Mutuals in Health Pathfinders

University Hospitals of Leicester NHS Trust ('UHL')

Detailed Options Assessment

Executive Summary

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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.