A mutual would have flexibility over reward and recognition of staff and would be more likely than a FT to take advantage of those powers because of its governance and accountability to staff.<br><br>There will be need to be strategic consideration to the impact of the protections given to existing staff by TUPE in respect of making changes to terms and conditions. | FTs already have powers to opt out of collective agreement and reach local pay agreement, but these powers are not often utilised. You stated that you do not have a view of what staff currently want or value in their package, and some research in this area might help you to see what is possible.<br><br>With all options, changes would need to be collectively agreed, and likely to be accompanied by union and staff opposition, should T&Cs be perceived as lesser value than the current ones. |
| **Developing the right behaviours** | Innovative model for acute hospital; independent provider yet not for profit. Not in the public sector but with a public sector ethos. The fact of moving to a mutual will force greater staff consultation in order to make the change happen successfully. Over time this should bring greater engagement, however in the short term there may well be a dip in engagement as staff consider the consequences of change. As with the previous option there needs to be a clear narrative around the reasons for changing and a higher purpose – similar to the NHS Constitution. As above, you need to link your core HR processes, leadership role modelling and business strategy to ensure that staff are rewarded and recognised for the 'right' behaviours. | The process of thinking through and considering options, could be used with staff to create a new narrative about why you should stay 'as is'. You could focus on the NHS Constitution, explain why this is such a core and fundamental purpose and reengage staff with this purpose. Don't be embarrassed about being proud to say that remaining part of the NHS Family is the best thing for patients staff and communities.<br><br>By changing the narrative about staying as an FT, you can have a powerful vehicle for change, to support staff in developing the behaviours you need.<br><br>The best way to encourage the 'right' behaviour is to integrate performance management processes, business strategy and leadership role modelling. In your current state as an FT, you have all of the tools available to enable you to do this. |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Membership & ownership structures** | **Community Interest Company**<br>Clearly defined, tangible ownership, through a company limited by shares incorporated as a Community Interest Company. Shares could be held by employees in their personal capacity, or on their behalf, by an employee benefit trust. More likely to create a sense of ownership and empower staff to have a greater say in the running of the organisation<br><br>**Charity**<br>Less tangible ownership. If a charitable incorporated organisation or company limited by guarantee is used as the vehicle for the charity, then employees are members and hold a membership interest in the entity. If the charity takes the form of a trust, employees would not have an ownership share in the entity as such. Mutualisation less clear due to less tangible membership interest. | No change |
| **Purpose & constitution** | **Community Interest Company**<br>A CIC must satisfy the community interest test at formation and continue to do so for as long as it remains a CIC. The test is satisfied if a reasonable person would consider that the CIC's activities are being carried on for the benefit of the community.<br><br>**Charity**<br>Must be established for exclusively charitable purposes. The nature of a charity's purposes must be capable of benefiting the community at large. In addition, all charity trustees have a duty to operate their charity for the benefit of the public. | No change |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Governance framework** | **Community Interest Company**<br>Company directors have a series of specific statutory duties under the Companies Act 2006. Various prescribed matters, (for example constitutional arrangements, identity of directors, changes to capital structure) are reserved to the shareholders at 50% and 75% voting thresholds depending on the matter in question.<br><br>**Charity**<br>Good. Trustees must exercise the Charity's powers and perform their function in the way that they decide, in good faith, is most likely to further the purposes of the Charity, although their duties are not as clearly defined as those of the directors a company. A limited number of matters require the approval of 75% of the members, namely constitutional changes, merger with another Charity, dissolution of the Charity. | No change |
| **Liability** | **Community Interest Company**<br>Limited liability. The liability of shareholders is limited to the amount, if any, for the time being unpaid on the shares held by them.<br><br>**Charity**<br>Use of a Trust because it would mean there would be no separate legal entity, which in turn, would confer personal liability on the trustees.<br><br>Provided that the Charity is not a Trust, then the liability position will be broadly the same as for a CIC. | No change |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Decision making** | **Community Interest Company**<br>Day to day decisions are made by the Board of Directors. Non ordinary course matters (eg constitutional arrangements, changes to structure) are reserved to the shareholders at 50% and 75% voting thresholds depending on the matter in question. Shareholders can appoint and remove directors by ordinary (50%) resolution<br><br>**Charity**<br>Day to day decisions are made by the Trustees. The articles of association of a charitable company or the constitution of a charitable incorporated organisation may give the members of the company or power to elect charity trustees. | No change although may be an opportunity to expand influence of staff governors on the Council of Governors |
| **Cessation of employee participation** | **Community Interest Company**<br>Flexible. The CIC can buy back a member's share (known as redemption) if a member ceases to be an employee or require mandatory transfer of that share to a third party.<br><br>**Charity**<br>Flexible. Membership interest can be stated to lapse or be mandatorily transferred in a similar way to CIC, if for example, an employee resigned. | No change |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Reporting and administration** | **Community Interest Company**<br>Overall, less onerous than a FT regulation. An annual community interest company report detailing salaries, assets transferred and a description of how the CIC has benefited the community must be produced. A CIC must also maintain registers of members, prepare annual accounts and make filings at Companies House.<br><br>**Charity**<br>Reasonably significant but less onerous than FT regulation. The trustees must prepare an annual report on the activities of the Charity and complete an annual return for each of its financial years. The charity accounting regime is less onerous than the accounting regime applicable to companies, although it is likely audited accounts will still be required. | No change |
| **Asset lock** | **Community Interest Company**<br>CIC's benefit from an 'asset lock' which ensures that the CIC's assets cannot not sold at an undervalue and are used for the benefit of the community it was set up to.<br><br>**Charity**<br>Trustees must ensure that the charity is and will remain solvent. The income and property of the Charity must be applied solely towards the promotion of the objects of the Charity. | No change |

