Meeting Title	Mid and South Essex Acute Trusts (Three Trust Board in Common meeting) (meeting in public)		
Meeting Date	10th January 2018	**Agenda No**	**9**
Report Title	Proposed Future Organisational Form		
Lead Executive Director	Clare Panniker, CEO Tom Abell, Deputy CEO		
Report Author	Danny Hariram, Group Director People Strategy & Organisational Development Andrew Stride, Corporate Secretary BTUH		
Action Required	Decision ■ Discussion □ Monitoring □ *(please tick)*		
Background / Context	The future organisational form of the three acute trusts in Mid and South Essex has been under discussion to varying degrees since the early stages of the collaborative working between the three trusts from Spring 2016. From early 2017 there has been the development of a group model and Joint Executive team, which has made good progress, in particular development of pre consultation business case (PCBC) for longer term sustainable clinical service changes, within the acute hospital group. The current governance and leadership arrangements have always been regarded as temporary and, subject to the outcome of the public consultation on clinical service change, there will be a need for a new organisational form to be agreed and implemented. To support this ambition the Joint Working Board (JWB) commissioned in summer 2017, independent business, economic and legal advice and support from a partnership between KPMG and Addleshaw & Goddard, using a competitive procurement process. The appointment panel were assured by the experience of these companies in similar transactions in the public and private sector.		
Key Issue 1 ***(replace with a brief summary of the issue)***	On 14th December an options appraisal exercise to review and score a shortlist of options was undertaken and was facilitated by KPMG. This event was attended by more than 40 representatives from across the three trusts, including joint executives, non-executive directors, site leadership teams, company secretaries and governor/patient council representatives as well as a senior representative from NHS Improvement and from the CCG Joint Committee.		
Key Issue 2 ***(insert more lines if required)***	The preferred outcome of the options appraisal scoring exercise was for a proposed three-way merger.		
Timescale for Benefits to be Realised	Our aspiration would be for a new organisation to come in to being by April 2019. This would be subject to approvals from the three Trust Boards, the Councils of Governors of the two foundation Trusts, Southend University Hospitals NHS Foundation Trust and Basildon & Thurrock University Hospitals NHS Trust, NHSI and Competition and Markets Authority (CMA).		

Assessment of Implications	
Financials	The development of the strategic case and business case will require people resources in order to develop and deliver the programme of work.
Risk	A preliminary set of risks are described within the paper and will be included with in the Board Assurance Risk Register.
Equality and Diversity	N/A
Freedom of Information	*No exemptions apply*
Other *Implications Identified (including patient safety and quality, legal and regulatory compliance)*	*Could include Monitor/CQC compliance, infection prevention and control, NHS Constitution, recruitment and retention*
Recommendation	The Boards of Directors of Basildon and Thurrock University Hospitals NHS Foundation Trust, Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS Foundation are invited to: • Approve the preferred option recommended by the options appraisal workshop held on 14th December 2017 that the preferred future organisational state of the three trusts is a single merged organisation, subject to the completion of the strategic and business case phases of such a transaction and necessary approvals by NHS Improvement and the Competition and Markets Authority; • To approve the development of a Strategic Case for merger for submission to NHSI following the approval of the Boards in May 2018; • To note the risks associated with the proposed merger and that the corporate risk register and board assurance framework will be updated to reflect these in subsequent notes; • To note the financial implications and resource requirements of the proposed merger; • To approve the proposed governance structure for the Future Organisational Form Programme.
Appendices	Appendix 1 KPMG report following options appraisal workshop Appendix 2 Programme governance and leadership structure

FUTURE ORGANISATIONAL FORM

1.0 Background

1.1 Board members will be aware that the need to consider a future organisational form of the three acute trusts in Mid and South Essex has been under discussion to varying degrees since the early stages of the collaborative working between the three trusts from Spring 2016. The decision was taken at that stage to focus attention upon the development of the pre-consultation business case (PCBC) and a longer term sustainable clinical model. This has been supported through the committee in common structure that is currently in place. It has always been recognised that our current governance and leadership structures are time limited and that there would be a need for agreement of an end state organisational form to support the implementation of the clinical service changes, which are currently subject to a public consultation and final outcome from the Joint Committee of the five Clinical Commissioning Groups (CCGs) serving Mid and South Essex.

1.2 The PCBC has been supported by the three Trusts and the consultation on clinical service change is in progress, as such through the Future Organisational Form Steering group plans have been advanced to systematically consider the options for future organisational form, recognising that a clear strategic decision is now required to minimise uncertainty and disruption for clinical leaders, Trust staff, the Boards, patients and the public and to enable the delivery of the quality, staffing and financial benefits.

1.3 During summer 2017, the Joint Working Board (JWB) commissioned independent business, economic and legal advice and support from a partnership between KPMG and Addleshaw & Goddard, using a competitive procurement process. The appointment panel were assured by the experience of these companies in similar transactions in the public and private sector.

1.4 Discussions have also taken place with NHS Improvement who have been in informal communication with the Competition and Markets Authority (CMA).These are the two regulators with a key role in assessing and approving any change in organisational form for the three trusts.

1.5 The appointed advisors supported the Trusts in a three stage option appraisal process consisting of:

- 1 to 1 meetings with a range of stakeholders in the mid and south Essex region.

- Consideration of the outputs from these meetings at the Future Organisational Form Steering Group to create an initial view of both the evaluation criteria of options alongside a feasibility of the generated long list of options for future organisational form.

- A workshop on 14th December to collectively agree the evaluation criteria, the shortlisted options and the preferred option. This workshop was made up of members of the three boards, site leadership team members, governors/patient council representatives and commissioner representatives.

