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Mutuals in Health Pathfinders

University Hospitals of Leicester NHS Trust ('UHL')

Detailed Options Assessment

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1. Executive Summary

1.1 Introduction

The Mutuals in Health Pathfinder Programme (MIH) has been established by the Cabinet Office and Department of Health in order to:

- consider how mutual models could increase staff engagement across the organisation through greater staff control and/or ownership;
- explore and fully appraise the feasibility and potential benefits of a mutual model for the entire organisation of participating trusts or significant parts of their services;
- build skills, knowledge and capability in participating trusts in relation to appraising mutual models and contribute to wider knowledge sharing on mutuals models across new areas of the health sector including the acute sector; and
- support and inform any potential future policy around mutuals in new areas of the health sector by enabling government to build up an understanding of the practical, regulatory and legislative steps it may need to consider to facilitate new governance and ownership models.

University Hospitals of Leicester NHS Trust ("UHL" or "the Trust")) was successful in its bid to become a MIH Pathfinder. The partnership of Hempsons solicitors, Stepping Out (a business development consultancy specialised in mutuals) and Albion Care Alliance CIC (an alliance of three spin-outs providing community health services) ("HASO") was commissioned by Cabinet Office to work with UHL to deliver the assignment focused on UHL's objectives:

1.1. Explore the whole Trust mutual:

- develop a - high level- business case i.e. "this is what it could look like and how it could be done here"

1.2. Autonomous Teams (for UHL: Elective Orthopaedics, Trauma and Theatres):

- develop the framework and rules of engagement
- work with pilot teams to get them up and running

1.3. Embed staff engagement and a sense of ownership:

- research best practice
- develop plans to further embed staff engagement in the Trust's structure

Our work has confirmed the potentially significant benefits which could flow from a 'Whole Trust Mutualisation' (WTM), but also the significance of the barriers. Issues in relation to legislation, financial viability, access to finance, asset transfer and VAT have been identified as - under current policy and legislation - insurmountable barriers. Adding to that the implementation risks that are associated with mutualisation during a time of significant change for UHL, make the option of WTM as yet unattainable.

However, as the financial and non-financial benefits of the mutual model are highly attractive, and certain 'mutual' elements can be implemented without being affected by aforementioned barriers, we are not ruling out the WTM option, in the longer term, if the circumstances are right, and as such recommend a staged approach that allows UHL to achieve the benefits of mutualisation, as follows:

Stage 1: Creating an Autonomous Team within the Trust structure, whilst

Implementing improved Staff Engagement Measures elsewhere in the Trust

Stage 2: Enhancing the Trust model ("NHS Trust Plus") to include governance elements of a mutual in its legal structure, specifically staff and patient involvement in decision-making. This will require a change to law.

Stage 3: Transition into Foundation Trust Plus ("FT Plus"), once UHL meets the FT criteria, but subject to the FT model being enhanced with improved staff and patient governance elements. This will also require a change to law.

Stage 4: Moving into a Whole Trust Mutual, assuming that by then issues regarding the deficit, VAT and asset transfers have been addressed and it is clear at that time that there would be sufficient benefit over and above Stages 1-3. Again, this will require a change to law and policy to make this viable.

1.2 Strategic Considerations

1.2.1 The strategic context

As one of the largest acute NHS Trusts in the country, with 12,000+ staff, £800+m budget and treating over 1 million patients a year from three hospital sites, UHL has its complexities and challenges. It operates one of the busiest A&E sites in the country, runs one of the country's leading heart centres and areas of world-renowned expertise include diabetes, cancer and cardio-respiratory diseases.

UHL's strategic challenges include its historic and ongoing operational deficit (forecast to be c. £40m for 14/15), its £320m capital re-configuration plan (to include development of the Emergency Floor, a new Treatment Centre and an investment in a new Children's Hospital and maternity service) as well as the requirement to respond to the NHS' strategic direction as laid out in the Five Year Forward View and the Dalton Review which outline new models of care and alternative organisational forms to support service integration and sustainability.

UHL has an important strategic partnership in place to address some of the challenges in the local health economy, through Better Care Together (focused on health and social care in Leicester, Leicestershire and Rutland) which is in line with its own strategic directional plan.

Furthermore, UHL has been challenged by the NHS Trust Development Authority ("NTDA") to go "further, faster" in the implementation of its programmes.

1.2.2 The case for change

Although UHL has been delivering good outcomes and made impressive progress in recent years, it is ambitious in achieving more for its patients. Staff Engagement has been identified as one of the key enablers. A lot of work has gone into improving staff engagement through its Listening into Action Programme (LiA), though results from the most recent survey suggest further improvements are possible.

Research shows that Mutuals have a track record of outstanding staff engagement scores. This translates into better patient outcomes whilst achieving significant financial benefits for the organisation. Mutuals generally substantially outscore other healthcare organisations in the areas of staff sickness rates, staff turn-over, patient satisfaction, Friends & Family Tests and staff satisfaction surveys.

As such the central question for this study has been "How can mutualisation help UHL take staff engagement to the next level", and thereby improving patient outcomes, reduce costs and be an enabler for the large programmes of complex change.

1.3 Economic considerations

1.3.1 The long list

Our study has looked into the feasibility and desirability of a range of models along a number of agreed criteria. This long list of models was established as follows:

Option 1: Current Trust	Doing more within the current NHS Trust framework, building on UHL's transformational work to date including the autonomous incentivised teams
Option 2: Foundation Trust	Doing more within a Foundation Trust model. This will include exploring the potential offered by the mooted 'FT Plus' model
Option 3: Service mutual	Transfer one or more UHL services or businesses into another legal structure (which could be owned by UHL, separate from it, or a pre-existing structure) with 'mutual' characteristics. This will explore the appetite and feasibility of specific services 'spinning out' of UHL and mutualising
Option 4: Pathway mutual	Transfer one or more UHL services or businesses into another legal structure in the same way as for Option 3, but linking the transfer to a pathway by involving other partners delivering services on the pathway as well (such as community, primary and voluntary sector providers)

Option 5: Whole Trust Mutual	UHL itself becoming a mutual by 'spinning out' into a new legal structure
Option 6: Joint Venture	Working with a joint venture partner to achieve any of the above. This could be on a contractual basis by setting up a new legal structure distinct from the partners, or by using an existing legal structure belonging to a partner

1.3.2 The short list

After debating the results from the Feasibility Study, the following shortlist of options emerged which we have subsequently studied more in-depth, to clarify how each option might work, how they are to be implemented, what risks and benefits are associated with each and any hurdles that might be encountered.

1.3.2.1 Shortlist option 1 – Current Trust model: enhancing engagement within current framework

Within this option, improvements may come from building on LiA, strengthening formal recognition ("Caring at its Best"), continued leadership development ensuring focus on coaching, feedback, informal recognition & effective communication etc.

Possible benefits include incremental improvement in patient care and staff involvement, improved leadership capability, better inter-departmental collaboration etc, without the need to overhaul the structure of the organisation.

1.3.2.2 Shortlist option 2 – Autonomous Team(s)

This option involves the creation of an Autonomous Team led by a Committee of the Board with significant powers and freedoms delegated to it by the Trust Board as defined in a "Mandate". It would allow the Trust to experiment with mutual-like governance arrangements within the confines of its current framework.

Improvements may therefore come from active involvement of staff (and patients) in decision-making, a - virtual - sense of 'ownership', being incentivised through re-investment in the service and possible other non-financial incentives.

The potential benefits of this option include the simplification of processes, speeding up of decisions and ultimately better patient care. Furthermore, this is a low risk option requiring low investment but with a high potential upside.

1.3.2.3 Shortlist option 3 – Whole Trust Mutual

The Whole Trust Mutual (WTM) option would involve transferring the Trust organisation into a new legal entity based on a mutual footprint, i.e. predominantly owned by staff and patients, with a strong element of empowerment of frontline staff. The option could involve splitting UHL into a "PropCo" to hold assets, and - possibly - access finance, and an "OpCo" to run the business and deliver services on the footprint of a mutual.

Based on our experience, this option could potentially provide the best possibility for UHL to gain the financial and non-financial benefits that mutuals achieve. Our modelling suggests a hypothetical financial benefit could amount to £17m p.a. by year 5 as a result of mutualisation.

However, significant barriers exist which make this option currently unviable, which include the issues of UHL's deficit, irrecoverable VAT (potentially adding up to £29m to the cost base), question marks around access to finance (essential for UHL in view of its deficit and estate reconfiguration programme), whether assets would be permitted to transfer to the new entity and procurement issues relating to the award of service contracts to the new entity. Without these barriers being removed by changes in law or policy, WTM remains realistically unattainable for UHL.

1.3.4 Recommended approach: Four Stage Implementation

Having considered in more detail the implications, benefits and barriers of the Shortlist Options described, the study arrived at the conclusion that in effect these options are not mutually exclusive. Rather, they can be considered as part of a staged approach towards potential mutualisation, thereby allowing UHL:

- To keep implementation risk and investments low
- Learn from early experiences

- Bring staff and stakeholders along on the way to mutualisation
- Allow national policy changes to emerge which will enable UHL to take the next step on its journey.
- Make each stage a well-controlled and considered decision for the Trust Board, requiring significant and demonstrable benefits to be expected over and above achievements in the previous stage.

As such we recommend that UHL considers a staged implementation consisting of the following elements:

Stage 1: Creating an Autonomous Team within the Trust structure along the lines of Shortlist Option 2, whilst

Implementing improved Staff Engagement Measures elsewhere in the Trust

Stage 2: Enhancing the Trust model ("NHS Trust Plus") to include governance elements of a mutual in its legal structure, specifically staff and patient involvement in decision-making. This will require a change to law.

Stage 3: Transition into Foundation Trust Plus ("FT Plus"), once UHL meets the FT criteria, but subject to the FT model being enhanced with improved staff and patient governance elements. This will also require a change to law.

Stage 4: Moving into a Whole Trust Mutual as described in Shortlist Option 3, assuming that by then issues regarding the deficit, VAT and asset transfers have been addressed and it is clear at that time that there would be sufficient benefit over and above Stages 1-3. Again, this will require a change to law and policy to make this viable.

1.4 Commercial considerations

Stages 1, 2 and 3 do not raise specific commercial considerations in themselves. Stage 4 raises a number of commercial considerations that will need to be addressed, including financial and procurement law issues, legal form of any new mutual entity and regulatory issues.

1.5 Financial case

Stages 1, 2 and 3 do not raise specific financial considerations in themselves, except in relation to financial incentives for staff if remuneration policy is changed to permit greater freedom for this.

Mutualisation does bring financial challenges. Through our modelling we have identified:

- irrecoverable VAT impact based upon current reclaimed VAT on contracted out services (potentially £19m per annum)
- potential additional VAT from charges for asset use if assets are not transferred to the new mutual and instead are to be leased from a so-called PropCo (potentially £10m per annum)
- Corporation Tax payable if the new organisation moves into surplus (potentially around £3m per annum).

In order to realistically consider WTM, there is therefore a need to deal with these downside issues through recommendations to be made to Cabinet Office and Treasury.

Our modelling also suggests that the hypothetical financial benefit of WTM (under the assumption that the above issues are addressed and on a like-for-like basis of current Trust projections) could amount to up to £17m p.a. or £55m over 5 years. The main drivers of these benefits are lower costs as a result of reduced staff sickness and turnover, and further efficiencies related to improved working practices.

The Four Stage Implementation will avoid any of VAT, tax and asset issues in the early stages, but these are also less likely to deliver on the full expected benefits. The staged approach will allow UHL to monitor the impact of the changes made, and make an informed decision whether moving on to the next stage is the right thing to do.

1.6 Management considerations

Realistically this is a multi-year programme spanning at least 5 years. We anticipate that implementing Stage 1 could take approximately 6 months for the Autonomous Team (though assessing its impact will take at least another year), whereas implementing other improved staff engagement measures depends on the scope decided upon.

In view of their unique 'mutual' elements, both the Autonomous Team stage and Whole Trust Mutual stage will require a combination of internal, corporate and external resources and UHL may benefit from some external resources too when considering moving into NHS Trust Plus and FT Plus. In view of the strategic importance of the programme, the project governance should have appropriately senior reporting lines and reflect the mixed nature of resources.

A high-level estimate of implementation costs for both internal and external resources suggests costs between £100 and £200k in the first instance for an AT implementation and costs would rise considerably in the event of Whole Trust Mutualisation.

Naturally each proposed stage has risks attached to it, and we present these in some detail in our report. However, we believe that the staged nature of the implementation allows UHL to minimise and assess most of these risks as it progresses from one stage to the next. It is therefore important to make each stage a well-controlled and considered decision for the Trust Board, requiring significant and demonstrable benefits to be expected over and above achievements in the previous stage.

Ultimately, UHL is a complex organisation in deficit on an ambitious journey of transformation, and the main risks with any long-term transition process is associated with whether it can bring its stakeholders along, and whether mutualisation is regarded as a distraction or enabler.

For the option of WTM the identified barriers as well as the need to be clear about what a possible failure regime should look like are its key risks.

1.7 Conclusions & Recommendations

A number of conclusions and recommendations have resulted from our study, some relating to UHL, others directed towards policy makers and influencers in Government. Most of our conclusions and recommendations have been touched upon in this Executive Summary. We summarise them below.

1.7.1 Recommendations for UHL

In view of all things considered we acknowledge the significant potential benefits (financial and non-financial) that come with mutualisation. We are not ruling out the WTM option, in the longer term, if the circumstances are right, and as such recommend a staged approach that allows UHL to achieve the benefits of mutualisation. This will keep risks and interdependencies manageable, allows the organisation to grow into its proposed Mutual mould over time at its own pace, and enables policy and/or legislative changes to take shape in the meantime.

We firmly believe that the staff - and stakeholder - ownership element to a WTM as well as its financial independence are key ingredients to what makes mutuals so successful and it is for this reason we recommend that the WTM option remains of interest to UHL in the longer term.

Furthermore, we recommend that the established momentum is kept and both the Autonomous Team and Staff Engagement Improvement programmes are mobilised in the short term.

Finally, it is our experience that it takes a considerable amount of time for staff, management, directors and other stakeholders to get used to the ideas and concepts involved in mutualisation. Winning hearts and minds is generally greatly helped by seeing mutuals in action. As such we recommend that UHL develop an exchange programme with existing mutuals in health, so that those initial trepidations are overcome and concepts and ways of working are adopted more naturally into the organisation.

1.7.2 Recommendations for Cabinet Office / Department of Health

In order for mutuals in health to become a viable option for organisations of scale and complexity, key issues need to be tackled. Our recommendations therefore refer first and foremost to the technical issues raised regarding irrecoverable VAT, access to finance and the ability to retain assets.

Secondly, both the NHS Trust governance model and the Foundation Trust governance model would be greatly enhanced by giving a more prominent role for staff and patients. There are several ways of achieving this but these roles need to be meaningful and encompass real power.

Finally, it has become clear that for mutualisation to stand a chance in NHS organisations a slow and gentle pace is required. A fair amount of anxiety regarding the concept has been detected at all levels in the organisation and this is evidently reflected in other Pathfinder organisations. In our view it will take time for organisations to arrive at a balanced view of the facts and whether mutualisation is right for them. In fairness, even the most successful mutuals have taken several years from inception to implementation. We would recommend that - in future - studies like these are given more time with a stronger focus on learning and exploration.

2. The Strategic Case

2.1 Introduction

This document describes developments for University Hospitals of Leicester NHS Trust ("UHL") that might be facilitated as a result of the Trust's participation in the Mutuals in Health Pathfinder programme in 2015. The Mutuals in Health: Pathfinder Programme has been established by the Cabinet Office and Department of Health in order to:

- consider how mutual models could increase staff engagement across the organisation through greater staff control and/or ownership
- explore and fully appraise the feasibility and potential benefits of a mutual model for the entire trust or significant parts of UHL's services and develop a robust outline business case for the preferred model
- build skills, knowledge and capability in UHL in relation to appraising mutual models (and developing accompanying business cases) and contribute to wider knowledge sharing on mutuals models across new areas of the health sector including the acute sector
- support and inform any potential future policy around mutuals in new areas of the health sector by enabling government to build up an understanding of the practical, regulatory and legislative steps it may need to consider to facilitate new governance and ownership models.