Likely strong benefit | Likely some benefit | Little or no change in cost / benefit | Likely some cost / risk | Likely extra cost / risk

| Key factor | Mutualisation of whole Trust | Remain as FT or FT Plus |
|---|---|---|
| **Distribution of profit** | **Community Interest Company**<br>A CIC to pay dividends to shareholders (or apply them for the benefit of shareholders), subject to certain constraints. A CIC's ability to declare dividends is capped at 35 per cent of distributable profits. Again, this cap can be reduced to prohibit or further reduce the size of dividends that are declared.<br><br>**Charity**<br>A charity must use any such profit solely for the charitable purposes they have been established to pursue. Charities are, however, restricted from distributing their profits to their owners and/or managers. | No change |

# Financial analysis

| Costs of becoming a mutual* | Low £'000 | High £'000 |
|---|---|---|
| **Recurrent:** | | |
| Increased cost of insurance [1] | 0 | 150 |
| VAT impact (loss of s41 status) [2] | 1,500 | 2,000 |
| **Recurrent costs** | **1,500** | **2,150** |
| | | |
| **One off:** | | |
| Legal and professional costs [3] | 500 | 600 |
| Transition costs [3] | 400 | 500 |
| VAT on transfer of assets [4] | 0 | 13,950 |
| **One off costs** | **900** | **15,050** |

| Benefits of becoming a mutual* | Low £'000 | High £'000 |
|---|---|---|
| **Recurrent:** | | |
| Reduced cost of insurance [1] | 0 | 90 |
| Productivity improvements [5] | 500 | 1,200 |
| Non-pay cost savings [6] | 500 | 1,000 |
| Potential for zero-rating relief, applicable if charitable status only [7] | 0 | 4,000 |
| **Recurrent benefits** | **1,000** | **6,290** |

* These are major identifiable costs and benefits that can be quantified at this stage, there may be other costs and benefits not included here, for example changes to pension costs and incremental income. High level estimates have been provided, which would require extensive further validation as part of a full business case assessment.

**Notes:**

1. Estimate of increased / reduced insurance costs as a result of alternative insurance provision
2. Based on analysis of current cost base.
3. High level estimate based on previous transactions.
4. In the highly unlikely event that this is not a TOGC or affected under a Statutory Transfer Order, then 20% VAT on the net assets transferred would apply
5. Low case assumes bank and agency spend reduced by c20%. High case assumes total pay bill cut by c2%.
6. Assumption that non pay costs reduced by 1% (low case) and 2% (high case).
7. Based on analysis of current cost base.

# Appendix 3

Options Appraisal Scoring Matrix

Each evaluation criteria to be scored on a scale of 1 to 4 for each option

| | Options Appraisal Matrix | Consensus | | Option 1<br>Do nothing | Option 2<br>Implement plan to better engage and empower staff within the current FT model | Option 3<br>Implement plan to better engage and empower staff but also seek legislative changes to FT model which will help to improve | Option 4<br>Implement plan to better engage and empower staff but also further explore spinning out of the NHS into an employee owned |
|---|---|---|---|---|---|---|---|
| **Theme** | **Evaluation Criteria** | **Logic** | **Weighting** | | | | |
| **Strategic** | Fit with strategic vision, values and objectives | Options which are closely aligned to strategy score higher | 4 | 8 | 14 | 12 | 8 |
| | Fit with external stakeholder views, e.g. commissioners | Options which are closely aligned to external stakeholder views score higher | 2 | 4 | 7 | 6 | 4 |
| | Fit with patient user views | Options which are closely aligned to patient user views score higher | 2 | 6 | 8 | 4 | 4 |
| | Fit with staff views | Options which are closely aligned to staff views score higher | 4 | 8 | 16 | 16 | 4 |
| | | | | **26** | **45** | **38** | **20** |
| **Staff** | Ability to engage and empower staff | Options which have the potential to increase staff engagement and empowerment the most score higher | 4 | 8 | 12 | 12 | 12 |
| | Quality and security of terms and conditions for staff | Options which disrupt terms and conditions the least score higher | 4 | 8 | 12 | 12 | 10 |
| | Quality and security of pensions for both existing staff and new hires | Options which disrupt pensions the least score higher | 4 | 8 | 8 | 8 | 12 |
| | Ability to recruit and retain staff | Options which improve ability to recruit and retain staff score higher | 4 | 8 | 12 | 12 | 12 |
| | | | | **32** | **44** | **44** | **46** |
| **Financial and commercial** | Ability to access financing & financial support | Options which have greater access to financing or financial support score higher | 4 | 16 | 16 | 16 | 8 |
| | Financial benefit, i.e. level of cash savings | Options with greatest financial benefit score higher | 4 | 8 | 12 | 12 | 8 |
| | Time to realise savings | Options which achieve savings quicker score higher | 4 | 8 | 12 | 12 | 16 |
| | Investment required | Options with lowest investment costs score higher | 4 | 16 | 12 | 12 | 4 |
| | Ability to improve growth | Options which the potential to increase growth score higher | 4 | 8 | 8 | 12 | 12 |
| | Scope for collaboration arrangements with other public sector bodies | Options which have the potential to better enable collaboration score higher | 4 | 12 | 12 | 16 | 12 |
| | | | | **68** | **72** | **80** | **60** |
| **Quality** | Ability to maintain and improve quality of care | Options which have the potential to improve the quality of care the most score higher | 4 | 8 | 12 | 12 | 16 |
| | Scope for innovation in design and delivery | Options which encourage innovation and disrupt the status quo score higher | 3 | 6 | 9 | 9 | 12 |
| | | | | **14** | **21** | **21** | **28** |
| **Management** | Degree of organisational change required | Options with lower complexity score higher | 1 | 4 | 3 | 3 | 1 |
| | Organisational flexibility to respond to changing circumstances | Options which provide greater freedoms and less regulation score higher | 3 | 6 | 6 | 9 | 12 |
| | Impact on organisational risk profile | Options which maintain or least increase organisational risk score higher | 3 | 12 | 12 | 9 | 3 |
| | | | | **22** | **21** | **21** | **16** |
| | **Totals** | | | **162** | **203** | **204** | **170** |