1.6 The recommendations arising from the workshop is presented to the Trust Boards for approval of the preferred option and the subsequent next steps. This is included as appendix one

2.0 Options Appraisal Workshop – 14th December 2017

2.1 This event, facilitated by KPMG, was attended by more than 40 representatives from across the three trusts, including joint executives, non-executive directors, site leadership teams, company secretaries and governor/patient council representatives as well as a senior representative from NHS Improvement and from the CCG Joint Committee. The full report from the options appraisal workshop is appended to this paper. See appendix 1

2.2 A shortlist of options was derived from an initial feasibility assessment by KPMG and the Future Organisational Form Steering Group. These shortlisted options were evaluated by attendees against the four criteria domains which would be used by NHSI to make a decision on any future organisational form - Quality, Finance, Sustainability and Deliverability.

2.3 The scoring produced during the workshop resulted in a very clear preferred option: **a merger of the three trusts**.

2.4 The aspiration would be for the new organisation to legally come into being on 1st April 2019. This is in line with informal discussions in recent months by the JWB. The risks to achieving this timescale are noted below, in view of the demands of producing the strategic case followed by the business case and the associated internal approvals and external regulatory processes.

2.5 This outcome is now presented to the Boards of Directors of the three trusts as a recommendation for approval.

3.0 Regulatory Process

3.1 The NHSI and CMA approval process run largely in tandem although they are legally distinct; the latter taking significant assurance from the former. NHSI apply the new Single Oversight Framework (SOF) to assess risk factors in any new organisational form including:

- Alignment to the local health and care system strategy,
- Funding position and funding requirements;
- Leverage from enlarged organisations;
- Existing financial and quality risk profile;
- Experience in services;

- Options appraisal and strategic rationale;
- Management capacity.

3.2 The proposed change in organisational form for the acute hospitals in Mid and South Essex will be one of, if not the first occasion when the new NHSI guidance on "transactions" (published in November 2017[1]) has been utilised. The stages of approval required by this new guidance are summarised below.

Stage One – Strategic Case

3.3 This is a combination of a Strategic Outline Case (SOC) and Outline Business Case (OBC) with which Board members will be more familiar. The key elements of the Strategic Case are:

- Strategic rationale;
- Competition and patients benefits case (which will be the primary focus of the CMA's review);
- Performance and risk assessment;
- Financial viability;
- Plan to deliver
- Appended documents – including corporate risk register, pertinent Trust Board papers, latest CQC comprehensive inspection reports for all transacting parties (trusts), the latest Well-Led report and the draft patient benefits case.

3.4 Fundamentally, the Strategic Case is seeking approval from the three Trust Boards and then NHSI to spend time, money and effort doing the work required to prepare for authorisation for a new organisation / transaction. NHSI take four to six weeks to reach a decision on a submitted Strategic Case.

3.5 **Timescale** – in discussion with NHSI and KPMG, it is envisaged that the first draft of the Strategic Case will be available at the end of March 2018. The final draft would be presented to the Trust Boards for approval at the beginning of May 2018. A decision from NHSI would then be expected no earlier than the end of May 2018.

Stage Two – Business Case

3.6 The Business Case provides significantly more detailed risk-based due diligence, integration planning, demand, capacity and financial modelling, benefits case and competition analysis, concurrently with the CMA approval process. The demands of this expectation should not be underestimated

3.7 **Timescale** – the development and approval of the Business Case will take approximately 10 months from the completion of Stage One. As such, Stage Two is likely to be completed no earlier than January 2019.

[1] https://improvement.nhs.uk/resources/supporting-nhs-providers-considering-transactions-and-mergers/

Stage Three – NHSI and CMA approval and a decision by the Trust Boards and by the Councils of Governors of the two current NHS Foundation Trusts

3.8 At this stage, key risks are refreshed, final due diligence is undertaken if needed, day one and 100 day detailed integration plans are reviewed and there is shadow running of the target operating model. The internal governance and statutory approvals are completed in this stage and a "go live" date for the new organisation, simultaneous with the legal dissolution of the predecessor organisations, is set.

3.9 **Timescale –** this final approval stage may take approximately two months, being completed therefore no earlier than April 2019. Wherever possible these timescales will be compressed

4.0 Engagement and Communications Process

4.1 Whilst the formal regulatory process is an essential requirement for moving to a new organisational form, it is clear that open, transparent and proactive engagement with internal and external stakeholders will be essential to not only approving but more importantly building and establishing a new organisation which brings the anticipated benefits to the local health and care system.

4.2 Following the approval of the Trust Boards, a dedicated communications and engagement plan through to the completion of the strategic case stage for the project will be developed rapidly, with an aim of addressing the needs of all stakeholders. A particular focus will be upon the Governors and Patient Council at MEHT given their role in ultimately approving the merger transaction and their statutory duties to represent the public and staff membership. We will hold regular briefing sessions and utilise the Governor in common meetings to communicate, receive feedback and respond to questions. The communications and engagement plan will be provided to the JWB during January 2018. See programme governance and leadership structure appendix 2.

5.0 Programme Governance and Leadership

5.1 In order to deliver the strategic and business proposals for change a dedicated Programme Governance and Leadership structure has been drawn up (appendix two). This structure aims to make the best use of internal talent to drive forward particular work streams within the project as part of the Programme Delivery Group, with executive and non-executive leadership provided by a Programme Board, reporting to the JWB and the three Trust Boards.

5.2 The project will be led through the Strategic Case phase at JEG level by the Deputy Chief Executive (Tom Abell) as Senior Responsible Officer (SRO) and the Group Director of People Strategy and Organisational Development (Danny Hariram). This leadership structure will be revisited once an

appointment to the Chief Commercial Officer role has been made, which is currently anticipated to be in the new financial year.