University Hospitals of Leicester NHS Trust ("UHL" or "the Trust")) was successful in its bid to become a MIH Pathfinder. The partnership of Hempsons solicitors, Stepping Out (a business development consultancy specialised in mutuals) and Albion Care Alliance CIC (an alliance of three spin-outs providing community health services) ("HASO") was commissioned by Cabinet Office to work with UHL to deliver the assignment focused on UHL's objectives:

1. Explore the whole Trust mutual: develop a business case i.e. "this is what it could look like and how it could be done here"
2. Autonomous, incentivised teams (for UHL, Orthopaedics and Orthopaedic Theatres / MSK): develop the framework and rules of engagement work with pilot teams to get them up and running

3. Embed staff engagement and a sense of ownership: research best practice; develop plans to further embed staff engagement in the Trust's structure

University Hospitals Leicester NHS Trust and is one of the ten biggest and busiest Trusts in the country (and a leading teaching hospital), servicing a core catchment of £1m+ patients plus a broader catchment via its specialisms. Its strategic vision is "In the next 5 years UHL will become a Foundation Trust that is internationally recognised for placing quality, safety and innovation at the centre of service provision. We will build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience".

The Trust provides over 1700 beds and employs nearly 12,500 people. In 2013-14 it earned £770.4m and spent £809.9m. It currently has three acute sites and a range of satellites: Leicester Royal Infirmary (where the only A&E department is sited), Leicester General and Glenfield. It plans to reduce this to two.

The Trust has links and works closely with the University of Leicester, Loughborough University and De Montfort University. St Mary's Birth Centre provides care for pregnant women and their families for the Trust. UHL is expert in the diabetes, genetics, cancer and cardio-respiratory clinical areas. It is home to 3 NIHR biomedical research units, and the local branch for the NIHR Clinical Research Network, with more than 800 clinical trials in a year. The 'Respiratory' and 'Lifestyle, Diet and Nutrition' Biomedical Research Units opened in 2014, (the latter as part of the Leicester Diabetes Centre) and UHL will house a £100m Cancer Research UK Centre in the next few years.

2.2 The Strategic Context

2.2.1 The Strategic Context: The NHS

From a national perspective two 2014 documents are key: the NHS Five Year Forward View and the Dalton Review on options for providers of NHS-funded care. These two documents set the context for the NHS over the next few years and UHL needs to know how it will respond to these key papers. Both are driving consideration of new models of care and UHL

has been named as a participant in one of NHS England's Forward View "vanguard" sites. There is potentially some cross-over between the Forward View models and the models considered here. Dalton also specifically references mutualisation as an option.

The Trust is planning a two phase implementation of its Five Year plan following the TDA challenge to go "further, faster". Inthe first phase, lasting two years the Trust will focus on in hospital efficiency and productivity with the aim of repositioning key clinical services from outliers in terms of benchmarked data (for example length of stay and day case rates) to top quartile. In complement, the Trust will work with partners to support the safe transfer of patients who no longer require acute care, into out of hospital, community settings. The first phase will also involve four urgent developments.

The second phase from 2016 onwards is to effect major reconfiguration of the hospital estate which coincides with the second phase of services coming on line in the community.

UHL is on the pathway to becoming an FT. An FT structure does offer a number of improvements over the current NHS Trust structure that could better help UHL achieve its aims than is the case within the current structure. FTs allow for improved governance structures which, whilst certainly not perfect with regard to staff and stakeholder engagement, do nevertheless build these things in to governance arrangement. FTs can also set up subsidiaries in a way that NHS Trusts cannot.
Current NHS policy states that all NHS Trusts should become Foundation Trusts (the timescale for this is not quite clear): foundation status was originally awarded as a mark of excellence when Trusts are considered organised enough to run semi-independently from their local health authority. According to the NHS Confederation, in February 2015 there were 156 acute trusts (including 100 foundation trusts), 56 mental health trusts (including 42 foundation trusts) , 34 community providers (15 NHS trusts, 3 foundation trusts and 16 social enterprises) and 10 ambulance trusts (including 5 Foundation Trusts).

According to the health regulator Monitor (quarterly report, February 2015) NHS Foundation Trusts were £321m in deficit. More than half of all Foundation Trusts were in the red (78, or 53%, of which 60 are acute Trusts like UHL that manage hospitals in England). 61 Foundation Trusts contributed to a national surplus of £60m.

2.2.2 The Strategic Context: UHL

UHL is planning strategically for its future. UHL:

- recognises a need to change – to become smaller, more specialised, and more able to support delivery of non-urgent care in the community
- intends to increase quality and safety working in partnership with others through Better Care Together
- plans to consolidate acute services into a smaller footprint (likely to be the Royal Infirmary and Glenfield sites, though this is still to be confirmed)
- plans to use the General Hospital site to further support the Diabetes Centre of Excellence, integrated community services and to be a home for East Midlands Ambulance Service and existing services provided by Leicestershire Partnership NHS Trust (also still to be confirmed)
- intends, broadly, to split the five year plan into two phases: increasing efficiency and productivity (years 1 and 2) and major re-configuration of the hospital estate (years 3 to 5)
- Wishes to address the provision of meals, catering and cleaning had been outsourced from the Trust's own staff to an independent company. There have been significant issues in the level of service delivered through this contract
- Is dealing with a £40m deficit at the 2014 year-end, and improving some key services that should generate profits but are running at loss
- Is investing in staff and seeing improvements in staff and patient satisfaction surveys, including Friends and Family Test scores

2.2.3 The Strategic Context: UHL's Business

UHL's business is operating within a challenged health economy but has targeted a range of improvements and is showing marked successes. There are evidenced "steady improvements to quality", with a "decent" report from CQC in January 2014. However, the Trust acknowledges that it remains in a "difficult financial position" (a £40m deficit at the 2014 year-end, some key services that should generate surpluses running at loss). The planned capital and service developments are important here: the combined effect of the planned material changes to the provision of services and their underpinning business models (and 'tools') is expected to return the Trust to a breakeven position from 2018/19.

Encouraged by the CQC inspection conclusion in January 2014, UHL is investing in staff and seeing improvements in staff and patient satisfaction surveys, including Friends and Family Test scores (although staff surveys seem to have reached a 'plateau' recently).

The Trust has one of the lowest rates of hospital-acquired infections in the country and has reduced its rates of pressure ulcers and falls. Performance against key targets has not been good but all are now on an improving trajectory. It achieved its 95% compliance targets for Statutory and Mandatory Training, turning this around throughout 2014-2015. The Trust sees its key improvement areas as 4 hour performance, Referral to Treatment (18 weeks), cancer and finance.

2.2.4 The Strategic Context: UHL Plans

Internally, there are many frameworks and initiatives in place to support communication and management. These include medical engagement via the 'Egan Skilled Helper' model, improvement workshops with consultants and doctors on their PLICS Systems (Patient-level information and costing systems) and a Clinical Senate, for example.

From the UHL perspective recent important strategies such as its Five Year plan, Better Care Together, combined with the Listening into Action initiative mean that UHL has already done significant thinking about its priorities over the next few years and how to increase staff engagement. It is important to note that MIH and the work we are doing with UHL in relation to it is not intended to undermine or replace these strategies and initiatives but rather to complement and to inform them as they develop.

Key plans include the following:

Better Care Together (BCT) is a five year plan that UHL describes as its "vehicle for change". The plan describes how staff need to work differently, in mixed teams, to treat 'the whole person'; how services need to be more joined up to deliver better value for money; how it is important to develop "different ways of working". The plan also describes a commitment to "public involvement" and "plans to support successful change". BCT seeks to transform 8 pathways (Urgent Care, Frail and Older People, Long-Term Conditions, Planned Care, Maternity and Neonates, Children / Young People / Families, Mental Health and Learning

Disabilities. Whilst the UHL Trust currently comprises three hospitals, BCT proposes smaller hospitals, fewer acute beds, more specialised care / teaching / research, redeveloped A&E, concentrated acute services across 2 sites (LRI and Glenfield) and re-shaped general hospitals. The plan acknowledges that it will require "several years to implement". The strategy focuses on integrated quality care, workforce change and value for money. Of its six objectives, two are perhaps of most interest in the context of Mutuals in Health: "System Objective Four: to optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system" and "System Objective Six: to improve the utilisation of our workforce and the development of new capacity and capabilities where appropriate, in our people and the technology we use".

In November 2012 the Trust published its 'Strategic Direction' which set out at a high level the future shape of UHL's clinical services…

> *"Overall Leicester's hospitals will become smaller and more specialised and more able to support the drive to deliver non-urgent care in the community. As a result of centralising and specialising services we will improve quality and safety… this will be done in partnership with other local health organisations and social care though the Better Care Together programme. We will save money by no longer supporting an old expensive and under used estate and we will become more productive."*

Since then the Trust has worked on the development of its 5 year plan which seeks to ensure that the vision of *"smaller more specialised hospitals"* becomes a reality, and that the ongoing issues with emergency and urgent care are solved and that the Trust returns to financial balance.

2.3 The Case for Change

2.3.1 External Drivers

There are external and internal drivers that are significant in UHL's planning. Externally, these include:

The anticipated requirements of clinical standards for congenital heart services, in particular the need for colocation of children's services on one site (July 2014)

Part of UHL's response to changes in clinical standards for congenital heart services includes a very substantial capital programme to enable patients and staff to feel a sense of pride in their local NHS. There is a substantial capital re-configuration plan underway across the Trust. The Trust plans to build a new A&E, a Treatment Centre, a new children's hospital, a new maternity centre and a new multi storey car park. At the same time it plans, with its LLR health and social care partners, to transform the General Hospital into a 'multi-speciality community provider', to bring together community clinical teams to provide the kind of care which, especially for frail older people, reduces the risk of hospital admission.

Building on clearly articulated clinical consensus the Trust intends to consolidate its main acute services onto two sites, enabling patients and clinicians alike to benefit from properly co-located services and eliminate the inefficiencies of running multiple acute sites. This level of reconfiguration will require substantial investment in the hospital estate, currently estimated to be in the region of £320m. Included within this would be the development of the Emergency Floor, a new Treatment Centre and an investment in a new Children's Hospital and maternity service.

As well as reducing the number of sites (and beds) the plan aims towards rationalisation of existing services and support of developing ones. Phase one of this will be four urgent developments: the Emergency floor at the Royal Infirmary, the transfer of vascular services from the Royal to Glenfield Hospital, the consolidation of ITU services on to the Royal Infirmary and Glenfield Hospital sites and the establishment of a Treatment Centre. Phase two (from 2016 onwards) is a major reconfiguration of the hospital estate to allow safe rebalancing of bed numbers, and coinciding with the second phase of services coming on line in the community and repurposing ,or moving out of, buildings which are no longer required.

Publication of the NHS's Five Year Forward View (November 2014) and the Dalton Review (December 2014) which outline a number of new models of care and alternative organisational forms that providers may consider to support service integration and sustainability.

Responding to the NHS's Five Year Forward View (November 2014) and the Dalton Review (December 2014) as an NHS Trust, it is open to UHL to consider the models of care

suggested in the Forward View and organisational forms suggested in the Dalton Review. Indeed, UHL has been named as a participant in a Multispeciality Community Provider vanguard site.

Much of what UHL is aiming to achieve can be done within the existing NHS Trust model. UHL has further embarked on implementing Dalton recommendations by starting to look at alternative organisational structures. UHL has a clear strategic direction from the Board about an openness to exploring mutualisation.

The thinking that has led to this programme has been a belief in the potential of the workforce if freed from many of the constraints imposed by the NHS Trust/Foundation Trust regimes. Staff engagement to achieve mutualisation will clearly be critical, but equally important will be engagement with the Council, parliamentarians, CCGs and the media. The Trust has been considering "settings" for care and overarching service models. Better Care Fund documentation refers to "collaborative primary care", "engaging stakeholders" and "new staffing models". More significantly, in its annual report, the Trust declares priorities for 2014-2015 that include: *"Experiments in autonomy, incentivisation and shared governance"*

The challenge to the Trust from the TDA to go "further, faster" in the delivery of UHL's plans, with the aim of achieving recurrent balance by 2018/2019.

In addressing the challenge to the Trust from the TDA to go "further, faster" to achieve a recurrent balance by 2018/19, the Trust is responding by considering, in addition to mutual models, the Forward View models of care as noted above. ITU consolidation is an urgent imperative for the Trust (some of this is being carried out 'at risk'). The Trust acknowledges that it requires "rapid and significant change to the fundamentals of the underlying business and clinical models currently in place within the Trust and throughout the wider health economy" and warns that "This will not be an easy journey".

Local demographics and their impact on the LLR health economy

In Leicester, Leicestershire and Rutland (or 'LLR'), the NHS, in all its forms, served a population of just over one million people in 2014-2015. The people of Leicester, Leicestershire and Rutland (LLR) represent one of the most diverse populations in the country in terms of age, education, ethnicity, wealth, health and health needs. Better Care Together: a Blueprint for Health and Social Care in Leicester, Leicestershire and Rutland identifies three issues that currently exist and need to be addressed:

1. Some NHS health care is currently organised in centralised hospital facilities, which is not always convenient for patients
2. In some groups of patients, particularly older people, services can seem geared towards responding to a crisis once it has occurred rather than helping to prevent and manage conditions before an incident happens.
3. It is not a cost effective way of delivering health care, and is unsustainable in the long term.

Specifically, in LLR

- The LLR population is ageing (12% more over 65s by 2019). This means more long term, complex illness and disability - increasing demand for health and social care.
- There is also inequality. For example, men in some parts of Leicester live more than nine years longer than those in other areas.
- Skilled professionals are in short supply, particularly in some specialties.
- Staff will need to work differently, in mixed teams that treat the 'whole person' rather than just one condition at a time
- Quality: Services need to achieve the highest possible standards and be more joined up, to provide excellent results and experience for the people using them.
- Value for money: We need to do more with less.
- The LLR health and social care economy is deemed to be 'financially challenged', with particular pressure in Leicester's hospitals. If no action is taken, by 2019 the funding gap for the NHS locally will be around £400m.

2.3.2 UHL Drivers

Internally, driving factors for change include:

- A significant increase in the level of clinical risk associated with the current configuration of ITU services.
- Alongside and linked to this, the most pressing of strategic issues is the Trust's deficit (c £40m). The Board and Executive realise that UHL's future success as a sustainable Trust requires significant change to the fundamentals of the underlying business and clinical models currently in place within the Trust and throughout the wider health economy and this is reflected in the Five Year Strategy and other related documents.

- UHL has committed itself to a focus on projects and developments that result in improved patient care. The organisation is working to integrate care, improve workforce capacity and capabilities, provide for a growing older population and deliver value for money. The Trust is reducing its nurse staffing shortage, managing the pressures in A&E and handling outsource "issues" (meals, catering and cleaning are outsourced).
- More care is to be delivered in people's homes and other community settings, using improved care pathways supported by Trust staff. This will require health and social care providers to work together to jointly design and deliver safe, effective services that are tailored and personalised to a patient's age, ethnicity, and health and social care needs. In five years' time, the Trust expects to be delivering better care to fewer patients, significantly smaller, more specialised, and financially sustainable. By making its specialist expertise available to primary and social care it intends to work to jointly design and deliver safe, effective services that are tailored and personalised to a patient's age, ethnicity and health and social care needs. The Trust intends to play a much bigger role in preventing illness and supporting patients before they reach a point of crisis. This will reduce the need for people to come into hospital, reduce the number of beds and ultimately enable the Trust to run its specialist services from two, rather than three big hospitals.