Weightings - 1 = Lower Priority; 4 = Higher Priority

Each evaluation criteria to be scored on a scale of 1 to 4 for each option

| | **Options Appraisal Matrix** | **Pessimistic** | | **Option 1** Do nothing | **Option 2** Implement plan to better engage and empower staff within the current FT model | **Option 3** Implement plan to better engage and empower staff but also seek legislative changes to FT model which will help to improve | **Option 4** Implement plan to better engage and empower staff but also further explore spinning out of the NHS into an employee owned |
|---|---|---|---|---|---|---|---|
| **Theme** | **Evaluation Criteria** | **Logic** | **Weighting** | | | | |
| **Strategic** | Fit with strategic vision, values and objectives | Options which are closely aligned to strategy score higher | 4 | 8 | 12 | 8 | 8 |
| | Fit with external stakeholder views, e.g. commissioners | Options which are closely aligned to external stakeholder views score higher | 2 | 4 | 6 | 6 | 4 |
| | Fit with patient user views | Options which are closely aligned to patient user views score higher | 2 | 6 | 8 | 4 | 4 |
| | Fit with staff views | Options which are closely aligned to staff views score higher | 4 | 8 | 16 | 16 | 4 |
| | | | | **26** | **42** | **34** | **20** |
| **Staff** | Ability to engage and empower staff | Options which have the potential to increase staff engagement and empowerment the most score higher | 4 | 8 | 12 | 12 | 12 |
| | Quality and security of terms and conditions for staff | Options which disrupt terms and conditions the least score higher | 4 | 8 | 12 | 12 | 8 |
| | Quality and security of pensions for both existing staff and new hires | Options which disrupt pensions the least score higher | 4 | 8 | 8 | 8 | 12 |
| | Ability to recruit and retain staff | Options which improve ability to recruit and retain staff score higher | 4 | 8 | 12 | 12 | 12 |
| | | | | **32** | **44** | **44** | **44** |
| **Financial and commercial** | Ability to access financing & financial support | Options which have greater access to financing or financial support score higher | 4 | 16 | 16 | 16 | 8 |
| | Financial benefit, i.e. expected case NPV | Options with greatest financial benefit score higher | 4 | 8 | 12 | 12 | 8 |
| | Time to realise savings | Options which achieve savings quicker score higher | 4 | 8 | 12 | 12 | 16 |
| | Investment required | Options with lowest investment costs score higher | 4 | 16 | 12 | 12 | 4 |
| | Ability to improve growth | Options which the potential to increase growth score higher | 4 | 8 | 8 | 12 | 12 |
| | Scope for collaboration arrangements with other public sector bodies | Options which have the potential to better enable collaboration score higher | 4 | 12 | 12 | 16 | 12 |
| | | | | **68** | **72** | **80** | **60** |
| **Quality** | Ability to maintain and improve quality of care | Options which have the potential to improve the quality of care the most score higher | 4 | 8 | 12 | 12 | 16 |
| | Scope for innovation in design and delivery | Options which encourage innovation and disrupt the status quo score higher | 3 | 6 | 9 | 9 | 12 |
| | | | | **14** | **21** | **21** | **28** |
| **Management** | Degree of organisational change required | Options with lower complexity score higher | 1 | 4 | 3 | 3 | 1 |
| | Organisational flexibility to respond to changing circumstances | Options which provide greater freedoms and less regulation score higher | 3 | 6 | 6 | 9 | 12 |
| | Impact on organisational risk profile | Options which maintain or least increase organisational risk score higher | 3 | 12 | 12 | 9 | 3 |
| | | | | **22** | **21** | **21** | **16** |
| | **Totals** | | | **162** | **200** | **200** | **168** |