6.0 Resource Requirements

6.1 The JWB has to date approved the resources for the independent advice and support provided by KPMG and Addleshaw & Goddard. The financial and human resources required to deliver the future organisational form project are currently being scoped and will be presented in detail to the JWB in February 2018.

6.2 Board members are asked to note that additional resources may be needed to backfill key individuals to dedicate time to the project and for competition and market assessment.

6.3 Board members will be aware that an estimate of the level of resourcing for this project for 2018/19 has already been considered as part of the "Resourcing Change" paper discussed last month.

7.0 Preliminary Risk Analysis

7.1 A detailed project risk register will be developed as a priority by the Programme Board and Programme Delivery Group. However members are asked to note the following key risks at this stage:

- The future organisational form project may provide a distraction from business-as-usual at one or more of the trusts or within the group infrastructure, leading to a deterioration in operational performance or the delivery of key local performance targets.
- The project may provide a distraction from the delivery of the clinical service transformation and from the consultation activities.
- The resource implications for the project may create an unacceptable financial pressure on one or more of the trusts.
- The move to a new organisational form may generate adverse publicity as an inappropriate use of public funds if the benefits case is not appropriately articulated, damaging the reputation of the current trusts and the new organisation;
- Whilst the target date for the proposed new organisation coming into being is 1st April 2019, the regulatory approval process outlined above creates a significant risk that this date may not be achievable. The scale of this risk will become clear during the Strategic Case stage and will be closely monitored through the Programme Governance Structure;

7.2 If the preferred option is approved today, the corporate risk registers and board assurance framework will be updated to reflect these risks.

8.0 Next Steps

8.1 Following approval by the three Boards in common, the following immediate next steps are envisaged:

- Commencement of work on the Strategic Case;
- Implementation of the Programme Governance and Leadership Structure;
- Detailed update to JWB on 7th February 2018;
- An extraordinary meeting of the three Trust Boards in Common in late March 2018 to review and endorse the first draft Strategic Case for submission to NHSI.

9.0 Recommendation

9.1 The Boards of Directors of Basildon and Thurrock University Hospitals NHS Foundation Trust, Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS Foundation are invited to:

- Approve the preferred option recommended by the options appraisal workshop held on 14th December 2017 that the preferred future organisational state of the three trusts is a single merged organisation, subject to the completion of the strategic and business case phases of such a transaction and necessary approvals by NHS Improvement and the Competition and Markets Authority;

- To approve the development of a Strategic Case for merger for submission to NHSI following the approval of the Boards in May 2018;

- To note the risks associated with the proposed merger and that the corporate risk register and board assurance framework will be updated to reflect these in subsequent notes;

- To note the financial implications and resource requirements of the proposed merger;

- To approve the proposed governance structure for the Future Organisational Form Programme.

Mid and South Essex NHS Options Appraisal

Appraisal of options for the future organisational form of Southend University Hospital NHS Foundation Trust, Mid Essex Hospital Services NHS Trust, and Basildon and Thurrock University Hospitals NHS Foundation Trust

05.01.2017

Contents

1 Executive summary

Southend University Hospital NHS Foundation Trust, Mid Essex Hospital Services NHS Trust, and Basildon & Thurrock NHS Foundation Trust ('the three NHS Trusts') have been working together on how to deliver a sustainable health economy in mid and south Essex. They are now looking to identify the organisational form that will best enable them to deliver the necessary changes to ensure a high quality and sustainable care for the population of mid and south Essex. This report summarises the approach that was followed and the proposals following on from the appraisal of the preferred route to achieve a sustainable organisational form. A three-step approach was followed that included:

1. **'1-2-1' meetings** with a range of stakeholders in the mid and south Essex region. This included structured meetings in either small groups or with individuals;
2. **Future Organisational Form Steering Group** on 06 December 2017 to review the summary outputs of the '1-2-1' meetings and develop an Initial view on both the evaluation criteria and perform a feasibility assessment of the options.
3. **Future Organisational Form Workshop** on 14 December 2017 to collectively agree the evaluation criteria, the shortlisted options and the preferred option.

The stakeholders that were involved in the above approach included all members of the Joint Executive Group for the three NHS Trusts (JEG), site leadership teams for each of the Trusts (including clinical, operational and financial leads), the chair / deputy chair and other NEDs for each of the three NHS Trusts, governors or members of the local patient council for each of the three NHS Trusts, NHS Improvement, and the CCG and STP lead. Questions considered during this process included:

- What evaluation criteria should be adopted as the basis for decision making?
- Should those evaluation criteria be weighted equally?
- What options are there for the future organisational form of the three NHS Trusts?
- Which options are feasible and should be scored as part of a shortlist of options?
- What is the preferred option and why?

The preferred option identified during the Workshop was for the three NHS Trusts to merge into a single NHS organisation. The option was viewed as the most likely to deliver better patient outcomes and a sustainable future health system. This was supported by enabling joined up planning of operations and the workforce as well as more effective decision-making.

1.1 Key recommendations

On the basis of the Workshop on 14 December 2017 and this summary report, it is recommended that the Board for each of the three NHS Trusts approves the following:

- That the preferred option for the future organisational form is to merge the three NHS Trusts into a single organisation;
- That it is satisfied with the approach followed for identifying the preferred option at this stage; and
- To proceed to the development of a 'Strategic Case' to meet the requirements of the NHSI Transactions Guidance, including development of a plan to complete this and an assessment of any 'red flags' to the transaction proceeding.

2 Introduction and context

This section summarises the national and local context within which the options appraisal took place.