There already exists a range of providers delivering NHS services in Leicester, Leicestershire, and Rutland. Work has already taken place to date under Better Care Together to allow for closer working together.

2.4 Strategic Benefits

2.4.1 Financial benefits

Our experience (including that as health service providers and as specialist consultants) has led us to believe that UHL can benefit financially from adopting mutual approaches and practices. For example:

- Potential to reduce staff sickness levels, with potential savings estimated at £2.7m.
- Better staff retention could help save £1.5m.
- Mutualisation could help to reduce the risks attached to the Trust's current cost reduction plans. Using an efficiency gain of 1.5% of staff costs, the impact could be as much as £7.5m

- Potential benefits from the use of cash and interest receivable could (using a modest, risk-free interest rate of 1.2%) create an interest advantage of up to £400k.
- UHL would have more opportunities for diversification and the creation or growth of more revenue streams within a mutual model

2.4.2 Non-Financial benefits

We further believe there are potential non-financial benefits for UHL:

- There is evidence that more engaged staff mean better outcomes for patients
- Mutual organisations often provide additional social value and capital (eg choosing to work with local suppliers, supporting community causes)
- Mutuals:
    - Create jobs
    - Do better in retention and recruitment of high-quality staff
    - Have paid higher wages on average than non-employee-owned organisations
    - Have better staff performance
    - Deliver greater customer satisfaction
    - Innovate

INDICATOR	UHL	Albion
Staff absence through sickness	3.78%	< 3%
Staff turnover	10.17%	< 4%
Service user satisfaction	71.1% (inpatients) and 59.5% (A&E) Family & Friends Test	> 97% Family & Friends Test
Percentage of staff who are proud of the services they deliver	86%	96%

Fig. 2.1: Comparison of key measures UHL v Albion

Fig. 2.1 compares some measures from Albion Care Alliance CIC (an alliance of healthcare mutuals) with those from UHL to provide an indication as to what might be achievable under the mutual model. Please refer to Appendix A for a further illustration of the range achievements of this group of health mutuals.

Francis Maude (Cabinet Office Minister) has also stated that "Employee-owned businesses have the kind of grit and resilience our economy needs. During the recession, they grew more than 11% compared with just 0.6% for other businesses in the UK. Now they are also contributing to the recovery."

By freeing employees to deliver and improve their services as they know best, mutuals enable innovation, and because they feel more engaged, staff are likely to stay longer with the organisation and miss fewer days of work." (Cabinet Office website, 2015). In our exercise, UHL was asked to rank the order in which they perceived the Mutuals' characteristics to be of interest to their organisation.

Employees who feel that they have influence on outcomes are typically happier, healthier and more productive: one survey found that 70% of businesses reported an improvement in the quality of their products and services after the ownership shake-up.

Figure 2.2 lists some of the typical characteristics of mutuals and to what extend these are perceived to be of interest to UHL.

UHL ranking	Characteristics of Mutuals
1	Improved care
2	Clarity of purpose / shared purpose
3	Staff taking ownership
4	Public & patient involvement
5	Autonomy
6	Efficiency/Productivity
7	Reinvestment in service/community
8	Innovation

9	Clarity of priority
10	Staff involvement

Fig. 2.2: Perceived attractive characteristics of Mutuals

3. The Economic Case

3.1 The long list

Our study has looked into the feasibility and desirability of a range of models along a number of agreed criteria. This longlist of models was as established follows:

Option 1: Current Trust	Doing more within the current NHS Trust framework, building on UHL's transformational work to date including the autonomous incentivised teams
Option 2: Foundation Trust	Doing more within a Foundation Trust model. This will include exploring the potential offered by the mooted 'FT Plus' model
Option 3: Service mutual	Transfer one or more UHL services or businesses into another legal structure (which could be owned by UHL, separate from it, or a pre-existing structure) with 'mutual' characteristics. This will explore the appetite and feasibility of specific services 'spinning out' of UHL and mutualising
Option 4: Pathway mutual	Transfer one or more UHL services or businesses into another legal structure in the same way as for Option 3, but linking the transfer to a pathway by involving other partners delivering services on the pathway as well (such as community, primary and voluntary sector providers)
Option 5: Whole Trust Mutual	UHL itself becoming a mutual by 'spinning out' into a new legal structure
Option 6: Joint Venture	Working with a joint venture partner to achieve any of the above. This could be on a contractual basis by setting up a new legal structure distinct from the partners, or by using an existing legal structure belonging to a partner

3.2 The short list

After discussing the results from the Feasibility Study, the following shortlist of options emerged which we have subsequently studied in more depth. Our studies have sought to

clarify how each option might work, how they are to be implemented, what risks and benefits are associated with each and any potential hurdles:

- Shortlist option 1 – Current Trust model: enhancing engagement within the current framework
- Shortlist option 2 – Autonomous Team(s)
- Shortlist option 3 – Whole-Trust Mutual

Each of these options is detailed in the following paragraphs.

*3.2.1 **Shortlist option 1** – **Current Trust model**: enhancing engagement within current framework*

Within this option, improvements may come from building on LiA, strengthening formal recognition ("Caring at its Best"), continued leadership development ensuring focus on coaching, feedback, informal recognition & effective communication and so on.

There are no specific legal or regulatory implications to this option. The workforce's terms & conditions, pensions and so on would not be affected and as such it is a non-controversial option. It is an option very much aimed at creating incremental improvements internally, and these do not require significant investment or external engagement.

Possible benefits include incremental improvement in patient care and staff involvement, improved leadership capability, better inter-departmental collaboration and so on, without the need to overhaul the structure of the organisation. This option focuses on the findings from our Engagement Report (see Appendix B).

In order to ensure an integrated approach, we have considered engagement activity under four themes:

- Opportunity:
    - Continue to build on LiA and extend use of process
    - Increase inter-departmental working and knowledge
- Feedback:
    - Find ways of engaging more people in design and use of performance data
- Development:
    - Continue leadership development, ensuring focus on coaching, feedback, informal recognition and effective communication
- Recognition

- Keep and strengthen formal recognition (‘Caring at its Best’)

What could be done	Possible benefits	Possible hurdles
Continue to build on LiA & extend use of process	Continued incremental improvement in patient care & staff involvement	Resources & time Communication of success Training
Keep & strengthen formal recognition (‘Caring at its Best’)	Reinforcement of core values & behaviours, resulting in better patient care	Resources & time Ownership of & commitment to values
Continue leadership development, ensuring focus on coaching, f/back, informal recognition & effective communication	Improved leadership capability & incremental increase in staff engagement / patient care	Resources & time Quality of management ‘stock’ Will to address poor management performance Ability to attract talent
Increase inter-dept. working & knowledge	Better inter-departmental collaboration, more engagement opportunity & better patient care	Resources & time Attitudes of functional mgrs Lack of shared responsibility
Find ways of engaging more people in design & use of performance data	Increased ownership of performance management, better staff engagement & improvements in care	Resources & time NHS/Gov prescription Lack of openness

For more detailed recommendations please refer to our staff engagement report in Appendix B.

3.2.2 Shortlist option 2 – Autonomous Team(s)

This option involves the creation of an Autonomous Team (AT) with significant powers and freedoms given to it as defined in a “Mandate”. It would allow the Trust to experiment with mutual-like governance arrangements within the confines of its current framework.

Improvements may therefore come from active involvement of staff (and patients) in decision-making, a - virtual - sense of ‘ownership’, being incentivised through re-investment in the service and possible other non-financial incentives.

The potential benefits of this option include the simplification of processes, speeding up of decisions and, ultimately, better patient care. Furthermore, this is a low risk option at low investment but with a high potential benefits.

3.2.2.1 Legal and governance structure

This option is available immediately to UHL. It may be achieved in two ways:

- By setting up an AT as a discrete business division within the Trust, in much the same as the current CMGs, or
- By setting up an AT as a committee of the Board, or a sub-committee of an existing committee of the Board.

A separate piece of work in relation to ATs is considering which of these models would best achieve the objectives of an AT, including whether the committee approach offers any advantages by allowing UHL to formalise the rights and obligations of an AT within its governance structure. For the purpose of this document we assume that a committee structure would be adopted, but, subject to the findings of the separate piece of work referred to above, the same principles as set out below would apply to the discrete business division structure.

Under the committee option UHL would set up a committee of the Board to pilot operating a part of the Trust's business (initially the Elective Orthopaedic, Trauma, and Theatres Teams) as an AT, see Fig. 3.1. This would allow UHL to formalise the rights and obligations of the AT within its governance structure with the aim of improving staff and stakeholder representation/influence. In so doing UHL would be able to establish, in a virtual sense, a distinction between 'ownership' and management:

- *Ownership:* the Board would act as the owner of the AT with ultimate control of the AT and the power to make decisions on key 'reserved matters'
- *Management:* the AT committee would manage its business under powers delegated to it by the Board. Staff and other stakeholders may set up some form of group to influence decision-making.

Although the ownership/management split would be virtual, it may be enough to generate some of the benefits that mutuals demonstrate.

In legal and governance terms the AT model would be set up in the following way:

- Powers of the committee: under the NHS Trusts (Membership and Procedure) Regulations 1990, an NHS Trust may make arrangements for the exercise, on behalf of the Trust, of any of its functions "subject to such restrictions and conditions as the trust thinks fit". UHL would need to consider which powers it wishes to delegate to the committee. These may include:

- To manage the AT business up to agreed delegated limits
- To set up a trading account for the AT (any bank account would need to remain in UHL's name)
- To retain surpluses for the AT business year on year (subject to UHL rights to claw back surpluses in agreed circumstances; this would need further consideration)
- To recruit staff to the AT business
- To set up staff and stakeholder groups ('councils') to provide input into AT decision-making (see Fig. 3.2). These would not be groups in any legally constituted sense but instead would simply be working groups able to make recommendations but not take decisions (nevertheless it would be important to set out their membership and rights/duties)

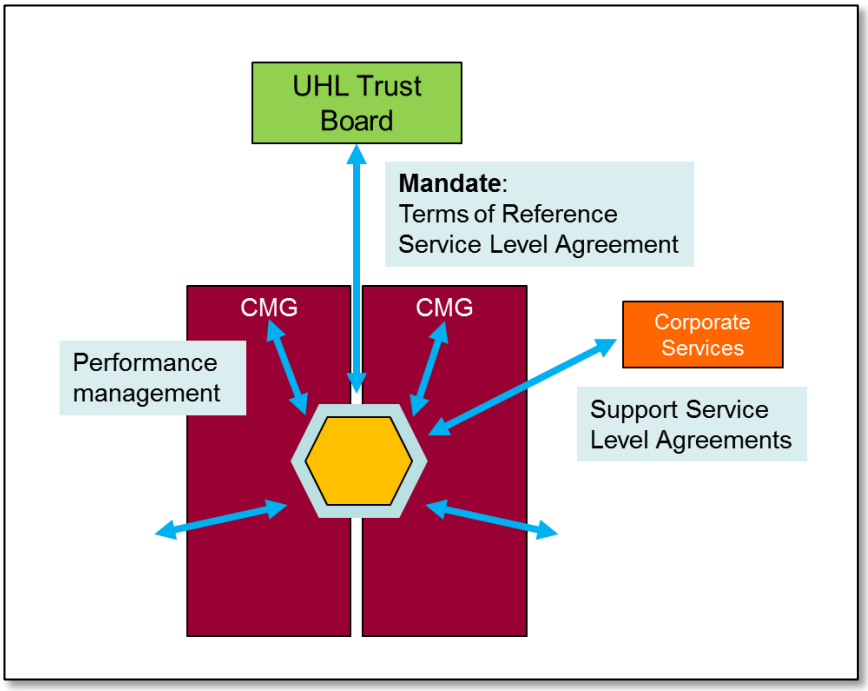


Fig. 3.1: Governance of the Autonomous Team

- To buy equipment and other assets for the AT business up to agreed delegated limits.

It would be important to note that at any time UHL's Board would be able to revoke these delegations and take these powers back.

- Appointments: In order to appoint a committee, UHL would by necessity need to appoint an initial two members to the committee. These could, for example, be representatives

from the appropriate CMGs. However, UHL could delegate the function of co-opting any *other* committee members to the committee itself through the Terms of Reference (see below). This would allow the committee to co-opt members that it deems suitable and / or that have been nominated by a staff or stakeholder 'council'. UHL would need to ensure that its Standing Orders were amended to reflect this (which may be achieved through the Terms of Reference themselves).

- Mandate: The UHL Board would be able to give the committee a 'mandate' for the AT business. This would comprise:
  Terms of Reference – this would document the functions of the committee, its delegated powers, its appointees and its meeting arrangements (frequency, quorum, voting etc).

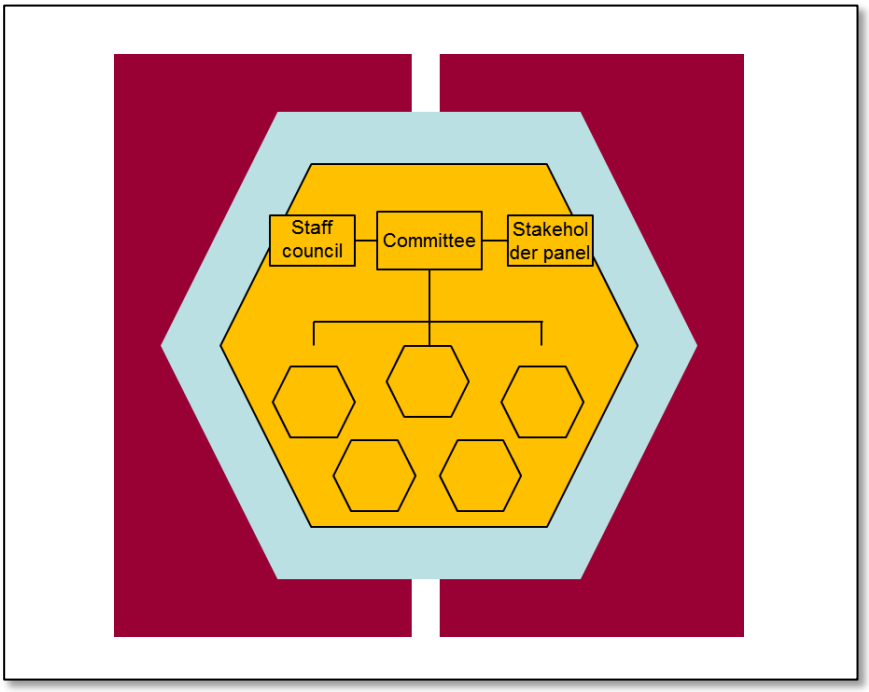


Fig. 3.2: The AT has its own internal governance

It would also set out a list of 'reserved matters' being those matters which require the consent of the Board/CMG appointees to the committee at all times. These may include:

- Agreement of the annual business plan for the AT
- Significant recruitments or equipment acquisitions
- Significant decisions concerning internal purchasing

- *Service Level Agreement* – this would be a non-legally binding internal SLA between the Board and committee setting out the services to be delivered by the AT. It would need to balance:
    - "Commissioning" outcomes from the AT in order to give the AT as much freedom as possible to run the business, and
    - Specific performance standards that would be required in order for UHL to comply with the terms of its commissioning contract for the AT service (which would be in NHS England's NHS Standard Contract form).

It may also be possible to explore replicating this structure by setting up multiple ATs in a 'honeycomb' structure. It would be difficult though to set up a 'whole trust' committee, in other words for the Board to delegate all its powers to an AT committee to run the entirety of UHL's operations, with staff and stakeholders having some representation/influence through this structure. This is because the current regulatory structure (including TDA's Accountability Framework, the well-led framework and Board Governance Assurance Framework) requires NHS Trusts to be able to demonstrate effective governance at Board level. In delegating all its powers to an AT committee the Board would effectively be disenfranchising itself which would make it difficult to demonstrate this effective governance.