Weightings - 1 = Lower Priority; 4 = Higher Priority

Each evaluation criteria to be scored on a scale of 1 to 4 for each option

| | **Options Appraisal Matrix** | **Optimistic** | | **Option 1** Do nothing | **Option 2** Implement plan to better engage and empower staff within the current FT model | **Option 3** Implement plan to better engage and empower staff but also seek legislative changes to FT model which will help to improve staff | **Option 4** Implement plan to better engage and empower staff but also further explore spinning out of the NHS into an employee owned organisation to |
|---|---|---|---|---|---|---|---|
| **Theme** | **Evaluation Criteria** | **Logic** | **Weighting** | | | | |
| **Strategic** | Fit with strategic vision, values and objectives | Options which are closely aligned to strategy score higher | 4 | 8 | 16 | 16 | 8 |
| | Fit with external stakeholder views, e.g. commissioners | Options which are closely aligned to external stakeholder views score higher | 2 | 4 | 8 | 6 | 4 |
| | Fit with patient user views | Options which are closely aligned to patient user views score higher | 2 | 6 | 8 | 4 | 4 |
| | Fit with staff views | Options which are closely aligned to staff views score higher | 4 | 8 | 16 | 16 | 4 |
| | | | | **26** | **48** | **42** | **20** |
| **Staff** | Ability to engage and empower staff | Options which have the potential to increase staff engagement and empowerment the most score higher | 4 | 8 | 12 | 12 | 12 |
| | Quality and security of terms and conditions for staff | Options which disrupt terms and conditions the least score higher | 4 | 8 | 12 | 12 | 12 |
| | Quality and security of pensions for both existing staff and new hires | Options which disrupt pensions the least score higher | 4 | 8 | 8 | 8 | 12 |
| | Ability to recruit and retain staff | Options which improve ability to recruit and retain staff score higher | 4 | 8 | 12 | 12 | 12 |
| | | | | **32** | **44** | **44** | **48** |
| **Financial and commercial** | Ability to access financing & financial support | Options which have greater access to financing or financial support score higher | 4 | 16 | 16 | 16 | 8 |
| | Financial benefit, i.e. level of cash savings | Options with greatest financial benefit score higher | 4 | 8 | 12 | 12 | 8 |
| | Time to realise savings | Options which achieve savings quicker score higher | 4 | 8 | 12 | 12 | 16 |
| | Investment required | Options with lowest investment costs score higher | 4 | 16 | 12 | 12 | 4 |
| | Ability to improve growth | Options which the potential to increase growth score higher | 4 | 8 | 8 | 12 | 12 |
| | Scope for collaboration arrangements with other public sector bodies | Options which have the potential to better enable collaboration score higher | 4 | 12 | 12 | 16 | 12 |
| | | | | **68** | **72** | **80** | **60** |
| **Quality** | Ability to maintain and improve quality of care | Options which have the potential to improve the quality of care the most score higher | 4 | 8 | 12 | 12 | 16 |
| | Scope for innovation in design and delivery | Options which encourage innovation and disrupt the status quo score higher | 3 | 6 | 9 | 9 | 12 |
| | | | | **14** | **21** | **21** | **28** |
| **Management** | Degree of organisational change required | Options with lower complexity score higher | 1 | 4 | 3 | 3 | 1 |
| | Organisational flexibility to respond to changing circumstances | Options which provide greater freedoms and less regulation score higher | 3 | 6 | 6 | 9 | 12 |
| | Impact on organisational risk profile | Options which maintain or least increase organisational risk score higher | 3 | 12 | 12 | 9 | 3 |
| | | | | **22** | **21** | **21** | **16** |
| | **Totals** | | | **162** | **206** | **208** | **172** |

Weightings - 1 = Lower Priority; 4 = Higher Priority

## Appendix 4 – Pensions

### If the Trust became a public service mutual, what could pension provision for both existing staff and new hires look like?

The Trust currently participates in the NHS Pension Scheme. Initial consultation with staff has identified that, (as part of the quality of employment) pension provision is a key issue for consideration and this extends beyond current staff to include provision for new staff.

This part of the report identifies the key assumptions, options and issues that the Trust has considered as part of the options appraisal.

The NHS Pension Scheme is the pension scheme made available to the vast majority of workers associated with the delivery of public healthcare. In England and Wales approximately 1.2 million workers are in the scheme and these are spread across some 10,000 employers.

There are several sections of membership depending in the date that a worker joined the NHS, their employment type, and whether they elected to change sections when offered. A new NHS Pension Scheme 2015 is being introduced from 1 April 2015 and approximately 75% of members would move to this new Scheme for their future pension accrual. New entrants to the NHS after 1 April 2015 would join this section.

Membership criteria is wide ranging and most NHS workers are able to join when starting work for an NHS employer. Membership is automatic for new joiners and the Scheme is the NHS's Qualifying Pension Scheme (QPS) for Auto-enrolment (AE) purposes. Those whom the regulations prevent from joining must be provided with an alternative Qualifying Pension Scheme under separate legislation to comply with Auto-Enrolment requirements. The date that an AE QPS is required to be provided depends on the PAYE size of an organisation and whether it has determined to postpone or defer its "staging date". By 2018 all employers are required to have an AE compliant QPS in place.

Regardless of the selected corporate body being explored, this assumption considers that all currently employed staff who are, or are eligible to be, members of the NHS Pension Scheme would be able to continue their membership without any break. This is a fundamental issue for existing staff.

Current pension costs are 14.3% of pensionable pay (from 1 April 2015) for the NHS Pension Scheme and 1% of pensionable pay for staff in the Auto Enrolment Scheme with NEST.

One of the key considerations under this option is whether the new Mutual would be able to be classified as an NHS Employing Organisation under the NHS Pension Scheme regulations.

If it is, there is little scope for change to the financial impact of pensions as the FT would continue to provide access to the NHS Pension Scheme for all current and all future staff. There is a degree of flexibility that the FT can explore to provide alternative reward structures for individuals who may not wish to participate in the NHS Pension Scheme (perhaps because of potential Pension Tax issues), or who are unable to join the NHS Pension Scheme as they are prohibited by the Scheme regulations.

Such individual discussions and agreements are not common place but may serve as useful incentives to retain (or recruit) key staff. Care should be taken if agreeing to

alternative rewards that the staff member is not able to take the alternative offered and then choose to join the NHS Pension Scheme without giving these up.

If the Mutual is not able to be classified as an NHS Employing Authority under the NHS Pension Regulations there are alternative options for providing continued access to the NHS Pension Scheme. In this instance there are further options for providing access to the Scheme for transferring staff and new recruits, or new recruits may be able to be offered an alternative pension arrangement which could be of lower or higher cost to the Mutual.

For example, assuming that all transferring staff remain eligible for the NHS Pension Scheme and a new Defined Contribution (DC) Scheme is offered for new recruits with a 10% employer contribution would result is a 4.3% saving on pension costs for each new recruit. The savings would build up over time as more recruits are taken on into the DC scheme and the overall savings are therefore reliant on the turnover of staff.

To retain a “one-tier” workforce, these lower pension costs may be retained by the Mutual or re-provisioned into alternative rewards for staff to maintain the same Total Reward spend.

Options for paying the same level of employer contribution would not create “savings” and a higher employer contribution rate would create additional cost up to the current level of pension contributions.

There may also be additional running costs of providing an alternative pension scheme depending on the type offered.