2.1 National and local context

The NHS faces challenges nationally insofar as there is a growing demand for health services (driven by demographics, lifestyle changes and expectations of what a modern health system should provide) that is not being matched by a proportionate increase in funding or of the workforce. For example, in Essex in the two years from 2014 to 2016 the over 75 population grew by 2.3% and emergency admissions grew by 6% between 2015 and 2016. The NHS Five Year Forward View set out why improvements were needed on the triple aim of better health, better care, and better value. The plan calls for greater specialisation of services where possible to deliver higher standards of care.

The Mid & South Essex Sustainability & Transformation Plan (STP) was the regional response and linked together the planning for the mid and south Essex health and care economy, including Southend University Hospital NHS FT (SFT), Mid Essex Hospital Services NHS Trust (MEHT) and Basildon & Thurrock NHS FT (BTFT). This identified that performance was in areas below average against national standards. This included measures of patient experience, cancer waiting time standards, and the perceptions of care and support received by people living with long term conditions. There is also variation in outcomes between providers and challenges in performance at one Trust that do not exist at others but that could be responded to with greater collaboration (including variation in the waiting times for patients at certain times).

Some of the underlying challenges include:

- Across Essex there are multiple small providers (revenues of approximately £300 million per provider) offering most services at most sites and preventing appropriate specialisation of health services. Monitor have previously recognised the sustainability challenges associated with smaller NHS acute providers due in part to the lack of economies of scale.
- Workforce and talent gaps in terms of consultant and nursing cover and challenges recruiting into leadership roles. This is driven in part by a lack of specialisation of services, lack of academic opportunities and the relative pull of large acute Trusts in London to offer these opportunities.
- Protracted decision-making with significant time and effort spent on revisiting strategic planning driven in part by senior managers and clinical leaders only having the bandwidth to respond to immediate operational challenges.

A combination of these issues led to mid and south Essex being placed within a Success Regime. The overall aim of the STP is to improve health and care outcomes whilst managing any financial deficits or existing issues of service quality. This identified a reconfiguration of the acute provider model and out of hospital care as key priorities for the region.

2.2 Pre-Consultation Business Case ('PCBC'

Since the STP, the three NHS Trusts and local commissioners have developed a Pre-Consultation Business Case (PCBC in relation to a proposed reconfiguration of acute health services in the region. It identified that change has to happen to maintain the safety and quality of care in future, and the need to address the issues above in a way that will improve outcomes for patients and the communities in mid and south Essex, as well as to support our staff. The underlying principles of the PCBC are:

- Make the “front door” the best it can be for patients;
- Achieve the best outcomes for patients and deliver safer complex care;
- Modernise services and smooth care pathways for patients by co-locating dependent services; and
- Help make planned care more reliable and safer for patients.

The changes within the clinical model set out within the PCBC are currently out to public consultation with the current consultation end date being March 2018. The PCBC sets out an ambition to provide the very best care for people in mid and south Essex with better outcomes and a more sustainable health service. This options appraisal will in part be driven by the solution that offers the best model for enabling delivery of the PCBC objectives, which includes:

- Transforming acute services plays a crucial part in transforming and modernising the health and care system;
- More efficient acute care to support the release funding to support out of hospital care and to better support self-care, develop localities with multidisciplinary teams and promote the use of technology; and
- Supports the collective ambition to keep people out of hospital and supported by services closer to home.

However, the decision on organisational form is not dependent on the outcome of the PCBC as those remain about changes in the care model over the short to medium term. The organisational form decision is about the best form for enabling change across the health and care system both now and in the future. The PCBC does however provide useful context for the scale of the transformation required across mid and south Essex to deliver a sustainable health system.

2.3 Trust context and vision

To respond to the national and local context the Trusts have started working closer together and have agreed temporary joint working arrangements across the three Trusts with the Competition and Markets Authority (CMA). This includes the Joint Executive Group (JEG) that operates as a common executive team across the three Trusts and a Joint Working Board (JWB) that includes the JEG as well as Non-Executive representation from each of three NHS Trusts. The Trusts do remain separate with individual Trust Boards and individual statutory duties. The three NHS Trust Boards includes the JEG as executives but with separate NED membership for each Trust as well as the separate governor arrangements in place for the two Foundation Trusts. There are also separate Site Leadership Teams in place at each of the three NHS Trusts including a Managing Director, director roles covering medicine, nursing, finance, operations, HR and estates and a separate Company Secretary. The Managing Directors attend their respective NHS Trust Boards in a non-voting capacity. Collectively, these arrangements are described as a ‘Committee in Common’ structure elsewhere in this document.

As well as these temporary joint working arrangements the three Trusts have developed a shared vision that includes the following (these four areas are also mapped to the evaluation criteria in section 3.2 below):

- A health network that delivers excellence in local and specialist services;
- Demonstrably improve the health and wellbeing of our communities;
- Provide a vibrant place for staff to develop, innovate and build careers; and
- Service and financial sustainability and resilience.

The vision will be delivered through a five part strategy, involving:

- Standardised clinical services informed by evidence, patient co-design and reduced variation;
- Efficient corporate and clinical support services;
- Establish a culture of high performance;
- Value adding physical and technological assets with a timely flow of patient information; and
- A commercially astute, partnership focused organisation.

The future organisational form should enable the delivery of this vision to improve the health services for the popualtion of mid and south Essex.

2.4 Advisory support

KPMG were engaged to provide advisory support for the appraisal of options of the future organisational form of the three NHS Trusts as well as an analysis of competition matters. This paper covers the first of those two areas and summarises the outputs of its stakeholder engagement and the Workshop that KPMG facilitated on 14 December 2017 to consider the preferred option for the future organisational form of the three Trusts.