3.2.2.2 Workforce

Under this model, things would stay as they are for individual staff members, except that they would be "assigned" to the AT. Nothing would change in respect of their NHS Terms and Conditions and access to the NHS Pension Scheme. Any future changes to staff employed by UHL would be governed by the Agenda for Change arrangements and any new joiners would be in the same position.

Whilst financial incentives in the form of performance related pay currently exist for staff at Director level in the AT, exploration of non-financial incentives is more likely to be explored and agreed within permitted arrangements with all staff in the AT.

3.2.2.3 Assets

The AT would still be part of UHL. UHL would continue to own its premises and equipment, but the SLA could 'grant' use of these to the AT. The Terms of Reference could delegate rights to buy equipment up to a certain value.

3.2.2.4 Branding

The AT could develop its own brand, though it would in all likelihood be linked to that of UHL.

3.2.2.5 Regulation

The AT would still be part of UHL and would be regulated as such, i.e. by the NHS Trust Development Authority (TDA) and CQC.

The AT would be able to continue to access NHSLA cover.

3.2.2.6 Impact of failure

As an NHS Trust, UHL would be subject to the TDA's oversight regime under which the TDA can place Trusts in special measures. The special measures process would apply to UHL if it had serious failures in quality of care and / or financial performance, along with concerns that existing leadership could make the necessary improvements without intensive oversight and support. Ultimately, failures could lead to the TDA deciding to place UHL in its transaction pipeline (which may involve being acquired by another organisation under a merger or acquisition). The Secretary of State could also place UHL in trust special administration, one of the results of that also being merger or acquisition. The consequences of merger or acquisition would be as follows:

- **Staff** – staff may transfer under TUPE to an acquiring organisation. However, where multiple organisations acquire elements of an NHS Trust's business, there would be a risk that some staff would be 'left behind' and would not transfer under TUPE, giving rise to redundancy.
- **Services** – NHS Trusts are not subject to the 'Commissioner Requested Services' regime but TDA and commissioners would act as necessary to protect essential services
- **Assets** – these would be acquired by the acquiring organisation or, alternatively, revert to the Secretary of State
- **Legal entity** – UHL would be dissolved.

3.2.2.7 Staff engagement implications

Allowing a degree of autonomy to teams within UHL presents a potentially wider range of activities on engagement by virtue of being 'freed' from some of the constraints faced by the wider organisation and of being seen as a 'test bed' for new ideas that might be more difficult or risky to undertake across the entire Trust. Grouped in our four themes, suggestions are as follows:

- Opportunity:
    - AT engages staff in review of 'top 5 frustrating processes'

  - AT engages staff/patients in review of involvement in decision-making forums
  - AT engages staff in re-design of briefing/ team meeting process
- Feedback:
  - AT engages stakeholders more in collection & use of performance data inc staff & patient surveys
- Development:
  - AT engages staff in design & pilot of alternative performance management process
- Recognition:
  - AT agrees additional incentive schemes to pilot

What could be done	Possible benefits	Possible hurdles
AT engages staff in review of 'top 5 frustrating processes'	Simplification of processes, speeding up decisions, better patient care, learning for UHL	Coordination & consistency with wider UHL UHL restrictions on autonomy
AT engages staff/patients in review of involvement in decision-making forums	Increased AT staff/patient engagement, improved care, UHL able to pilot poss. change	Resources & time (all below) Perceived inequality UHL restrictions on autonomy
AT engages staff in re-design of briefing/ team meeting process	AT staff engagement, better care, UHL pilot poss. change	Perceived inequality management skills UHL restrictions on autonomy
AT engages staff in design & pilot of alternative performance management process	AT staff engagement, better care, UHL pilot poss. change	Perceived inequality UHL restrictions on autonomy
AT engages stakeholders more in collection & use of performance data inc staff & patient surveys	AT staff engagement, identify improvements, better care, UHL able to pilot poss. change	Perceived inequality Lack of openness UHL/ NHS/Government prescription
AT agrees additional incentive schemes to pilot	AT staff engagement, better care, UHL pilot poss. change	Costs, perceived inequality UHL restrictions on autonomy

3.2.3 Shortlist option 3 – Whole Trust Mutual

The Whole Trust Mutual (WTM) option would involve transferring the Trust organisation into a new legal entity based on a mutual footprint, i.e. predominantly owned by staff and patients, with a strong element of empowerment of frontline staff. The option could involve splitting UHL into a "PropCo" to hold assets and historic liabilities/deficits, as well as - possibly - access finance, and an "OpCo" to run the business and deliver services on a footprint of a mutual (see Fig. 3.3).

We believe that this option ultimately provides the best possibility for UHL to gain the financial and non-financial benefits that mutuals achieve. Our modelling suggests a

hypothetical financial benefit could amount to £17m p.a. by year 5 as a result of mutualisation.

However, significant barriers exist which make this option currently unviable, which include the issues of UHL's deficit, irrecoverable VAT (adding up to £29m to the cost base), question marks around access to finance (essential for UHL in view of its deficit and estate reconfiguration programme), whether assets would be permitted to transfer to the new entity and procurement issues relating to the award of service contracts to the new entity. Without these barriers being removed by changes in law or policy, WTM remains realistically unattainable for UHL.

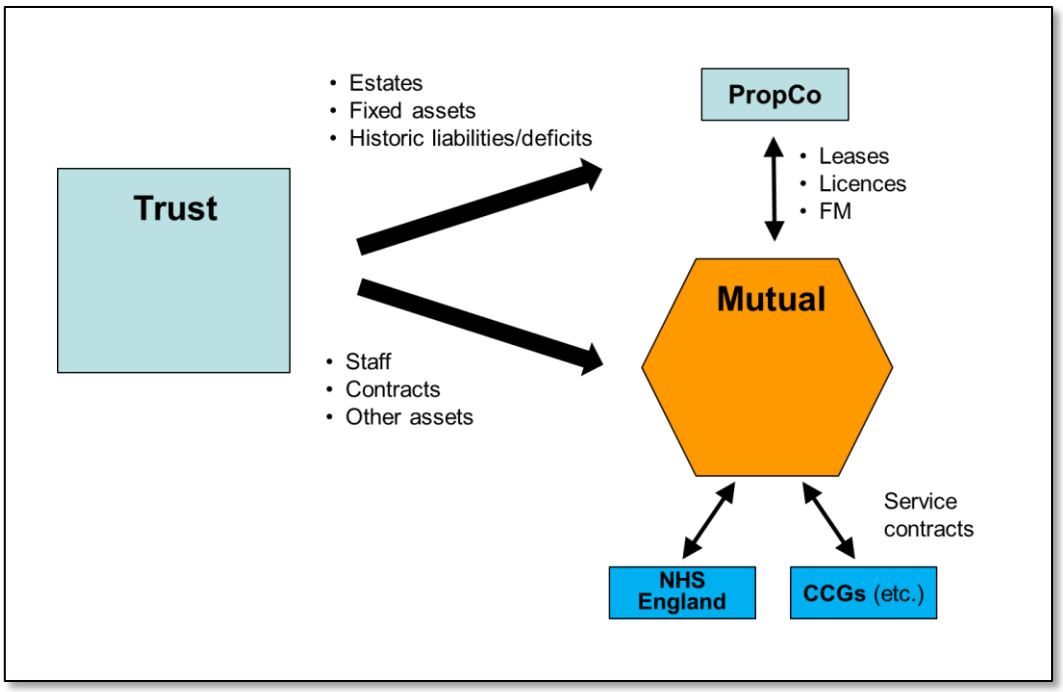


Fig. 3.3: Creating the Whole Trust Mutual using a PropCo

3.2.3.1 Legal and governance structure

It would not be possible to convert UHL's existing legal structure as an NHS Trust directly into a mutual model. Therefore a new legal structure would need to be created into which UHL's staff and assets could be transferred. This would be by way of a commercial transfer since the Secretary of State would not have powers to transfer UHL's staff and assets to a new legal structure.

We assume that the new legal structure would be a company though other legal structures may also be applicable. Within the company options, we see the Community Interest

Company (CIC) as being the best candidate due to the statutory asset lock and requirement for the organisation to benefit the community. The Feasibility Study highlighted the key features of all options for legal structures and we refer you to that document for further information on the alternatives.

The involvement of staff, patients and other stakeholders in the governance structure of the new company could be at director and / or at 'ownership' level, depending in what was desired, though in order to be a mutual the organisation would need to be at least partly owned by staff.

It is important to note that 'ownership' in this context refers to the power to take certain types of decisions rather than employees needing to put in a financial stake to the mutual. Given the number of staff concerned, we do not assume that each member of staff would own a share (if a company limited by shares) or be a member (if a company limited by guarantee) since this would lead to an additional administrative burden every time someone joined or left the organisation; instead we assume that there would be some form of employee benefit trust which would hold the shares or membership rights on behalf of all staff (akin to the John Lewis model). If not wholly owned in this way, then there would be room for other significant stakeholders to be shareholders / company members, including UHL itself in its capacity as holder of the assets (see below on Assets).

Our assumption is that there would be a formal staff engagement structure which would have rights to appoint to the overall Board. There would also be frameworks for formal involvement of patients and other stakeholders, though not having rights to appoint to the Board.

As noted above, a mutual governance model has the ability to include a variety of different stakeholders if so desired and this could certainly include patients. One would need to carefully consider the appropriateness of having patients acting as directors but, in legal terms, this is certainly feasible. Patients can already be involved at membership level in an FT structure so the same (or a variation of it) could be replicated here.

The same general points above made in relation to staff and patient involvement, and the ways of doing that, apply in relation to other stakeholders too: this approach offers freedom to design a bespoke governance structure that best fits the new mutual. In many mutuals, stakeholders are given a place in advisory body and at times also have a place at the Board table.

3.2.3.2 Workforce

Staff would transfer to the new mutual organisation under the TUPE Regulations 2006 when responsibility for the organisation or provision of its services changed. That would mean that the mutual would inherit the staff and their employment liabilities.

There would be a need for strategic HR advice concerning post-transfer changes and also concerning how pre-transfer liabilities would be dealt with. For instance, the mutual as a new organisation would need to be funded for these employment liabilities (i.e. new staff costs) and ordinarily should require indemnities from the previous employer(s) to cover pre-transfer liabilities. A key issue would be the identity of organisation which could give such an indemnity (would this be UHL as 'PropCo'? – see Assets below).

Where TUPE applies, the terms and conditions and the continuity of service of the transferring employees are protected after the transfer. It would therefore be important that through the pre-transfer due diligence process and prior to any transfer taking effect, that the mutual is fully aware of the transferring employees' terms and conditions of employment and the risks and liabilities relating to them.

Any changes that the new organisation/service provider makes to the transferring employees' terms and conditions of employment would be void if the reason for the change is the transfer unless there is an economic, technical or organisational reason (ETO) for the changes which entails changes in the workforce (i.e. a post-transfer restructuring which results in changes to working arrangements).

In transferring under TUPE to the new mutual, existing staff would retain their NHS terms and conditions. Going forward, the mutual may not be bound by any new collective agreement (most notably the next Agenda for Change); this is an area of some uncertainty legally and would need to be explored.

However, there would also be the option for these staff to agree to new terms and conditions with the mutual which could include both non-financial incentives and (if considered appropriate and proportionate) financial incentives. For new joiners, the mutual would have more flexibility on such matters.

Pensions do not automatically transfer under TUPE. But transferring employees would be able to retain access to the NHS Pension Scheme (NHSPS) once employed by the mutual because the "New Fair Deal" guidance introduced in 2013 provided that "*staff who are compulsorily transferred from the public sector would be offered continued access to a public service pension scheme rather than being offered a broadly comparable private pension scheme. In broad terms, all staff whose employment is compulsorily transferred from the public sector under TUPE, including subsequent TUPE transfers, to independent providers of public services would retain access to their current employer's pension arrangements*".

In order for these staff to continue to be eligible to be members of the NHSPS they would need to remain continuously employed on the delivery of the outsourced service or function and, if so, the new employer of these staff would need to provide them with access to the NHSPS and would therefore need to enter into a participation agreement with the NHSPS.
From the point of view of any transferring employees, therefore, anyone who is currently part of the NHSPS must be offered access to the NHSPS by the new employer. In that sense, pensions would continue as before for those staff. The new employer would have the ability to offer a different pension scheme for any new staff joining later on.

Under changes to NHS pensions regulations introduced in 2014, independent sector providers (such as mutuals) can also apply for NHS Pensions access for all staff, i.e. even those who have not transferred to them from the public sector under New Fair Deal. This option is only available for staff spending the majority of their time on NHS services under a defined type of NHS contract.

3.2.3.3 Assets

For the reasons stated in the Feasibility Study, we do not consider it likely that buildings and land, as well as capital assets worth over around £5k, would be permitted to transfer to a whole trust mutual. For the purposes of this model, we assume that what is currently UHL would remain as a legal entity but having the sole purpose of continuing to hold these assets (a 'PropCo') as well as UHL's historic liabilities/deficits. This approach would avoid a need for these things to be transferred to some other central holding body, such as NHS Property Services Limited or the Secretary of State, so reducing the complexity of the overall mutual setup.

What would then transfer to the new mutual would be the staff, the contracts, and any assets not retained by UHL. State aid would make it difficult for UHL to transfer its land or equipment to a mutual for anything other than market value.

The mutual would then get a lease of buildings and assets from UHL, subject to overcoming the hurdle of VAT, capital charges, and the ability to borrow without assets to secure that borrowing against. We also assume that the new mutual would be commissioned directly by CCGs and NHS England subject to overcoming the hurdle of procurement law, as raised in the Feasibility Study. This then leads to what could be described as a 'PropCo / OpCo' model.

We assume that the mutual would purchase estates and facilities management services from the UHL 'PropCo'. Linked to this, we assume that all other corporate functions would transfer to the mutual.

Going forward, it would generally be up to the mutual to decide how to deal with its assets, including those leased/licensed from UHL and assets owned in its own right. However, where the mutual holds a Provider Licence from Monitor and it delivers 'Commissioner Requested Services' (CRS) under that licence (i.e. essential NHS services), it would need to comply with Monitor's guidance on disposal of assets used in CRS. The guidance requires a provider to list 'relevant assets' on an asset register (land, buildings and major equipment above a de minimis level). It also requires the provider to seek Monitor approval for a disposal of those assets where Monitor believes the provider is at risk of no longer being a going concern.

3.2.3.4 Branding

If UHL were to continue to provide NHS services through a mutual it would most likely still be possible for the organisation to continue to use NHS branding, assuming that it wished to do so. The mutual may also want to develop its own brand.

3.2.3.5 Regulation

The new mutual would need its own CQC registration and Provider Licence from Monitor. The mutual, provided it was delivering services directly to an NHS commissioner, would be able to join CNST.

3.2.3.6 Impact of failure

The first issue to consider here is what we mean by 'failure'. Failure of a provider of NHS funded services may be failure financially or in terms of quality of care. Poor quality care may lead to regulatory sanction which, ultimately (through loss of commissioning contracts), may lead to financial failure. In that situation:

- **Staff** – staff may transfer under TUPE to an acquiring organisation but where multiple organisations acquire elements of a provider's business, there is a risk that some staff would be 'left behind' and would not transfer under TUPE, giving rise to redundancy.
- **Services** – where the mutual holds a Provider Licence from Monitor and it delivers 'Commissioner Requested Services' (CRS) under that licence (ie essential NHS services), it would need to comply with the Continuity of Service conditions in the licence. These require it to continue delivering the services at Monitor's direction and to cooperate with Monitor in times of financial distress. In practice, Monitor and commissioners would act as necessary to protect essential services
- **Assets** – where it provides CRS, Monitor's consent for disposal of relevant assets would be required where Monitor believes the provider is at risk of no longer being a going concern. Assets generally would be dealt with in accordance with relevant insolvency legislation where the mutual is in financial failure
- **Legal entity** – the treatment of the mutual as a legal entity would depend on any relevant insolvency legislation applied to it.