**If the Trust became a public service mutual, how would we maintain NHS Pensions access for staff transferring into the public service mutual under TUPE?**

All currently employed staff who are, or are eligible to be, members of the NHS Pension Scheme would be able to continue their membership without any break. An analysis of the key issues is summarised in the table below.

| The New Organisation is classified as an NHS Employing Authority | Staff transfer to the new organisation under TUPE and new Fair Deal applies | The new organisation becomes an Approved Employer through the Access route | Comments and summary notes |
|---|---|---|---|
| An NHS Employing Authority for pensions purposes is defined in the NHS Pension Scheme Regulations.<br><br>The list of types of Employing Authorities is amended through the legislative process when new NHS delivery bodies are created and the Government wishes them to be included in the NHS Pension Scheme, for example, Independent Providers were added to the definition from April 2014.<br><br>Additionally the definition includes the discretion of the Secretary of State to determine that *"any other body that is constituted under an Act relating to health services (in whole or in part) and which the Secretary of State agrees to treat as an employing authority for the purposes of this Section of the scheme"* may be included in that definition.<br><br>In the 2015 Regulations these have similar definitions for "NHS Organisations" in place of "Employing Authorities" | As pensions are not covered under the requirements of TUPE alternative action is required to cover pensions for transferred staff.<br><br>Fair Deal is the Government's non-statutory policy on how staff pensions are to be treated when staff are transferred from the public sector to independent providers delivering public services.<br><br>The guidance was originally introduced in 1999 and was updated in October 2013 to allow for continued access to the employees current pension arrangements.<br><br>The requirements of the policy also allow for continued access should their be any subsequent reorganisation or TUPE transfer | Any organisation that is providing NHS services through an NHS (or Local Authority) Standard Contract is able to apply for Approved Employer status.<br><br>This would allow access to the NHS Pension Scheme for eligible employees.<br><br>Eligible employees must continue to be eligible by working on NHS contract work so if there are alternative work activities that fall outside of this they would lose the right to remain in the Scheme.<br><br>There may be an option for the organisation to apply for Open or Closed access. Open Access allows all staff to join the NHS Pension Scheme, whilst Closed Access will only allow those staff who were eligible for NHS Pension membership in the 12 months before joining the Approved Employer to join.<br><br>There are limitations on salary/contract value and time spent on NHS work to consider | Either option explored here will allow for current staff to remain in the NHS Pension Scheme if applicable.<br><br>There may be a need for change to the regulations of the Scheme if the new body falls outside of the current definition (or for the SoS to agree).<br><br>There may also be decisions required to confirm that new Fair Deal would apply and also if the Approved Employer route was selected which level of access was suitable.<br><br>Under Access if the new organisation was to deliver additional non-NHS work this may mean that staff working on that work may lose eligibility for membership under the Access route. |

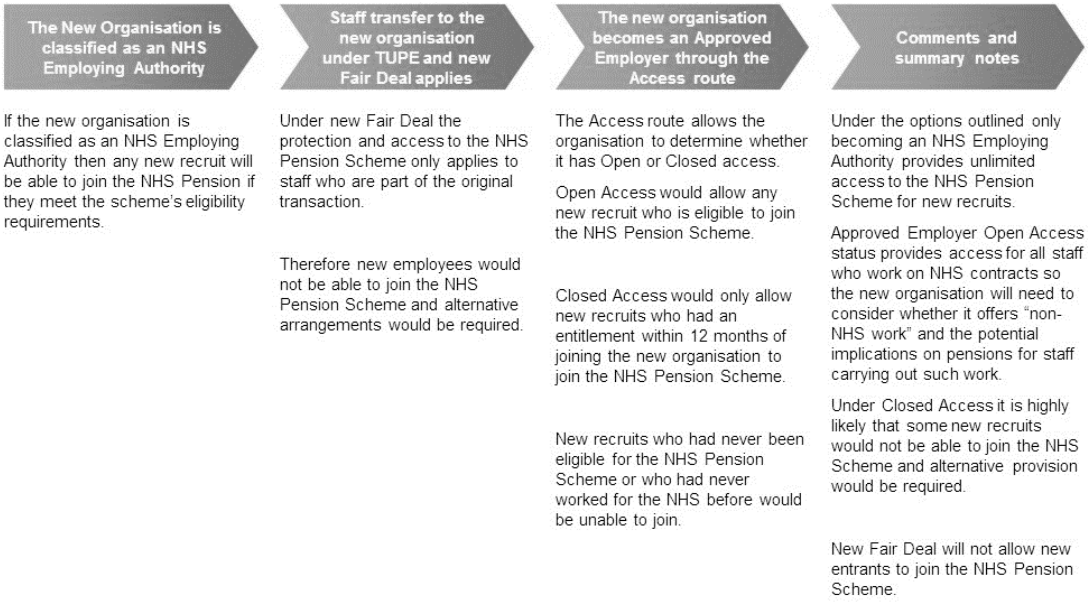
**If the Trust became a public service mutual, would new hires be able to join the NHS Pensions scheme?**

In short, yes. The organisation would be able to offer new staff membership to the NHS Pension Scheme (subject to the scheme eligibility criteria).

The main benefits of doing this is that the Trust would avoid having to manage a two-tier workforce and maintaining a separate pension scheme for new staff. It may also help with recruitment and retention of staff.

However, the main cost of doing this would be that it would provide less flexibility in the way the organisation could reward and recognise staff.

An analysis of the key issues is summarised in the table below.




Alternatively, the Trust could choose not to offer access to the NHS Pension Scheme to new hires.

This option would provide greater flexibility in how the Trust rewarded and recognised new hires. For example, the Trust could compensate new hires with higher basic salaries if the alternative pension provision offered is less attractive. The other benefit of this option is that may allow for greater financial savings which would help the Trust to reduce pay expenditure.