3 Options appraisal

In this section we have set out the approach and summary findings of the options appraisal. Broadly, the approach was designed to deliver an options appraisal process that would:

- Look at all the options;
- Involve stakeholders throughout the process; and
- Apply a robust and auditable process.

A three-step approach was followed that included:

1. **'1-2-1' meetings** with a range of stakeholders in the mid and south Essex region. This included structured meetings in either small groups or with individuals;
2. **Future Organisational Form Steering Group** on 06 December 2017 to review the summary outputs of the '1-2-1' meetings and develop an Initial view on both the evaluation criteria and perform a feasibility assessment of the options.
3. **Future Organisational Form Workshop** on 14 December 2017 to collectively agree the evaluation criteria, the shortlisted options and the preferred option.

3.1 Approach

3.1.1 1-2-1 meetings

KPMG met with the following individuals or groups of people during November and December 2017. The aim of these meetings was to understand the objectives and perspectives on opportunities and risks from the relevant stakeholder groups. KPMG met with executives from the three Trusts and gathered opinions about the challenges and potential solutions. Questions asked included:

- What is your view of the current arrangements in place within the three trusts?
- How does this impact your organisation?
- What options are there for the future organisational form of the three NHS Trusts?
- What is important to consider when differentiating between suitable options?
- Are there any benefits that you can see from integrating the three Trusts?
- Would you be willing to collaborate with other Trusts to provide those services?
- What do you think are the risks and issues with regard to this process?

The table below sets out the stakeholders consulted as part of the '1-2-1 meetings':

Table 3A: System engagement

	Role	Organisation
Operations		
Yvonne Blucher	Managing director & Operations Director	Southend
Clare Culpin	Managing Director	Basildon & Thurrock
Liz Wells	Operations Lead	Basildon & Thurrock
Sharon Salthouse	Operations Director	Basildon & Thurrock
Lisa Hunt	Managing Director	Mid Essex Trust
Peter Fry	Operations Director	Mid Essex Trust
Finance, IT and Estates		
Adrian Buggle	Director of Finance	Southend

	Role	Organisation
John Henry	Director of Estates	Southend
Stephanie Watson	Director of Finance	Basildon & Thurrock
Carolyn Lewis	Director of Estates	Basildon & Thurrock
Veronica Watson	Interim Director of Finance	Mid Essex Trust
Elmarie Swanepoel	Director of Estates	Mid Essex Trust
Clinical and Workforce		
Neil Rothnie	Medical Director	Southend
Denise Townsend	Director of Nursing	Southend
Cathy O'Driscoll	Director of HR	Southend
Tayyab Haider	Medical Director	Basildon & Thurrock
Dawn Patience	Director of Nursing	Basildon & Thurrock
Danny Hariram	Director of HR	Basildon & Thurrock
Dr Ellie Makings	Medical Director	Mid Essex Trust
Lyn Hinton	Director of Nursing	Mid Essex Trust
Bernard Scully	Director of HR	Mid Essex Trust
JEG		
Clare Panniker and Tom Abell	Chief Executive and Deputy Chief Executive	JEG
Celia Skinner and Diane Sarkar	Medical Director and Nursing Director	JEG
James O'Sullivan, Martin Callingham & Zoe Asensio-Sanchez	Chief Financial Officer, Chief Information Officer, and Director of Infrastructure	JEG
Mary Foulkes	HR and workforce	JEG
Danny Hariram	Programme lead	JEG
Broader engagement		
Nigel Beverley, David Parkins, Nick Alston	Chair or Deputy Chair for each Trust	The three NHS Trusts
Caroline Rassell	CCG / STP lead	Commissioner
Zoe Fiander	NHSI competition team	NHS Improvement

3.1.2 Future Organisational Form Steering Group

The information gathered from the '1-2-1 meetings' was used to as discussion material firstly for the Future Organisational Form Steering Group (the Steering Group) on 06 December 2017 and was used to:

- support the design of the Future Organisational Form Workshop (the Workshop);
- agree the intial evaluation criteria to use as a starting point for the Workshop; and
- agree an initial feasibility assessment of the longlisted options.

The members attending the Future Organisational Form Steering Group included Nigel Beverley (JWB Chair and Basildon & Thurrock NED, Mike Green (Southend NED, Colin Grannell (Mid Essex NED, Clare Panniker (JEG CEO, Tom Abell (JEG Deputy CEO, Celia Skinner (JEG Chief Medical Officer and James Day (Company Secretary.

3.1.3 Future Organisational Form Workshop

KPMG structured a Workshop to collectively assess the options for the future organisational form and to form the basis of recommendations to the three NHS Trust Boards on a preferred option. The Workshop was attended by 40 stakeholders and included representatives of each of the three NHS Trusts, CCGs and the STP, and NHS Improvement. The full list of invited persons and attendees is included in Appendix 1, which also shows how individuals were grouped by table for the working sessions.

The areas covered during the Workshop were:

- Understanding the strategic context (see section 2);
- Setting out the system engagement prior to the Workshop (see section 3.1.1);
- Evaluation criteria and weightings to be applied (as informed by the Steering Group and subsequently considered in the Workshop as described in sections 3.1.2, 3.1.3 and 3.2);
- Long list of options and the proposed shortlist (as informed by the Steering Group in and subsequently considered in the Workshop as described in sections 3.1.2, 3.1.3 and 3.3.1);
- Scoring of shortlisted options and selecting a preferred option (see sections 3.3.2 and 3.3.3); and
- Next steps (see section 4).

3.2 Evaluation criteria

This section sets out the evaluation criteria as developed through the three step process set out above.