3.2.3.7 Staff engagement implications

Should the above mentioned circumstances and legislative changes enable UHL at some future time to consider full mutualisation, then it would be more able to embark upon a wider range of changes, many of which it may already have piloted via Autonomous teams within the Trust. Grouped in the familiar four themes, suggestions include:

- Opportunity:
    - UHL has dialogue with staff on new vision, value, culture & brand
    - UHL engages staff in process simplification to 'de-clutter' & speed decision-making
    - UHL increases staff /patient involvement in governance & decision-making forums
    - UHL engages staff in re-design of briefing/ team meeting process
- Feedback:
    - UHL engages stakeholders in collection & use of performance data
- Development:

  - UHL engages staff in alternative performance management process implementation
- Recognition:
  - UHL introduces new reward & incentive schemes

What could be done	Possible benefits	Possible hurdles
UHL has dialogue with staff on new vision, value, culture & brand	Engaging staff in new future, creating sense of ownership	Resistance/ backlash from some staff – Resources & time
UHL engages staff in process simplification to 'de-clutter' & speed decision-making	Simplification of processes, speeding up decisions & improving patient care	Need to comply still with NHS supplier requirements & safety standards – Resources & time
UHL increases staff /patient involvement in governance & decision-making forums	Increased staff/patient engagement & improved patient care	Change in stakeholder mindset – more responsibility Resources & time
UHL engages staff in re-design of briefing/ team meeting process	Increased stakeholder engagement & improved care	Leadership quality/capability Resources & time
UHL engages staff in alternative performance management process implementation	Improved staff engagement, performance & better patient care	Fit with external requirements Resources & time
UHL engages stakeholders in collection & use of performance data	Engagement, identifying improvements, better care	NHS/Gov prescription Resources & time
UHL introduces new reward & incentive schemes	Increased staff engagement & improved patient care	Costs, fairness & transparency Resources & time

3.3 Recommended approach: Four Stage Implementation

Having considered in more detail the implications, benefits and barriers of the Shortlist Options described, we have arrived at the conclusion that in effect these options are not mutually exclusive. Rather, they can be considered as part of a staged approach towards achieving the benefits of mutualisation, thereby allowing UHL:

- To keep implementation risk and investments low
- Learn from early experiences
- Bring staff and stakeholders along on the way to mutualisation
- Allow national policy changes to emerge which will enable UHL to take the next step on its journey.
- Make each stage a well-controlled and considered decision for the Trust Board, requiring significant and demonstrable benefits to be expected over and above achievements in the previous stage.

As such we recommend that UHL considers a staged approach to make progress in achieving the benefits of mutualisation:

Stage 1: Creating an Autonomous Team within the Trust structure in accordance with Shortlist Option 2, whilst

Implementing improved Staff Engagement Measures elsewhere in the Trust

Stage 2: Enhancing the Trust model ("NHS Trust Plus") to include governance elements of a mutual in its legal structure, specifically staff and patient involvement in decision-making. This will require a change to law. We refer you to Appendix E for further information on this.

Stage 3: Transition into Foundation Trust Plus ("FT Plus"), once UHL meets the FT criteria, but subject to the FT model being enhanced with improved staff and patient governance elements. This will also require a change to law. We refer you to Appendix E for further information on this.

Stage 4: . Moving into a Whole Trust Mutual as described in Shortlist Option 3, assuming that by then issues regarding the deficit, VAT and asset transfers have been addressed and it is clear at that time that there would be sufficient benefit over and above Stages 1-3. Again, this will require a change to law and policy to make this viable.

The implications and caveats regarding Stages 1 and 4 are clear and have been described above. We have studied the requirements and implications of interim Stages 2 and 3 separately in Appendix E.

In summary, both require some changes to the law in order to become relevant to UHL in the context of mutualisation, but they provide useful interim steps in line with UHL's other strategic priorities.

4. Commercial considerations

4.1 Introduction

As part of this high-level assessment of transitional stages and options that are currently open to UHL, we have focused on some 'generic' commercial issues for consideration.

The proposed stages 1, 2 and 3 do not raise specific commercial considerations in themselves. Stage 4 raises a number of commercial considerations that will need to be addressed, including financial and procurement law issues, legal form of any new mutual entity and regulatory issues.

4.2 Internal Procurement Issues

Procurement is currently organised centrally at UHL.

One way in which mutuals can provide improved financial performance is through better buying and stock management control, all linked to closer supply chain relationships, local knowledge (industry, industry sector, and district/region), 'Lean' approaches to buying and stock management and delegated budgets and responsibility (because more people pay more attention to something over which they can have influence and for which they have responsibility).

UHL can begin, even in its current status, to consider how it will delegate budgets and buying to new cost (or profit) centres. The proposed Autonomous Team development will provide good opportunities to identify and delegate discrete budgets, then to monitor performance and improvement.

None of the other organisational forms proposed would be at odds with a delegated approach to procurement. The planning work would be significant, and responsible oversight and governance would need to be 'built in' to an NHS Plus, Foundation Plus or Whole-Trust Mutual for UHL.

4.3 Procurement, Legal and Regulatory Implications

We refer you to the analysis in Section 3 above and Appendix E. In summary, stage 1 raises no specific procurement or regulatory implications in and of itself. Stages 2 and 3 raise legal issues relating to governance structures and legal powers of NHS Trusts and Foundation Trusts.

The WTM option at stage 4 raises numerous procurement, legal and regulatory implications in particular:

- Whether a new mutual legal entity owned by staff and other stakeholders could be awarded a service contract without a competitive tender process
- Whether assets could be transferred to a mutual without giving rise to State Aid issues (broadly speaking, any transfers at less than full market value would give rise to issues). Any transfer of assets are also likely to need TDA, DH, and possibly HM Treasury approval
- There would be a TUPE transfer of staff to the new mutual; staff would retain existing terms and conditions and access to the NHS Pension Scheme
- Regulatory requirements for the mutual to register with the CQC and Monitor and ability to access NHS Litigation Authority schemes.

More detailed consideration is given to these points in the Feasibility Study.

4.4 Accountancy and other implications

The following are additional accountancy requirements as a result of mutualising. Note that some of these depend on which legal form is selected. For this purpose a Community Interest Company or CIC is used as an example.

- Corporation Tax Returns to HMRC
- Submission of Accounts to Companies House (and availability to General Public)
- Satisfying the requirements of the CIC Regulator
- Continued Registration with Monitor for Commissioner Requested Services
- Treasury Management Issues – need to stand alone without access to NHS Cash brokerage
- Access to capital (via Commercial Banks)
- Balance Sheet strength (asset position)

We are currently unclear (and there is no extant data to support) whether:

- R&D opportunities would benefit from UHL being known as a mutual organisation. There is currently a substantial clinical research aspect to UHL work, supported by a very large catchment area. There is a potential 'cachet' loss to (e.g. pharmaceutical businesses) in creating 'distance' from the NHS. Alternatively, research perceived as more 'independent' might have a greater cachet for investors/partners, and for audiences. This could be explored further with UHL's Director of Research and Development;
- Tendering opportunities may benefit from the freedoms associated with UHL being a mutual organisation. UHL is currently planning an expansion of its strategic business development capability (including competitive tendering for contract opportunities). Again the 'NHS' brand and brand values carry great weight, but it is possible that the additional flexibility of a mutual could add to the perceived and actual potential of UHL's abilities to deliver on a broader range of contracts
- If UHL is likely to be considering reduced in-house clinic sessions to help with cost savings, it is possible that mutualisation could support other alternative support delivery mechanisms more effectively by placing clinical groups in positions to propose and take responsibility for alternative patient care that can be planned and delivered more quickly.

5. The Financial Case

5.1 Introduction

This sets out the forecast financial implications of the Whole-Trust ('WTM') mutual model for UHL. The Trust provides over 1700 beds and employs nearly 12,500 people. In 2013-14 it earned £770.4m and spent £809.9m. It currently has three acute sites and a range of satellites.

Stages 1, 2 and 3 do not raise specific financial considerations for the Trust in themselves, except in relation to financial incentives for staff if remuneration policy is changed to permit greater freedom for this.

However, mutualisation does bring financial challenges. Through our modelling we have identified:

- Irrecoverable VAT impact based upon current reclaimed VAT on contracted out services (£19m per annum)
- Potential additional VAT from charges for asset use if assets are not transferred to the new mutual and instead are to be leased from a so-called PropCo (£10m per annum)
- Corporation Tax payable if the new organisation moves into surplus (around £3m per annum).

In order to realistically consider WTM, there is therefore a need to deal with these downside issues through recommendations to be made to Cabinet Office and Treasury.

Our modelling also suggests that the hypothetical financial benefit of WTM (under the assumption that the above issues are addressed and on a like-for-like basis of current Trust projections) could amount to up to £17m p.a. or £55m over 5 years. The main drivers of these benefits are lower costs as a result of reduced staff sickness and turnover, and further efficiencies related to improved working practices.

The Four Stage Implementation route will avoid any of VAT, tax and asset issues in the early stages, but these are also less likely to deliver on the full expected benefits. The staged approach will allow UHL to monitor the impact of the changes made, and make an informed decision whether moving on to the next stage is the right thing to do.

5.2 Impact on the organisation's Income and Expenditure

5.2.1 VAT implications

UHL currently benefits from the preferential VAT treatment on contracted-out services. This means that current service contracts (for example with IBM and Interserve) against which VAT is currently reclaimed will no longer attract this preferential treatment and the impact will be a significant amount of irrecoverable VAT. The contracted-out services rule will also impact upon lease car contracts, agency staffing expenditure and smaller contracts for services such as document storage, transport services and bought-in catering.

Our estimate of the VAT dis-benefit from all of these areas is around £19m per annum (the current level of VAT reclaimed by UHL against contracted-out services). In order to "sense check" this figure, the following are the key components of this amount:

- Interserve Contract VAT reclaimed: £6.1m
- IBM Contract VAT reclaimed: £1.2m
- Agency Staff Contracts VAT reclaimed (assuming all VAT is reclaimed): £3.9m

With these three elements alone accounting for £11.2m, it is reasonable to assume that the headline figure of £19m is correct. Both of the major contracts are baselines with additional billing taking place on top of the base contract value, and there are significant contracts in place for other services (e.g. lease cars at £358k) where additional VAT is currently reclaimed.

There are two possible mitigations for this issue. The organisation could consider whether it should bring some services back 'in-house'. This course of action would avoid a VAT issue, and also have the potential benefit of bringing more staff into the new mutualised organisation. The potential constraint to this course of action is the fact that long term contracts are in place. We have been informed that the Interserve contract is a ten year

arrangement and has only been in place for two years. This could lead to prohibitively high contract exit penalties. The second potential mitigation would be to lobby the Cabinet Office and Treasury to extend the preferential VAT treatment on contracted out services to an NHS mutual (this money is “circular” in any case).

At £19m, the VAT dis-benefit is therefore around 2.4% of baseline. This estimate is in line with other Stepping Out projects but slightly greater than Albion’s own experience (because Albion is a much smaller organisation and had no comparable service contracts at the time of mutualisation).

Dependent upon the treatment of assets when setting up the new Mutual, there could be further VAT implications. The experience of spin out organisations such as the Albion members is that the capital assets (such as buildings and major items of fixed equipment) do not transfer from NHS ownership on mutualisation. This leads to a need to put in place property and equipment leases between the NHS (usually NHS Property Services, or a dedicated “PropCo”) and the mutual. These leases need at least to cover the current capital charges of the land buildings and equipment, and would, in all likelihood, attract VAT that would not be recoverable. The following capital charges are currently accounted for by UHL:

- Depreciation and amortisation, Buildings and Equipment: £32.8m
- ROCE via PDC payments: £10.9m

If the assets were to be transferred to a property company, it is likely that this company would seek to recover these costs plus an overhead and margin, and the likely VAT implications of leasing current assets could be as much as £9.5m.

Once again, there are ways of potentially mitigating this issue. The first relates to the way that the commissioner pays for services: an NHS property company could retain the assets and receive funding via the commissioner, and the mutual could receive net tariffs for services less the costs of servicing assets. Further VAT advice would need to be sought as to whether this would be a viable option, and there are drawbacks regarding the ability of commissioners to “market test” the service where a full cost model is not in place. The second potential mitigation would be as above, and concern the possibility of extending the preferential VAT treatment on contracted out services to health mutuals.

The financial downside of mutualisation is clearly set out above, and reflects current VAT legislation regarding Section 41 of the 1994 VAT Act, whereby VAT for contracted out services is reclaimable by s41 bodies as per normal VAT rules on business activities. The Department of Health have received feedback from all of the Trusts in the Pathfinder programme and this feedback is consistently citing VAT as a constraint to rolling out mutualisation in the secondary care sector.

As a result of this, the Department of Health is making representation to the Treasury about the possible nomination of mutualised NHS trusts as section 41 bodies. If successful this would mean that the current dispensation agreed by UHL as a NHS trust would continue, and the downside on VAT would be negated.

For the purpose of the financial analysis of mutualisation, we have assumed that this attempted legislative change will be successful as the VAT downside is difficult to manage in any other way.

5.2.2 Corporation tax

The other key taxation implication concerns corporation tax: a new mutual would be liable to pay this. UHL is not currently in a position where it is generating surpluses, and its current long term plan shows that this will be the case for the next four years. This issue is therefore not the most pressing, but if UHL were to deliver an EBITDA of around 7% (£56m) per annum, and after Capital Allowances, this reduced taxable surpluses to around £11m, a 27% tax liability would be around £3m. Such a figure could, though, be offset through careful financial management and investment into services and research and development. This needs to be a consideration in further work, and that will feature in the next phase of the Mutuals in Health Pathfinder project.

5.2.3 Cost reductions

Current and recent experiences in mutualisation identify a number of potential financial enablers that would support UHL going forward. These include (not exhaustively)

- The potential to reduce staff sickness levels (and, therefore, to reduce lost productivity and additional agency/staff cover costs). Our current estimate of UHL expenditure on additional agency/staff costs specifically related to sickness is £10.7m. Our estimate of potential savings here is based on direct experience from

Albion and elsewhere (between 25% and 33%). We estimate potential savings as £2.7m.