However, the main drawbacks of closing the NHS Pension Scheme to new hires is that it would likely create a two-tier workforce on different reward packages. It would require the organisation to manage an alternative pension scheme. It may also impact on recruitment and retention of staff. Equally, it may cost the organisation more if it tried to replicate the benefits of the NHS Pension Scheme.

An analysis of the key issues under this options is summarised below:

| The New Organisation is classified as an NHS Employing Authority | Staff transfer to the new organisation under TUPE and new Fair Deal applies | The new organisation becomes an Approved Employer through the Access route | Comments and summary notes |
|---|---|---|---|
| If the new organisation is classified as an NHS Employing Authority then any new recruit will be able to join the NHS Pension if they meet the scheme's eligibility requirements.<br><br>If the intention is not to allow new recruits to join the Scheme this option will not be suitable. | Under new Fair Deal the protection and access to the NHS Pension Scheme only applies to staff who are part of the original transaction.<br><br>Therefore new employees would not be able to join the NHS Pension Scheme and alternative arrangements would be required. | The Access route allows the organisation to determine whether it has Open or Closed access.<br><br>Open Access would allow any new recruit who is eligible to join the NHS Pension Scheme.<br><br>Closed Access would only allow new recruits who had an entitlement within 12 months of joining the new organisation to join the NHS Pension Scheme.<br><br>New recruits who had never been eligible for the NHS Pension Scheme or who had never worked for the NHS before would be unable to join. | Under the options outlined becoming an NHS Employing Authority provides unlimited access to the NHS Pension Scheme for new recruits so would not suit this decision.<br><br>Approved Employer Open Access status provides access for all staff who work on NHS contracts.<br><br>Under Closed Access it is highly likely that some new recruits would not be able to join the NHS Scheme and alternative provision would be required.<br><br>New Fair Deal will not allow new entrants to join the NHS Pension Scheme and this option would best suit this decision. |

The organisation could determine that an alternative to the NHS Pension Scheme is offered, either to new staff or also to transferred staff.

The diagram below summarises the options available for different types of pension scheme and who may join them.

| "Mirror" NHS Pension Scheme benefits | Alternative DB Scheme | A DC Scheme (including Auto-enrolment) | Comments and summary notes |
|---|---|---|---|
| The new organisation may wish to provide a pension scheme that provides "broadly comparable" benefits to the NHS Pension Scheme and allow some or all staff access to this.<br><br>This may be suitable for new recruits if one of the previous options explored was unsuitable and/or could be offered to all staff, including those transferring staff, to replace the NHS Pension Scheme entirely.<br><br>There are significant implication of offering such a Scheme, not just financial, and these are explored in section X below. | It may be suitable to provide an alternative Defined Benefit pension scheme with different benefits to the NHS Pension Scheme.<br><br>This may be suitable to control costs (if lower benefits are offered) but may also have implications for recruitment and retention.<br><br>It is possible to offer higher benefits than the NHS Pension Scheme, or to tailor what is offered to direct benefits where they are most wanted by staff.<br><br>Similar implications of offering such a scheme apply as offering a "mirror" NHS scheme so please refer to slide X for details. | A Defined Contribution Scheme can be cost effective and also transfers financial risk to the members.<br><br>These are most commonly seen by new organisations and offer a great deal of flexibility in cost, investment and how benefits are taken.<br><br>While seen as inferior to a DB Scheme with sufficient levels of contribution (and future investment returns) these types of Schemes can provide good pension benefits.<br><br>At the very least the Organisation will be required to provide an Auto-enrolment compliant Qualifying Pension Scheme with minimum levels of contribution. This "lowest" option will be significantly cheaper than other options but is likely to create recruitment issues and could affect employee engagement. | When considering a new Scheme all options are opens and the type of scheme and contribution levels will be important to explore.<br><br>A mirror scheme provides the best match to the NHS Pension benefits and an AE compliant the lowest benefits for the least cost.<br><br>Selecting what level of provision is provided is likely to also require interaction with other parts of the reward package. |

# Appendix 5

Detailed Net Present Value Calculations

**Option 2 - Expected Case Scenario**

| Assumptions | |
|---|---|
| Cost of Capital | 3.5% |
| Cash Flow Interval (in years) | 1.00 |
| Investment periods | 2.0 |
| Payback periods | 28.0 |
| Start at period | 2.0 |
| Date Start | 01/04/2015 |

| Cash Out - Investment Period | Year | 0 | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Investment cash out | -225 | -113 | -113 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discount factor | | 1.00 | 1.04 | 1.07 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Present value | -221 | (113) | (109) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |

| Cash In - Payback Period | Year | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unlevered free cash flow | 22,400 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 |
| Discount factor | | 1.07 | 1.11 | 1.15 | 1.19 | 1.23 | 1.27 | 1.32 | 1.36 | 1.41 | 1.46 | 1.51 | 1.56 | 1.62 | 1.68 | 1.73 | 1.79 | 1.86 | 1.92 | 1.99 | 2.06 | 2.13 | 2.21 | 2.28 | 2.36 | 2.45 | 2.53 | 2.62 | 2.71 |
| Present value | 13,656 | 747 | 722 | 697 | 674 | 651 | 629 | 608 | 587 | 567 | 548 | 529 | 512 | 494 | 478 | 461 | 446 | 431 | 416 | 402 | 388 | 375 | 363 | 350 | 339 | 327 | 316 | 305 | 295 |

| | |
|---|---|
| Net present value | **13,434** |

**Option 2 - Worst Case Scenario**

| Assumptions | |
|---|---|
| Cost of Capital | 3.5% |
| Cash Flow Interval (in years) | 1.00 |
| Investment periods | 2.0 |
| Payback periods | 28.0 |
| Start at period | 2.0 |
| Date Start | 01/04/2015 |