3.2.1 1-2-1 meetings and Steering Group

The key areas for consideration during the evaluation from the '1-2-1 meetings' were grouped together as shown below with two criteria for each of the four 'domains' historically used for options assessment on previous NHS transactions (Quality, Sustainability, Finance and Deliverability).The approach taken was to present a set of criteria associated with each of these domains and then to work with the participants to agree both what the criteria should be and what they meant in the context of the aims of the future organisational forms. The four parts of the vision for the three NHS Trusts has also been mapped against the criteria and these are highlighted in green in Table 3B below.

Table 3B: Initial Evaluation Criteria agreed in the Steering Group

Quality

i. **Clinical strategies for the region**
   - A health network that delivers excellence in local and specialist services
   - To be outstanding hospitals within five years
   - Patients move through the system effortlessly

ii. **Improved outcomes and experience**
   - Demonstrably improve the health and wellbeing of our communities
   - Best in class health outcomes
   - Access for patients to the services they need
   - Patient experience and front door services
   - Harm-free
   - Maximise opportunity of medical school and linked academic posts
   - State of the art technology and investments

Sustainability

i. **Sustainability of workforce and operations**
   - Provide a vibrant place for staff to develop, innovate and build careers
   - Highly evolved operating model to deliver more outcomes more efficiently
   - High performance culture and whole career opportunities

- Innovation and R&D and MSB Institute
- Work with partners to support out of hospital care

ii. **Effective decision-making**
- Ability to make decisions on strategic direction quickly
- Clear accountability
- Leadership which is inclusive and values staff
- Developing a new organisation while retaining local identity that is empowered

Deliverability

i. **Regulatory and political barriers**
- Must meet regulatory requirements (including CMA and NHSI requirements)
- Politically achievable in terms of broader stakeholders

ii. **Pace, capacity and similar approaches elsewhere**
- An option that can be delivered at pace to give certainty to patients and staff

Finance

i. **Affordable in the short term**
- Driving value for the tax payer
- Generate surplus for reinvestment
- Value for money of upfront investment

ii. **Sustainable in the longer term**
- Service and financial sustainability and resilience
- Enabling investment in information and state of the art technology
- Efficient corporate support services model
- Development of specialist services across three
- Opportunities to repatriate from London

3.2.2 Workshop

During the Workshop the initial evaluation criteria were discussed first on four breakout tables and then collectively as a group to confirm that they covered the key points that should be used to evaluate the options. The following changes were proposed:

- **Quality:** it was proposed that the domain should be called Quality and Safety to highlight that this captures both care outcomes and care delivered in a safe way. It was also noted that the ability of options to deliver improved outcomes and experience should also consider the ability of the option to develop a reliable evidence base from which to make decisions and track progress.
- **Sustainability:** Under sustainability of workforce and operations it was proposed that in brackets it should be made clear that this included opportunities for workforce development and that effective decision making should be expanded to also cover clear accountability in terms of clincal pathways, operations and decision-making.
- **Finance:** it was proposed that affordability in the short term should be changed to value for money to reflect the fact that some investment costs could be justified by financial benefits.
- **Deliverability:** It was highlighted that barriers should include consideration of the need for active engagement with the local community on the proposals and the ability to deliver was expanded to also include consideration of cultural factors and

the ability to influence and respond to future system changes as well as the immediate challenges summarised in section 2.

Following those changes the final evaluation criteria applied for consideration of the options is shown below.

Table 3C: Final Evaluation Criteria agreed in the Workshop

Quality and Safety i. Delivery of the overarching clinical strategies for the region (incl. PCBC and integrating care). ii. Improved outcomes and experience for service users and their families (incl quality and access). Supported by an evidence base.	**Finance** i. Value for money in the short term. ii. Financially sustainable in the longer term.
Sustainability i. Sustainability of workforce and operations (incl. opportunities for workforce development). ii. Effective decision-making and accountability.	**Deliverability** i. Regulatory and political barriers (incl engagement with local community, choice and competition requirements) ii. Pace, capacity and culture to deliver and the ability to influence and respond to future system changes. To consider track record of similar approaches working elsewhere.

The agreed domains and criteria were subsequently assigned weightings to reflect their perceived relative importance to the transaction process. The starting point was to assume that all criteria were equally important. During the Workshop, attendees were divided into four breakout tables and were asked to give a rationale for weightings assigned. The results from the breakout tables were then discussed collectively as a group to reach consensus on the evaluation criteria weightings to be applied. Assessment criteria were weighted as shown by domain and for each of the eight criteria.

Table 3D: Weighting of assessment criteria

Domain	#	Criteria	Domain (%)	Criteria (%)
Quality & Safety	i	Delivery of overarching clinical strategies for the region	25%	12.0%
	ii	Improved outcomes and experience for those using the service and their families. Supported by an evidence base		13.0%
Sustainability	i	Sustainability of workforce and operations (incl. opportunities for workforce development)	25%	13.0%
	ii	Effective decision-making and accountability		12.0%
Deliverability	i	Regulatory and political barriers and engagement with local community	25%	12.5%
	ii	Pace, capacity and culture to deliver and the ability to influence and respond to future system changes. To consider a track record of similar approaches working elsewhere		12.5%
Finance	i	Value for money of any investments made in the short term	25%	11.0%
	ii	Financially sustainable in the longer term		14.0%

The rationale for the scoring of the criteria is summarised below. It was unanimously agreed by all the breakout groups that the overall domains should have an equal weighting as they were perceived as having equal importance and as being inter-related with success in one domain being contingent on success in another.