- There are currently severe problems with recruitment across the NHS. At UHL the agency, associated staffing (e.g. Overtime) and ongoing recruitment costs to fill this gap are currently £13.2m. A change to mutualisation would create more flexibility with regards to reward and recognition packages for staff, and could therefore make recruitment easier. Experience in spin-outs such as the Albion members has shown that staff turnover rates reduce by around 20%. Better staffing retention rates could potentially take 1-2% out of the vacancy factor, and lead to an avoidance of the premium rates paid to agencies, bank staff and additional staff hours. We estimate potential financial improvement here at £1.5m.
- Mutualisation could help to reduce the risks attached to the Trust's current cost reduction plans. Spin-out mutuals such as the Albion members can evidence improved and increased staff engagement leading to improved productivity and outcomes (including patient outcomes). The current cost reduction plan runs over five years and includes specific targets around staff reductions. It is difficult to consider that mutualisation will add further savings to an already challenging target, but there is an argument that mutualisation is an enabler that reduces the risk attached to the cost improvement programme. As such, it should be considered a relevant saving when assessing the viability of the mutualisation model. In assessing the impact, the experience of Albion partners has been used to consider the possible improvements to throughput (using LEAN processes) that are specifically attributable to mutualisation.
- Efficiency savings can emerge in health contexts from mutualisation. These can include:

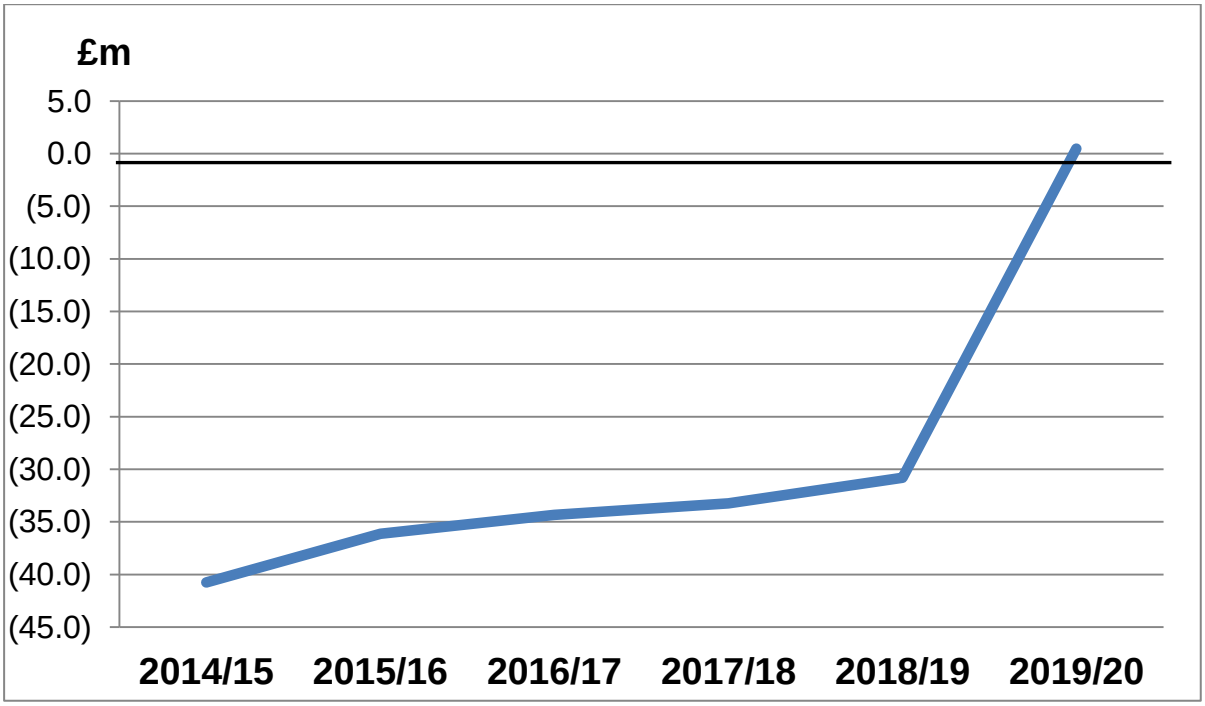
    - Improved staff attendance
    - Better staff motivation and performance
    - More efficient local cost management and decision-making (including delegated budgets)
    - Improved focus on supplier arrangements and contract management
    - Overall, more stakeholders engaged in end-to-end processes and their responsibilities throughout patient journeys (or production chains)

    It is accepted that efficiency improvements are multi-faceted and therefore at best this will become a very crude estimate. Using an efficiency gain of 1.5% of staff costs, the impact could be as much as £7.5m

- There are potential benefits regarding the use of cash and interest receivable, where mutualisation may present more freedoms for investing cash. Currently UHL's cash position is hindered by its recurrent deficit financial position, and whilst some interest is received (around £70k per annum) from its GBS account, the amounts are small. If the recurrent deficit issue is dealt with, and capital funding is excluded from the calculations, simple analysis of the cash flows from UHL's contracts and its profile and timing of expenditure would suggest that significantly increased levels of interest could be secured by utilising these freedoms. To be clear, the calculation assumes that all contract income is received equally over the twelve month period in line with NHS standard contract payments, creditors are paid on net monthly account, and staff are paid in the last week of each month with PAYE payable the following month. Using a modest (risk free) interest rate of 1.2%, there is a potential interest advantage of up to £400k.
- Whilst we have not witnessed a significant 'appetite' to increase private medical provision in UHL strategies or stakeholder views, UHL would have more opportunities for diversification and the creation or growth of more revenue streams within a mutual model. Although this additional revenue stream could be significant, we have not factored this in our model in absence of clear private income growth plans.

5.3 UHL Base Case Income & Expenditure

As a basis for our modelling we obtained financial projections for UHL - the 'base case' - for the next five years, see Fig. 5.1. These projections include agreed assumptions around the achievement of Cost Improvement Programme (CIP) targets as well as estate related cost reductions from year 5.



	£m	£m	£m	£m	£m	£m
Income	823.2	816.1	819.2	819.0	819.9	824.3
Expenditure	(863.9)	(852.2)	(853.5)	(852.3)	(850.7)	(823.9)
Surplus / Deficit	**(40.7)**	**(36.1)**	**(34.3)**	**(33.3)**	**(30.8)**	**0.5**
CIP	45	35	30	28	27	38
CIP%	0	6	1	8	7	4

Fig. 5.1: UHL Base Case 2014/15 - 2019/20

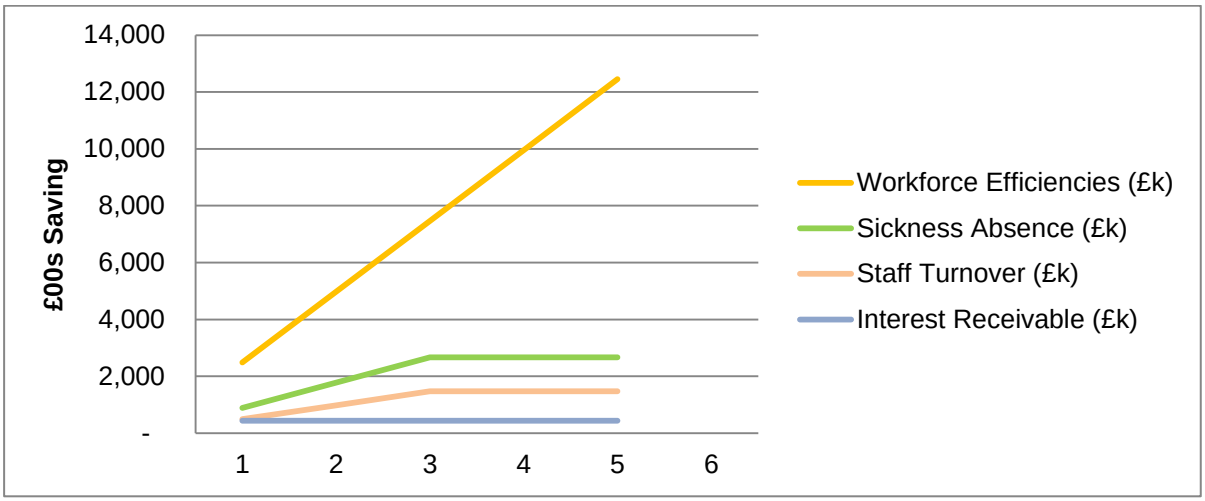
5.4 Impact of Mutualisation on the Base Case

To obtain a feel for the magnitude of the possible impact of mutualisation for UHL, we have modelled the range of assumptions onto the 'base case'. We have assumed here:

- A hypothetical like-for-like scenario: i.e. 'what would be the impact if UHL would benefit from similar 'mutual' effects from 15/16 through to 19/20'.
- The VAT disbenefit issue having been removed.
- Reductions to sickness absence based on Albion evidence of 25 – 33% over 3 years.
- Reductions in staff turnover based on 20 – 25% over 3 years.

- Workforce Efficiencies have been demonstrated in spin-out CICs and are delivered by either an increase in income from tariff or a reduction in workforce and other costs: 2.5% over 5 years.
- Interest receivable from better investment of cash (more freedom) – income received day 15, staff paid day 25, creditors paid day 31, PAYE paid day 59.

Efficiencies may be an enabler to achieve current cost improvement plans or over and above those, but either way they have a positive impact.



Year	1	2	3	4	5
	2015/16	2016/17	2017/18	2018/19	2019/20
Sickness Absence (£k)	891	1,782	2,673	2,673	2,673
Staff Turnover (£k)	491	981	1,472	1,472	1,472
Workforce Efficiencies (£k)	2,490	4,979	7,469	9,959	12,448
Interest Receivable (£k)	443	443	443	443	443
Total Cost Improvements (£k)	**4,314**	**8,185**	**12,057**	**14,546**	**17,036**

Fig. 5.2: Mutualisation effects

The results as depicted in Fig 5.2 show a possible positive impact of up to £17m in year 5 and a total over 5 years of up to £55m. See also Fig 5.3.

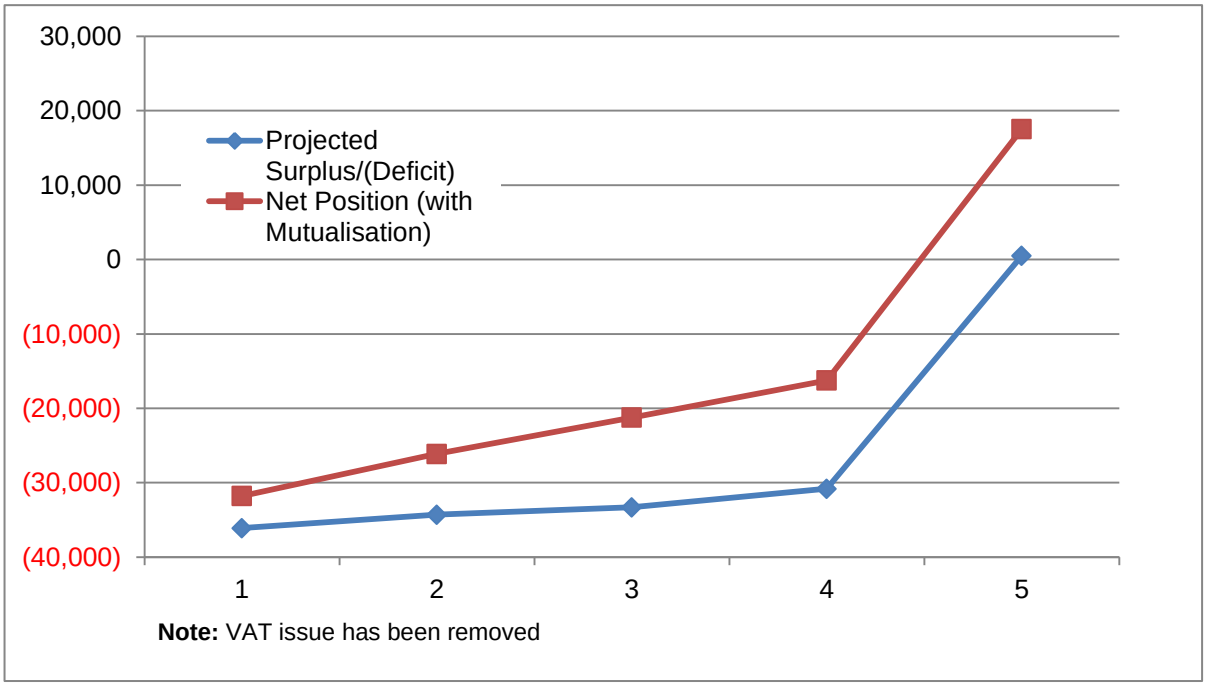


Fig. 5.3: Hypothetical impact of mutualisation on UHL Base Case

6. The Management Case

6.1 Introduction

Realistically this is a multi-year programme spanning at least 5 years. We anticipate that Implementing Stage 1 could take approximately 6 months for the Autonomous Team (though assessing its impact will take at least another year), whereas implementing other improved staff engagement measures depends on the scope decided upon.

In view of their unique 'mutual' elements, both the Autonomous Team strand and Whole Trust Mutual scenario will require a combination of internal, corporate and external resources and UHL may benefit from some external resources too when considering moving into NHS Trust Plus and FT Plus. In view of the strategic importance of the programme the project governance should have appropriately senior reporting lines and reflect the mixed nature of resources. In this chapter we propose a generic project structure that should work in most cases.

Naturally each proposed stage has risks attached to it, and we present these in some detail in this chapter. However, we believe that the staged nature of the implementation allows UHL to minimise and assess most of these risks as it progresses from one stage to the next. As such, each stage will require a well-controlled and considered decision from the Trust Board, requiring significant and demonstrable benefits to be expected over and above achievements in the previous stage.

Ultimately, UHL is a complex organisation in deficit on an ambitious journey of transformation, and the main risks with any long-term transition process is associated with whether it can bring its stakeholders along, and whether Mutualisation is regarded as a distraction or enabler.

6.2 Programme and project governance arrangements

6.2.1 Project arrangements Autonomous Team implementation

It is proposed to follow a project governance structure for Stage 1 (AT) that reflects the nature of the autonomy of the unit being created and builds on the programme structure in place for the Mutuals in Health programme at UHL (see Fig 6.1).

It is proposed to convene a Programme Board with a wide membership in order to marshal resources and remove potential roadblocks to the AT Project. Individuals from Corporate Services, Musculoskeletal, Theatres and other stakeholders should be members of this board and oversee the various specific work streams within the Project.

In order to enhance the sense of autonomy it is important to give the AT's governance structure - once established - a role early on. This may be a simply an advisory role, or a more formal role to be agreed with the Programme Board.

The various workstreams should reflect the combined nature of resources required for the programme:

- Internal: from Musculoskeletal service areas predominantly,
- Corporate: for various areas of expertise as well as to take ownership of support services to be designed and provided going forward
- External: to bring in expertise not currently available within UHL, especially where it concerns aspects of mutualisation.

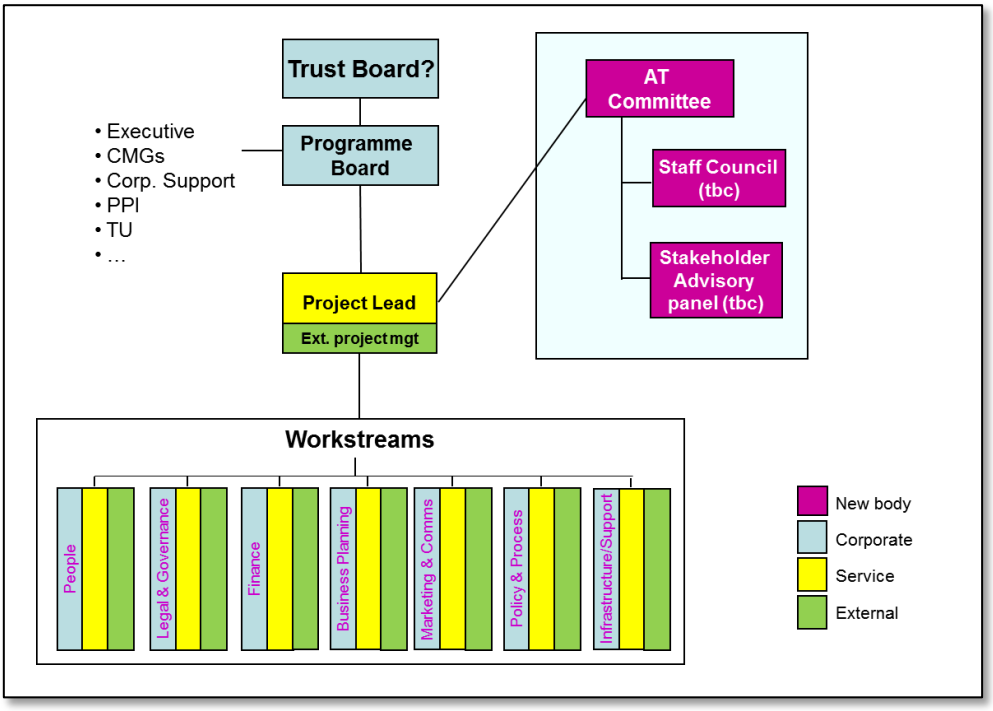


Fig. 6.1: Proposed project governance structure for Stage 1

6.2.1 Project arrangements Stage 2 to 4

For subsequent stages of the recommended journey towards potential mutualisation, we suggest a similar programme structure. We suggest reviewing the effectiveness of the structure following Stage 1, making amendments as required and subject to updated assessments as to the desirability and feasibility of the subsequent stage(s).