| Cash Out - Investment Period | Year | 0 | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Investment cash out | -250 | -125 | -125 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discount factor | | 1.00 | 1.04 | 1.07 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Present value | -246 | (125) | (121) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |

| Cash In - Payback Period | Year | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unlevered free cash flow | 14,000 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 | 500 |
| Discount factor | | 1.07 | 1.11 | 1.15 | 1.19 | 1.23 | 1.27 | 1.32 | 1.36 | 1.41 | 1.46 | 1.51 | 1.56 | 1.62 | 1.68 | 1.73 | 1.79 | 1.86 | 1.92 | 1.99 | 2.06 | 2.13 | 2.21 | 2.28 | 2.36 | 2.45 | 2.53 | 2.62 | 2.71 |
| Present value | 8,535 | 467 | 451 | 436 | 421 | 407 | 393 | 380 | 367 | 354 | 342 | 331 | 320 | 309 | 298 | 288 | 279 | 269 | 260 | 251 | 243 | 235 | 227 | 219 | 212 | 204 | 198 | 191 | 184 |

| | |
|---|---|
| Net present value | **8,289** |

**Option 2 - Best Case Scenario**

| Assumptions | |
|---|---|
| Cost of Capital | 3.5% |
| Cash Flow Interval (in years) | 1.00 |
| Investment periods | 2.0 |
| Payback periods | 28.0 |
| Start at period | 2.0 |
| Date Start | 01/04/2015 |

| Cash Out - Investment Period | Year | 0 | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Investment cash out | -200 | -100 | -100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discount factor | | 1.00 | 1.04 | 1.07 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Present value | -197 | (100) | (97) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |

| Cash In - Payback Period | Year | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unlevered free cash flow | 30,800 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 |
| Discount factor | | 1.07 | 1.11 | 1.15 | 1.19 | 1.23 | 1.27 | 1.32 | 1.36 | 1.41 | 1.46 | 1.51 | 1.56 | 1.62 | 1.68 | 1.73 | 1.79 | 1.86 | 1.92 | 1.99 | 2.06 | 2.13 | 2.21 | 2.28 | 2.36 | 2.45 | 2.53 | 2.62 | 2.71 |
| Present value | 18,777 | 1,027 | 992 | 959 | 926 | 895 | 865 | 835 | 807 | 780 | 753 | 728 | 703 | 680 | 657 | 634 | 613 | 592 | 572 | 553 | 534 | 516 | 499 | 482 | 465 | 450 | 435 | 420 | 406 |

| | |
|---|---|
| Net present value | **18,580** |

**Option 3 - Expected Case Scenario**

| Assumptions | |
|---|---|
| Cost of Capital | 3.5% |
| Cash Flow Interval (in years) | 1.00 |
| Investment periods | 2.0 |
| Payback periods | 28.0 |
| Start at period | 2.0 |
| Date Start | 01/04/2015 |

| Cash Out - Investment Period | Year | 0 | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Investment cash out | -225 | -113 | -113 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discount factor | | 1.00 | 1.04 | 1.07 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Present value | -221 | (113) | (109) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |

| Cash In - Payback Period | Year | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unlevered free cash flow | 33,600 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 | 1,200 |
| Discount factor | | 1.07 | 1.11 | 1.15 | 1.19 | 1.23 | 1.27 | 1.32 | 1.36 | 1.41 | 1.46 | 1.51 | 1.56 | 1.62 | 1.68 | 1.73 | 1.79 | 1.86 | 1.92 | 1.99 | 2.06 | 2.13 | 2.21 | 2.28 | 2.36 | 2.45 | 2.53 | 2.62 | 2.71 |
| Present value | 20,484 | 1,120 | 1,082 | 1,046 | 1,010 | 976 | 943 | 911 | 880 | 851 | 822 | 794 | 767 | 741 | 716 | 692 | 669 | 646 | 624 | 603 | 583 | 563 | 544 | 526 | 508 | 491 | 474 | 458 | 442 | |

| | |
|---|---|
| Net present value | **20,262** |

**Option 3 - Worst Case Scenario**

| Assumptions | |
|---|---|
| Cost of Capital | 3.5% |
| Cash Flow Interval (in years) | 1.00 |
| Investment periods | 2.0 |
| Payback periods | 28.0 |
| Start at period | 2.0 |
| Date Start | 01/04/2015 |

| Cash Out - Investment Period | Year | 0 | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Investment cash out | -250 | -125 | -125 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discount factor | | 1.00 | 1.04 | 1.07 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Present value | -246 | (125) | (121) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |

| Cash In - Payback Period | Year | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unlevered free cash flow | 21,000 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 | 750 |
| Discount factor | | 1.07 | 1.11 | 1.15 | 1.19 | 1.23 | 1.27 | 1.32 | 1.36 | 1.41 | 1.46 | 1.51 | 1.56 | 1.62 | 1.68 | 1.73 | 1.79 | 1.86 | 1.92 | 1.99 | 2.06 | 2.13 | 2.21 | 2.28 | 2.36 | 2.45 | 2.53 | 2.62 | 2.71 |
| Present value | 12,802 | 700 | 676 | 654 | 631 | 610 | 589 | 570 | 550 | 532 | 514 | 496 | 480 | 463 | 448 | 433 | 418 | 404 | 390 | 377 | 364 | 352 | 340 | 328 | 317 | 307 | 296 | 286 | 277 | |

| | |
|---|---|
| Net present value | **12,556** |

**Option 3 - Best Case Scenario**

| Assumptions | |
|---|---|
| Cost of Capital | 3.5% |
| Cash Flow Interval (in years) | 1.00 |
| Investment periods | 2.0 |
| Payback periods | 28.0 |
| Start at period | 2.0 |
| Date Start | 01/04/2015 |