- **Quality and safety:** It was agreed that this domain was to be weighted overall at 25% as this was the a key factor for service users in the short term. Within this domain a slightly higher weighting was given to the criteria on 'Improving outcomes and experience for those using the service and their families' (Qii) as this was considered to be the driving factor for improvement in quality.
- **Sustainability**: The domain was weighted as 25% as it was seen as important that the combined score for Quality and Sustainability was 50% overall. The critiera on the sustainability of the workforce and operations (Si) were weighted slightly higher as this was considered to be the more substantive goal the three NHS Trusts were working towards with effective decision-making and accountability (Sii) an enabler of that goal.
- **Deliverability**: There was a discussion on whether the Deliverability is the single most important factor when options were being looked at, but it was ultimately agreed that the importance of quality and sustainability meant it should be weighted at 25% overall. Within this domain both criteria were weighted equally.
- **Finance**: There was consensus among the Workshop attendees that that financial viability in the longer term (Sii) needed a greater weightage than the short term (Si) as it would have a greater impact on the ability of the three NHS Trusts to deliver high quality and sustainable health services in mid and south Essex, including investments in workforce, new technology, and new models of care.

3.3 Options considered and preferred option

This section sets out the longlist of options identified and considered during the process. The longlist was developed by consulting broadly with stakeholders through the 1-2-1 meetings and this was developed into a shortlist of three options following a feasibility assessment by the Steering Group and the Workshop. The shortlisted options were scored using the evaluation criteria set out in section 3.2 to identify a preferred option.

3.3.1 Longlisted options and initial feasibility assessment

During the 1-2-1 interviews and the Steering Group, attendees were encouraged to put forward any options they could foresee for the future organisational form for the three NHS Trusts. The output from this was a consolidated long list of 13 options for consideration.

They were also asked to consider which options were feasible based on the four domains of quality & safety, sustainability, finance and deliverability. The options for organisational forms were analysed and judged by the Workshop groups to be either:

- **Viable (green)** – Could meet the criteria although recognising that more information regarding how the option would be delivered is needed to determine final viability;
- **Possibly Viable (amber)** – May be able to meet the criteria but currently with significant questions outstanding; or
- **Not Viable (red)** – Will not be able to be able to meet one or more of the criteria.

The output of this is shown in the table below, including a short summary of the rationale for why options not shortlisted were considered 'Not Viable'. Only those options marked 'Not Viable' were not taken forward to the shortlist for the Workshop.

Table 3E: Longlist viability assessment from 1-2-1s and Steering Group

OPTIONS		COMBINED VIEW ON VIABLE OPTIONS
1	**Keep "Committee in Common" structure**	**Possibly Viable –** this was not seen as sustainable long term solution by many of the stakeholders, but as a temporary arrangement to help develop a vision for the three NHS Trusts. It was identified that many of the barriers remained to implementation of better care with this model and yet it might lead to similar substantive competition issues if it was to be proposed as a permanent solution.
2	**Revert to three Trusts and maintain 'buddying' arrangements**	**Viable** – a viable option, although substantial challenges to implementing more sustainable care in mid and south Essex.
3	**Merge two of the three Trusts (Southend, Basildon & Thurrock, Mid Essex)**	**Possibly Viable** – significant difficulties identified in delivery and differing views on which of the two Trusts should be merged. In either case there would be issues of one Trust being perceived to be 'left behind' or it was seen as likely to undermine the regional planning necessary to improve patient care in a sustainable way.
4	**Merge the three Trusts (Southend, Basildon & Thurrock, Mid Essex)**	**Viable** – a viable option, although delivering a three way merger is not common in the NHS.
5	**"Vertical integration" / Develop ACO or ACS with GPs and community services**	**Possibly Viable** – this will be identified as viable and merits a specific discussion in the Workshop on fit with longer term strategy. In the 1-2-1 sessions many individuals identified that this option could be progressed alongside one of the other options.
6	**Integrate with mental health providers in Essex**	**Not Viable** – further integration with mental health is desirable but mental health trusts in the region have just undergone their own merger and there are fewer opportunities to integrate health services and to deliver the sort of change identified in the PCBC. Integration with mental health providers in Essex could also raise fears around a loss of focus on mental health issues and mental health patients.
7	**Merge with Princess Alexandra Hospital (PAHT)**	**Not Viable** – this option was previously ruled out as part of Essex Success Regime and it is not aligned to strategic planning at STP level which considers mid and south Essex to be the suitable region for strategic planning of the health system. The Trust also faces significant difficulties, including with its estate and therefore attempts to merge with this Trust could create significant delays.

8	**Merge with Colchester**	**Not Viable** – this option was previously ruled out as part of Essex Success Regime and it is not aligned to strategic planning at STP level which considers mid and south Essex to be the suitable region for strategic planning of the health system. The Trust is also already looking to merge with the NHS acute provider in Ipswich.
9	**Integrate with other acute providers in other parts of country or even non-NHS / overseas providers**	**Not Viable** - already ruled out as part of ESR and not aligned to strategic planning at STP level. Some opportunities to share best practice but limited opportunities to integrate services to benefit patients at this stage. There is also limited evidence of providers operating at a 'national' level in the NHS.
10	**Essex "Devo" (e.g. Greater Manchester model)**	**Not Viable** – this option dependent on Council to act and not been an agenda that has been actively pursued at this stage.
11	**Joint venture model**	**Not Viable** – not supported as this offers is a limited change to the existing Committee in Common structure (which is already seen as inadequate) and then introducing additional contractual complexity.
12	**Service chain model (e.g. Moorfields)**	**Not Viable** – this option was viewed as likely to cause increased friction between the three NHS Trusts as it does not recognise the links between care services and could undermine development of care around user need. It is also untested as a whole health system solution, with examples of success being in specific areas of relatively low complexity elective services such as ophthalmology.
13	**Outsourcing services (back office to clinical) to one of the providers or a third party**	**Not Viable** – can be considered independently of options on future organisational form although greater scale through merger means potential for more robust services. This is not viable on its own as it is not a solution to all of the challenges identified for the health system.