6.3 Programme plan and resources requirements

6.3.1 Programme Plan

Realistically, this is a multi-year programme, with a range of decision points following each stage. This in view of the many significant interdependencies identified: with UHL's strategic plan, with required legislative and policy changes, with UHL's financial viability as a provider.

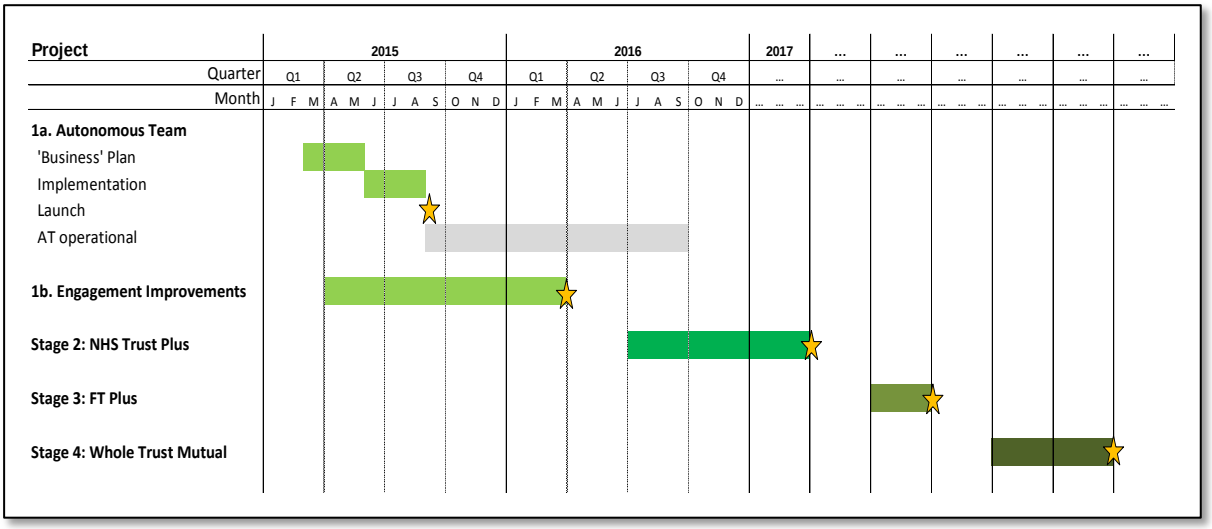


Fig. 6.2: Programme Gantt

6.3.2 Resource requirements AT

We have made an assessment of the resource requirements in the various workstreams for the AT Stages (Business Planning and Implementation). As per the proposed governance structure, we have made a distinction between internal service line, corporate and external resources. See Figures 6.3 and 6.4.

Business' Plan	**Resource focus**		
Workstream	**Corporate**	**Service Line(s)**	**External**
Finance	Data provision, overheads / indirects, due diligence	Determine scope, verification of models	Models / templates, benchmarks, modelling, projections, scenarios, investment requirements
People & Engagement	Data provision, external engagement (TUs, partners, …)	Org structure, desired behaviours, culture, engagement w staff and (internal) stakeholders	Models / templates, facilitation of org design, engagement, incentivisation, FAQs, skills gaps
Legal & Governance	Review and co-draft	Review and co-draft	Draft mandate, SLA, ToR, design governance structure
Business Plan	Strategic requirements / intents, targets, savings requirements	Vision, values, 'business model', expected benefits	Models / templates, benchmarks, growth strategies, risks
Marketing & Communications	N/A	N/A	N/A
Policies & Procedures	Compliance	Review and draft P&Ps within overall framework	Models / templates
Infrastructure	Identify costs of provision, review AT requirements, review SLAs	Define support and infrastructure requirements, review SLAs	Models / templates, draft SLAs
Project Management	Interdependencies w corporate programmes; drive corporate side	Manage service resources; prioritise	Plan, models

Fig. 6.3: Business planning resources for AT stage

Project planning is as set out in the following table:

Implementation	Resource focus		
Workstream	**Corporate**	**Service Line(s)**	**External**
Finance	Agree budget, inc indirects & overheads	Agree budget, inc indirects & overheads	Budget setting / negotiation, inc indirects & overheads
People & Engagement	Recruitment, ext engagement	Org structure, ongoing engagement w staff and (internal) stakeholders	Cultural change programme, org structure, JDs
Legal & Governance	Agree mandate	Agree mandate, implement (shadow) governance structure	Support negotiations. Implement governance strucuture: elect council members, select board reps.
Business Plan	Agree targets	Agree targets	Support negotiations
Marketing & Communications	N/A	N/A	N/A
Policies & Processes	N/A	Implement P&P changes	N/A
Infrastructure	Agree SLAs, implement agreed infrastructure	Agree SLAs, ensure infrastructure	Agree minimum suport infrastructure re financial management, HR support, ICT support, facilities mgt. Bank acct?
Project Management	Project mgt corporate	Project mgt service.	Support project mgt on service side.

Fig. 6.4: Implementation resources for AT stage

6.3.3 Resource requirements Stages 2 to 4

We have not made a detailed assessment for subsequent stages as to their resource requirements. This is mainly because stages 2 and 3 are largely internal in nature, plus are too far in the future.

However, for information we are providing an overview of the range or resources likely to be required should there be an external element of mutualisation be involved (stage 4) as this generally requires a very different resource mix (see Fig 6.5).

6.3.3 Project cost estimates

Based on our experience with other mutualisation projects we have made rough ‘ball park’ estimates of the costs involved of some of the options considered.

Without detailed project plans and resource requirements it should be stressed that these estimates are necessarily crude, but aim to provide some guidance. As implementation will require both internal and external resources, we have included an estimate for internal resources (in £ equivalent).

WTM Implementation	Resource focus		
Workstream	**Corporate**	**Service Line(s)**	**External**
Finance	Agree financial model as basis for contracts.	Agree financial model as basis for contracts.	Model VAT, tax and efficiency implications. Support negotiations re contract value, payment terms, tariffs/pricing and asset transfer, leases etc. VAT, PAYE registration.
People & Engagement	TUPE. External engagement	Ongoing engagement w staff and (internal) stakeholders. Recruit new key roles. Decide on training requirements	Support ongoing engagement, TUPE. Cultural change programme. Training and development as required.
Legal & Governance	Agree proposed legal form and governance	Agree Mem&Arts, contracts, registrations	Select legal form, design Mem&Arts, incorporate. Draft Business Ttransfer Agreement and Service Contracts. Novate contracts/leases. Support registration with NHSPA, CQC, NHSLA/insurance, ICO etc. Implement formal governance structure: elect board reps, recruit chair/NEDs.
Business Plan	N/A	Sign off	Update business plan with results from negotiations.
Marketing & Communications	Manage external comms	Engage staff and stakeholders in branding. Co-draft marcomms strategy.	Design brand, logo, guidelines for use. Develop marketing & comms strategy inc website and social media.
Policies & Processes	N/A	Implement P&P changes	Staff handbook. Clinical policies & guidelines.
Infrastructure	Agree SLAs, implement agreed infrastructure	Agree SLAs, ensure infrastructure	Assess arrangements required to financial management infrastructure, inc payroll, reporting, VAT etc. Bank acct. Ditto re HR support, ICT support, facilities mgt. Business continuity.
Project Management	Project mgt corporate	Project mgt service.	Support project mgt on service side.

Fig. 6.5: Implementation resources for Stage 4

	Optimistic estimate (£000s)				Conservative estimate (£000s)		
AT	Internal	External	Total		Internal	External	Total
Business Plan	22.5	37.5	60		30	50	80
Implementation	22.5	37.5	60		30	50	80
Other	2.25	3.75	6		3	5	8
Total	**47.25**	**78.75**	**126**		**63**	**105**	**168**
WTM	Internal	External	Total		Internal	External	Total
Business Plan	45	75	120		90	150	240
Sign-off	45	75	120		30	150	180
Implementation	90	150	240		180	300	480
Other	9	15	24		15	30	45
Total	**189**	**315**	**504**		**315**	**630**	**945**

Fig. 6.6: Project cost estimates

6.4 Risk Management considerations

The proposed trajectory in this report is not without risks. However, we believe that its benefits are ultimately numerous and likely to far outweigh the potential downsides. Equally, there risks attached to the status quo, which mean that doing nothing is an undesirable option.

We have identified the risks faced by UHL in the most relevant stages and appropriate measures to mitigate those risks. Similarly there are risks for the wider health economy, which can be minimised through a number of mitigating actions.

6.4.1 Risks of creating an AT

There are risks attached to creating the Autonomous Team, both for the AT itself and for the rest of the UHL organisation. We have identified the following, as well as some mitigating measures.

Risks to the AT	Before Mitigation		Mitigating action(s)/factor(s)	After Mitigation	
	Impact	Likeli-hood		Impact	Likeli-hood
Management team / Committee lacking right experience/skills	High	Medium	› Current management team has excellent track record. › Strengthen the team through a targeted leadership development programme and consider the recruitment of senior members if this is required. › Attract additional Non-Executive committee members with relevant experience.	Medium	Low
Service Mandate stifles organisational development & growth e.g. Financial savings are too stretching	High	Low	› Proper modelling of savings and growth opportunities › Negotiation of mutually beneficial mandate terms, with built in flexibility	Medium	Low

Policy shifts undermining AT's pricing/service strategy, e.g. future funding reductions	Medium	Medium	› Appropriate controls to be built in the mandate with the Board. › Aim for mutually beneficial arrangement between UHL and AT	Medium	Low
Support services obtained from UHL are not fit for purpose/competitively priced	Medium	Medium	› Full funding to be agreed in mandate › Agree degree of freedom for AT regarding support services › Agree - where possible - tapering over time › Design safeguards in contract. › Agree SLAs and build in efficiency targets where services obtained from UHL	Low	Low
Staff not bought in to strategy	Medium	Medium	› Ensure leadership is seen to be bought in. › Extensive engagement to take place on ongoing basis. › Enlist staff in helping shape the new organisation. › Staff to be given a strong say in the organisation through ownership and committee representation.	Medium	Low
AT services not attractive → CCGs not buying/using	Medium	Low	› Maintain dialogue with commissioners › Develop new service offerings to spread risk › Adopt appropriate pricing strategy / reduce unit costs	Low	Low
Patient groups not bought in to strategy	Medium	Low	› Continue open communication regarding the plans › Extensive engagement/ consultation (as appropriate) to take place › Patients to be given a strong say in the organisation through ownership and/or committee representation	Medium	Low

Risks to the wider UHL organisation	Before Mitigation		Mitigating action(s)/factor(s)	After Mitigation	
	Impact	Likeli-hood		Impact	Likeli-hood
Political fall-out/ reputational impact as a result of AT pilot failing	Medium	Medium	› As it is an internal pilot the visibility is low › Realistic 'business' plan demonstrating viability and ensuring buy-in › Appropriate performance management and governance arrangements should provide early warning signs for the Trust to act.	Low	Low
Performance management arrangements prove cumbersome	Medium	Medium	› Mandate to focus on outcomes/outputs › Performance management under the mandate should be well thought through and managed tightly initially until both parties are confident about it working well	Medium	Low
Arrangements regarding support services prove cumbersome	Medium	Medium	› A workable agreement of what support services are being provided to the AT is essential › Keep management of support services from being overly bureaucratic › Internal cross-charging to be kept to a minimum	Medium	Low
Trust Board and AT challenged by services/staff feeling treated differently	Medium	Medium	› Engagement and communications should involve all staff not just AT staff › Expectations to be managed to the nature and duration of the pilot, and that if successful other services will get the same opportunity › Offer internal application process for next AT candidates	Medium	Low
AT distracted by business development	Medium	Low	› Build in assurance that core outcomes are not to be affected by new	Low	Low

opportunities			developments.		
AT not meeting expectations	Low	Medium	› Clear performance targets (outcomes/outputs) to be agreed as part of mandate › AT to be given sufficient time to prove its viability › Being internal, if unsuccessful the AT can be unwound and re-absorbed into standing organisation without too much impact	Low	Low

6.4.2 Risks of moving towards Whole Trust Mutualisation

Equally, when considering Whole Trust Mutualisation there will be risks to the mutual as well as to the wider LLR health economy and beyond. We have identified the following, as well as some mitigating measures.

Please note that we have assumed here that hurdles identified earlier have been resolved, such as:

- VAT implications
- Historical liabilities (deficits)
- Ongoing operational deficits
- Access to investment and working capital
- Arrangements involving estates and other fixed assets

Risks to UHL 'mutual'	Before Mitigation		Mitigating action(s)/factor(s)	After Mitigation	
	Impact	Likeli-hood		Impact	Likeli-hood
UHL failing as independent provider	High	High?	› Business plan should prove viability › Failure regime arrangements should be clear › Impact on front line staff modest, though unsettling	Medium	Medium

Management team / Board lacking right experience / skills	High	Medium	› Current management team has excellent track record. › Strengthen the team through a targeted leadership development programme and consider the recruitment of senior members if this is required	Medium	Low
Improvements in efficiency and engagement not materialising	High	Medium	› Extensive engagement initiatives and culture change programme required. › Empowering staff and engaging patients and staff at local levels crucial. › Contract should reflect realistic expectations and allow the mutual flexibility to develop its business	Medium	Low
Estate arrangements proving restrictive	High	Medium	› Assuming estates won't transfer with the 'mutual', sufficient flexibility needs to be built in in lease/licence arrangements for estates. › Arrangements for alternative sources of investment in own estates to be identified as part of business plan.	Medium	Medium
Novation of contracts proves cumbersome (eg services contract, contracts with support service providers)	High	Medium	› Early engagement with contract parties essential › CCGs/NHSE needs to be fully behind mutualisation in order for it to be a realistic option. ›	Medium	Medium
Service Contract stifles organisational development & growth e.g. Financial savings are too stretching	High	Low	› Proper modelling of savings and growth opportunities required › Contract needs to be for sufficiently long term eg 10 yrs › Negotiation of mutually beneficial terms, with built in flexibility	Medium	Low
Policy shifts	Medium	Medium	› Appropriate controls to be built in the agreement with the	Medium	Low

undermining UHL's pricing/service strategy, e.g. future funding reductions			CCGs/NHSE. › Aim for mutually beneficial arrangement between CCG/NHSE and UHL		

Risks to the wider LLR health economy	Before Mitigation		Mitigating action(s)/factor(s)	After Mitigation	
	Impact	Likeli-hood		Impact	Likeli-hood
UHL failing as independent provider	High	High?	› Business plan should prove viability › Failure regime arrangements should be clear › Appropriate performance management should provide early warning signs	Medium	Medium
Improvements in efficiency and engagement not materialising	High	Medium	› Extensive engagement initiatives and culture change programme required. › Empowering staff and engaging patients and staff at local levels crucial. › Contract should reflect realistic expectations and allow the mutual flexibility to develop its business	Medium	Low
UHL becoming more focused on its own viability/success	High	Low	› UHL as mutual should have community benefit at its core. › Formal stakeholder arrangements could be considered.	Medium	Low
Political fall-out/ reputational impact as a result of mutual failing	High	Low	› Realistic business plan demonstrating viability › Contract structured so that UHL is not set up to fail › Appropriate contract performance management and governance arrangements should provide early warning signs.	Medium	Low

Contract challenged by other providers	Medium	Low	› Market value asset transfers; wholly-owned subsidiary mutual or demonstration of staff/stakeholder-owned mutual as only capable provider; legal advice will be taken to ensure this is the case	Low	Low

7. Conclusions and Recommendations

7.1 Introduction

This Detailed Options Assessment was carried out for UHL as part of the Mutuals in Health Pathfinder programme, with as ultimate aim to assess the feasibility and desirability of implementing - elements of - the mutual model in the Leicester organisation.