| Cash Out - Investment Period | Year | 0 | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Investment cash out | -200 | -100 | -100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discount factor | | 1.00 | 1.04 | 1.07 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Present value | -197 | (100) | (97) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |

| Cash In - Payback Period | Year | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unlevered free cash flow | 46,200 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 | 1,650 |
| Discount factor | | 1.07 | 1.11 | 1.15 | 1.19 | 1.23 | 1.27 | 1.32 | 1.36 | 1.41 | 1.46 | 1.51 | 1.56 | 1.62 | 1.68 | 1.73 | 1.79 | 1.86 | 1.92 | 1.99 | 2.06 | 2.13 | 2.21 | 2.28 | 2.36 | 2.45 | 2.53 | 2.62 | 2.71 |
| Present value | 28,165 | 1,540 | 1,488 | 1,438 | 1,389 | 1,342 | 1,297 | 1,253 | 1,211 | 1,170 | 1,130 | 1,092 | 1,055 | 1,019 | 985 | 952 | 919 | 888 | 858 | 829 | 801 | 774 | 748 | 723 | 698 | 675 | 652 | 630 | 608 | |

| | |
|---|---|
| Net present value | **27,968** |

**Option 4 - Expected Case Scenario**

| Assumptions | |
|---|---|
| Cost of Capital | 3.5% |
| Cash Flow Interval (in years) | 1.00 |
| Investment periods | 2.0 |
| Payback periods | 28.0 |
| Start at period | 2.0 |
| Date Start | 01/04/2015 |

| Cash Out - Investment Period | Year | 0 | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Investment cash out | -1,000 | -500 | -500 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discount factor | | 1.00 | 1.04 | 1.07 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Present value | -983 | (500) | (483) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |

| Cash In - Payback Period | Year | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unlevered free cash flow | 4,060 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 | 145 |
| Discount factor | | 1.07 | 1.11 | 1.15 | 1.19 | 1.23 | 1.27 | 1.32 | 1.36 | 1.41 | 1.46 | 1.51 | 1.56 | 1.62 | 1.68 | 1.73 | 1.79 | 1.86 | 1.92 | 1.99 | 2.06 | 2.13 | 2.21 | 2.28 | 2.36 | 2.45 | 2.53 | 2.62 | 2.71 |
| Present value | 2,475 | 135 | 131 | 126 | 122 | 118 | 114 | 110 | 106 | 103 | 99 | 96 | 93 | 90 | 87 | 84 | 81 | 78 | 75 | 73 | 70 | 68 | 66 | 64 | 61 | 59 | 57 | 55 | 53 |

| | |
|---|---|
| Net present value | 1,492 |

**Option 4 - Worst Case Scenario**

| Assumptions | |
|---|---|
| Cost of Capital | 3.5% |
| Cash Flow Interval (in years) | 1.00 |
| Investment periods | 2.0 |
| Payback periods | 28.0 |
| Start at period | 2.0 |
| Date Start | 01/04/2015 |

| Cash Out - Investment Period | Year | 0 | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Investment cash out | -15,050 | -550 | -550 | -13,950 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discount factor | | 1.00 | 1.04 | 1.07 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Present value | -14,104 | (550) | (531) | (13,022) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |

| Cash In - Payback Period | Year | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unlevered free cash flow | -32,200 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 | -1,150 |
| Discount factor | | 1.07 | 1.11 | 1.15 | 1.19 | 1.23 | 1.27 | 1.32 | 1.36 | 1.41 | 1.46 | 1.51 | 1.56 | 1.62 | 1.68 | 1.73 | 1.79 | 1.86 | 1.92 | 1.99 | 2.06 | 2.13 | 2.21 | 2.28 | 2.36 | 2.45 | 2.53 | 2.62 | 2.71 |
| Present value | -19,630 | (1,074) | (1,037) | (1,002) | (968) | (936) | (904) | (873) | (844) | (815) | (788) | (761) | (735) | (710) | (686) | (663) | (641) | (619) | (598) | (578) | (558) | (540) | (521) | (504) | (487) | (470) | (454) | (439) | (424) |

| | |
|---|---|
| Net present value | -33,734 |

**Option 4 - Best Case Scenario**

| Assumptions | |
|---|---|
| Cost of Capital | 3.5% |
| Cash Flow Interval (in years) | 1.00 |
| Investment periods | 2.0 |
| Payback periods | 28.0 |
| Start at period | 2.0 |
| Date Start | 01/04/2015 |

| Cash Out - Investment Period | Year | 0 | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Investment cash out | -900 | -450 | -450 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discount factor | | 1.00 | 1.04 | 1.07 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Present value | -885 | (450) | (435) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |

| Cash In - Payback Period | Year | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unlevered free cash flow | 176,120 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 | 6,290 |
| Discount factor | | 1.07 | 1.11 | 1.15 | 1.19 | 1.23 | 1.27 | 1.32 | 1.36 | 1.41 | 1.46 | 1.51 | 1.56 | 1.62 | 1.68 | 1.73 | 1.79 | 1.86 | 1.92 | 1.99 | 2.06 | 2.13 | 2.21 | 2.28 | 2.36 | 2.45 | 2.53 | 2.62 | 2.71 |
| Present value | 107,368 | 5,872 | 5,673 | 5,481 | 5,296 | 5,117 | 4,944 | 4,777 | 4,615 | 4,459 | 4,308 | 4,163 | 4,022 | 3,886 | 3,754 | 3,627 | 3,505 | 3,386 | 3,272 | 3,161 | 3,054 | 2,951 | 2,851 | 2,755 | 2,662 | 2,572 | 2,485 | 2,401 | 2,319 |

| | |
|---|---|
| Net present value | 106,483 |