A number of conclusions and recommendations have resulted from our study, some relating to UHL, others directed towards policy makers and influencers in Government. Most of our conclusions and recommendations have been addressed extensively in this report. In this chapter we highlight the key recommendations.

7.2 Recommendations for UHL

We firmly believe that the staff - and stakeholder - ownership element to a WTM as well as its financial independence are key ingredients to what makes mutuals so successful and it is for this reason that we recommend that UHL aspire to that end-goal, in the longer term.

However, we have identified significant barriers, internal and external, that lead us to recommend a phased approach. These barriers can be summarised as:

- Internal barriers:
    - Ongoing and historic operational deficit
    - Significant investment requirements in estate
    - Liquidity needs
    - Strong staff attachment to being part of NHS family as employees of a Trust
- External barriers:
    - Lack of provision in NHS Trust or (to a lesser extent) Foundation Trust governance models to have staff and other stakeholders having real powers
    - VAT and corporation tax significantly increases cost base for WTM
    - Lack of clarity regarding treatment of historic losses/liabilities

- Requirement to retain estate and other fixed assets
- Procurement law risks in awarding a service contract to a WTM
- Ability to access NHS funding facilities

In view of all things considered we acknowledge the significant potential benefits (financial and non-financial) that come with mutualisation. We are not ruling out the WTM option, in the longer term, if the circumstances are right, and as such recommend a staged approach that allows UHL to achieve the benefits of mutualisation. This will keep risks and interdependencies manageable, allows the organisation to grow into its Mutual mould over time at its own pace, and enables policy and/or legislative changes to take shape in the meantime.

Furthermore, we recommend that the established momentum is kept and both the Autonomous Team and Staff Engagement Improvement programmes are mobilised in the short term.

Finally, it is our experience that it takes a considerable amount of time for staff, management, directors and other stakeholders to get used to the ideas and concepts involved in mutualisation. Winning hearts and minds is generally greatly helped by seeing mutuals in action. As such we recommend that UHL develop an exchange programme with existing mutuals in health, so that those initial trepidations are overcome and concepts and ways of working are adopted more naturally into the organisation.

7.3 Recommendations for Cabinet Office / Department of Health

In order for mutuals in health to become a viable option for organisations of scale and complexity, key issues need to be tackled. Our recommendations therefore refer first and foremost to the technical issues raised regarding irrecoverable VAT, access to finance and the ability to retain assets and procurement law.

Secondly, both the NHS Trust governance model (in particular) and the Foundation Trust governance model would be greatly enhanced by giving a more prominent role for staff and

patients. There are several ways of achieving this but these roles need to be meaningful and encompass real power.

Finally, it has become clear that for mutualisation to stand a chance in NHS organisations a slow and gentle pace is required. A fair amount of anxiety regarding the concept has been detected at all levels in the organisation, as is evidently the case in other Pathfinder organisations. In our view it will take time for organisations to arrive at a balanced view of the facts and whether mutualisation is right for them. In fairness, even the most successful mutuals have taken several years from inception to implementation. We would recommend that - in future - studies like these are given more time with a stronger focus on learning and exploration.

Appendix A: Case study: the Albion Group

There are potential commercial advantages to UHL in mutualising. Some of these can be evidenced through a case study of the Albion Group. For example:

Productivity, Performance, Growth and Resource Management at Albion

ASPECT	Y / N	DATA
Increased productivity	✓	>40%
Hand washing audits	✓	100% compliance
Reduced waiting times for therapy services	✓	e.g SALT wait reduced from 24 weeks to 2 weeks for non-urgent support
Increased growth	✓	Average 20%
Reducing overheads	✓	Now trading 'enabling' services e.g IT services and Human Resources to reduce overheads and offer sustainable solutions for infrastructure services
Managing 4.5% funding reduction over last 4 years	✓	still delivering increased productivity and innovation
Securing resources for investment in frontline resources	✓	90% over last 4 years, in spite of 4.5% reduction in funding

Commercial advantage through mutualisation can extend beyond the financial:

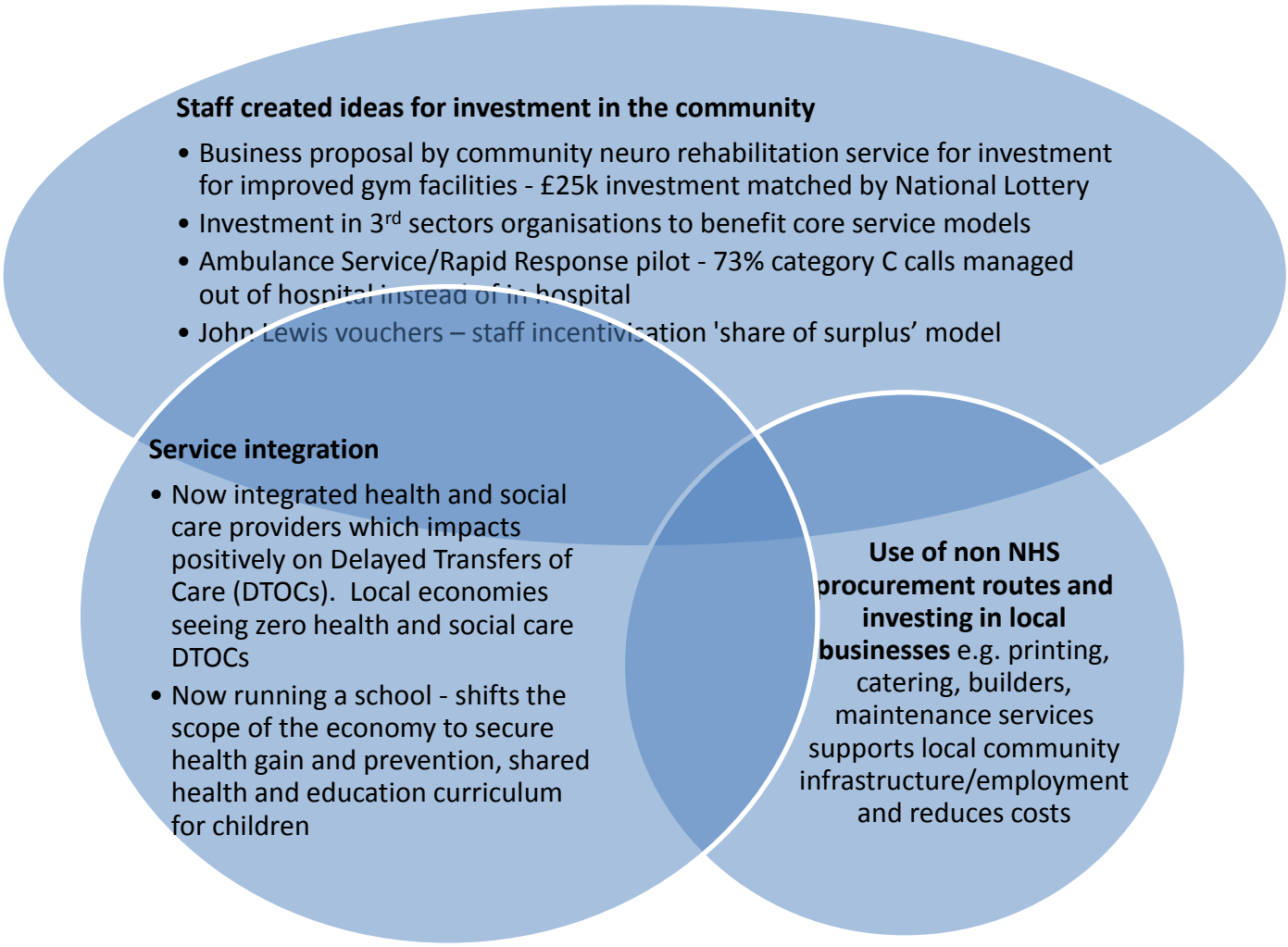


Fig. A.1 Added Social Value / Capital at Albion

Mid Essex is one of the top ten financially challenged health economies in England. It is in the bottom ten for resource allocation for health per head of population. Provide is an NHS spin-out and community health provider in Mid Essex. A recent Boston Consultancy Group report (BSG July 2014) found the following:

- Mid Essex spend below the national average on intermediate care and re-ablement including care beds yet has low rates to care homes
- Therapy services have a higher than average number of patients per 100k of population but have a lower than average cost per population and service user
- There are lower than average waiting times for community nursing, shorter than average length of case and, since 2011, 40% more patient-facing time

- Productivity across services has risen by 20% overall with some areas exceeding 40%
- Hospital Acquired Infection Rates have almost been eradicated (Between 2011 and 2015, improvement to MRSA screening of 0.4% (to 100% of screening within 2 hours of admissions)
- Staff hand washing and cleanliness surveys show that compliance is almost 100% consistently. (Between 2012 and 2015, increase in overall compliance to all High Impact Intervention Audits - overall improvement 1.4%)

Albion Group says of its own commercial approaches "Within our organisation, we have witnessed commercial benefit:

- Reduction in sickness absence from 14 days per annum to less than 7 over the last 4 years has allowed us to reduce the reliance on agency staff and invest in technology that improves staff rotas and case-load management
- Reduction in agency staff usage has enabled us to increase staff numbers on wards and in the community thus improving outcomes like length of stay: discharges have reduced by 17%
- In relation to falls we have seen a reduction year on year
- Between 2011 and 2015, 3.3% improvement in antibiotic prescribing on the wards
- Since we have been measuring data on our own compliments have risen every year from 513 to 1450
- Being an independent staff owned organisation means that product wastage is frowned upon: staff and managers are aware that waste is *their* waste and *their* money

Measures	2012 - 13	2014 -2015	% difference
Activity	374987	568193	52%
Caseload	47547	49802	5%
Referrals	7134	7929	11%
Discharge	7029	8202	17%

DNA	1266	1568	24%
Cancelled by unit	1783	1966	10%
Cancelled by service	2847	2440	-14%

Albion continues “One of the foundations of the mutual model is that staff have to take responsibility for their actions at all levels. Front line staff have to be empowered to make decisions so we have less layers of management. There is no “safety net” when you are outside the NHS. We do not run out of money if we mess up we go into liquidation. Staff know this and because they are empowered to make decisions are always conscious their responsibilities to the customers and the organisation as well as each other.

Our vision is simple: to provide a range of outstanding services that care, nurture and empower individuals and communities to live better lives. It is what we have all signed up for and is why we invest our surpluses in the communities we serve, which becomes a virtuous circle. This is what gets people out of bed and it was created and agreed by the staff. It is part of their induction and their performance measures - they are asked to demonstrate how they support our vision.” (John Niland, CEO of Provide, one of the Albion member organisations).

Appendix B: Report on Engagement at UHL

[Included as separate PDF attachment in final project documents email]

Appendix C: Stage 2 and 3 Considerations

Stage 2: NHS Trust Plus

Legal and governance structure

This option could be explored if enhancements were made to the FT model to deliver some of the benefits of mutualisation and it is decided to allow similar changes to the NHS Trust model. It remains Government policy, and is anticipated by the Health and Social Care Act 2012, that all NHS Trusts should become Foundation Trusts or, if that is not achievable, be subject to an alternative solution in accordance with the NHS Trust Development Authority's Accountability Framework. However, in view of the number of NHS Trusts still to reach FT status, and the time it is taking, the next Government may consider changing NHS Trust legislation to improve the legal and governance model until such time as all NHS Trusts can achieve FT status.

Enhancements that could be considered include:

- *Power to set up subsidiaries:* NHS Trusts currently have restricted powers to set up subsidiary companies but if the law changed then parts of UHL's operations could be transferred into wholly owned subsidiaries. But many of the barriers to the whole trust mutual option would also apply here and this option would not offer any real benefits over the AT option
- *Introduction of FT-style governance tiers:* The law could be changed to introduce FT-style governance tiers into an NHS Trust legal model. For example, an NHS Trust could have a membership and that membership could have rights to appoint individuals to a staff and stakeholder "council". This would give the members and council appointees certain powers. It is likely that the government would be reluctant to replicate full blown FT structures in an NHS Trust model given the intention to remove NHS Trusts as legal models, but there may be a minimum FT-style structure that could be introduced
- *Flexibility around Board composition:* The law could be changed to allow NHS Trusts greater power to appoint their own directors, removing the prescribed requirements of the 1990 Regulations. For example, the "council" referred to above could be given power to appoint NEDs to the Board.
- *Freedom to retain surpluses:* Existing powers of NHS Trusts to retain surpluses could be extended, as well as how they can be deployed.

- *Incentivising staff:* Financial incentivisation linked to performance could be extended to all staff, not just directors.

Workforce

Assuming this model would not involve setting up a subsidiary company into which staff would transfer then (other than greater representation and influence as described above) things would stay as they are for individual staff members in that they would continue to be employees of UHL.

Nothing would change in respect of their NHS terms and conditions (unless changes in Agenda for Change permitted more financial incentivisation) and access to the NHS Pension Scheme. Any future changes to staff employed by UHL would be governed by the Agenda for Change arrangements and any new joiners would be in the same position.

Assets

Assuming this model would not involve setting up a subsidiary company, UHL would continue to own its premises and equipment.

Branding

UHL would continue to access the NHS brand.

Regulation

Again assuming this model would not involve setting up a subsidiary company, regulation would be by the NHS Trust Development Authority and CQC under this interim option.
UHL would be able to continue to access NHSLA cover.

Impact of failure

The impact of failure would be the same as in the current NHS Trust regime, i.e. TDA would intervene.

Stage 3: Foundation Trust Plus

Legal and governance structure

This option could be explored if enhancements were made to the FT model to deliver some of the benefits of mutualisation. Enhancements that could be considered include:

- Allowing an FT greater freedom to delegate, for example replicating the powers of NHS Trusts to delegate to committees – this would allow an FT to set up an AT committee structure. Changes could be made to FT governance structures to give staff, patients, the public and stakeholders a formal role in committees (for example in some of the ways identified below)
- Making the members legal owners of an FT, in a way that they are not currently. Membership might entail economic ownership (e.g. a £1 share which is non-transferable) or another form of ownership interest
- Extending the rights of members, e.g. in relation to participation in decision-making over key organisational decisions such as amending the constitution
- Extending the rights of patients, carers and stakeholders, e.g. in relation to participation in decision-making in matters that could directly affect them
- Extending rights of staff to participate in decision-making (e.g. to appoint and dismiss directors) and to be incentivised (e.g. by introducing an employee benefit trust, similar to that operated by John Lewis, into the existing legal structure of an FT)
- Extending the rights of the Council of Governors, e.g. to appoint and dismiss directors and to participate in strategic business decisions.

Workforce

Assuming this model would not involve setting up a subsidiary company into which staff would transfer then (other than greater representation and influence as described above) things would stay as they are for individual staff members in that they would continue to be employees of UHL.

Nothing would change in respect of their NHS terms and conditions (unless an FT decided to move away from Agenda for Change or Agenda for Change was changed to allow more financial incentivisation). Access to the NHS Pension Scheme would remain. Any future changes to staff employed by UHL would be governed by the Agenda for Change arrangements and any new joiners would be in the same position.

Assets

Assuming this model would not involve setting up a subsidiary company, UHL would continue to own its premises and equipment.

Branding

UHL would continue to access the NHS brand.

Regulation

Again assuming this model would not involve setting up a subsidiary company, regulation would be by Monitor and CQC under this interim option.

UHL would be able to continue to access NHSLA cover.

Impact of failure

The impact of provider failure would to all intents and purposes be the same as for an NHS Trust, in that an FT would be subject to Monitor's intervention regime and may ultimately be dissolved.

Appendix D: Feasibility Study

[Included as separate PDF attachment in final project documents email]