The decision to not take forward options on integration with other organisations or development of different service models reflect the outcomes of the 1-2-1 meetings and the engagement with the Steering Group.

In the Workshop, the approach through which the longlist was generated was set out and the group was asked to give views on the shortlisted options, including specifically on:

- Whether additional options should be considered as part of the shortlist; and
- Whether options currently shortlisted should be removed on the basis that they were not viable.

Having completed that exercise the following options were removed from the shortlist:

- **Merge two of the three Trusts:** this option was discounted quickly with strong consensus that it would undermine the necessary integration of workforce and services to deliver the expected level of patient outcomes now and in the future. It would create an imbalance in the region with one large and one small provider and would create tensions as one provider could feel 'left behind'.
- **Accountable Care Organisation:** this was seen as a strategically important initiative to deliver the out of hospital care model, but not as an option that could be delivered in the short term. Specifically, it was identified that successful models typically required substantive involvement with primary care groups such as GPs. There is currently no GP group operating at sufficient scale in mid and south Essex and therefore this option will be pursued separately to this process. It was also agreed that a successful accountable care model would be made substantially easier to deliver if there was stable and sustainable acute provision in the region, so it was agreed that this should form the basis of the options appraisal rather than including an accountable care organisation within this appraisal.

Following the feasibility review in the Workshop then there were three options considered as part of the shortlist:

- Maintain Committee in Common;
- Separate back to three standalone NHS Trusts; and
- Merge three NHS Trusts into a single NHS Trust.

3.3.2 Shortlisted options

The scores used to assess the options were gauged by participants relative to the following scale:

- 0 – Will not meet the required criteria;
- 3 – Is likely to have some difficulty in delivering the required criteria;
- 5 – Neither better nor worse;
- 7 – Is likely to deliver the required criteria; and
- 10 – Will exceed the required criteria.

The report provides a description of the consensus of the attendees at the Workshop on 14 December 2017. For information, we have presented the scores by table in Appendix 1, which includes a summary of our observations of the discussions. A collective decision was made on the scores by first averaging the different results from the different tables and then discussing any significant differences in open forum to see if there was a case for adjusting the scores. The table below represents the output from that process. These scores were then agreed overall by the Workshop attendees as representing the consensus.

Table 3F: Weighted scoring of the options

Areas		Criteria	Weight (%)	Committee in Common	3 x standalone Trusts	Merge 3 Trusts
Quality & Safety	i	Delivery of overarching clinical strategies for the region	12.0%	4.3	2.3	7.0
	ii	Improved outcomes and experience for those using the	13.0%	4.0	3.3	7.3

		service and their families. Supported by an evidence base.				
Sustainability	i	Sustainability of workforce and operations (incl. opportunities for workforce development	13.0%	3.8	2.3	6.3
	ii	Effective decision-making and accountability	12.0%	3.0	5.8	7.3
Deliverability	i	Regulatory and political barriers and engagement with local community	12.5%	2.8	4.0	5.0
	ii	Pace, capacity and culture to deliver and the ability to influence and respond to future system changes. To consider a track record of similar approaches working elsewhere	12.5%	3.0	3.5	5.8
Finance	i	Value for money of any investments made in the short term	11.0%	3.8	2.3	4.5
	ii	Financially sustainable in the longer term	14.0%	3.3	1.3	6.8
			100.0 %			
		Raw score (out of 80)		27.8	24.5	49.8
		Weighted score (out of 10)		3.5	3.0	6.2
		Rank (1 is highest)		2	3	1

- **Qi** – Three standalone NHS Trusts would be able to deliver only some of the clinical strategies but not others as the opportunities for the Trusts to work together would be limited and pressures on individual organisations would likely take precedence over the aims of the broader system. Those strategies that were delivered would be more difficult to achieve due to reduced collaboration and would take longer to implement. The Committee in Common offers some additional opportunities for service integration as there is a common governance arrangement, shared learning and decision making but as long as there remains three statutory organisations then organisational pressures will continue to create a conflict with regional health system objectives. It is not expected to be able to implement best in breed services or fully streamlined pathways or to take full advantage of potential research and education opportunities. The merged Trust is substantially better insofar as there will be a framework within which to deliver the acute care strategies of today and in the future. There will be opportunities to specialise certain services to ensure that sufficient investment is made in the latest technologies and that operational improvements can be made to waiting lists and other areas. The score is held back from being higher in recognition of the fact that after a merger there would still be additional transformation to deliver a sustainable health system.
- **Qii** – Similarly to Qi, the Committee in Common structure makes it difficult to address the challenges or concerns about patient experience as there are limited opportunities to open up the availability of resources across the three NHS Trust. Three standalone entities would continue to create barriers to seamless care for patients and a merger would by contrast create new opportunities to share best in breed of services across the organisations.
- **Si** – Three standalone entities would have systematic problems such as competing amongst each other, particularly to recruit and retain clinical and support staff. This

creates instability in the workforce for each of the providers and makes it more difficult to offer careers for life in the way that leading teaching Trusts in London can. There are also challenges in terms of the misalignment of terms and conditions for staff across the three NHS Trusts that cannot be resolved whilst they remain separate statutory organisations. The Committee in Common structure would have the barriers similar to the standalone option, however it would provide better collaboration than standalone entities. A merger may cause some disruptions in the workforce in short term, but over the long term there were perceived to be significant opportunities around staff movement, rotas, pay scales and career pathways. This would be supported by opportunities to develop a medical training partnership with Anglia Ruskin University. This would improve both recruitment and retention of staff within the system and it would be easier to share staff between sites to meet shortages. The merger option has still only scored a six on the basis that national workforce shortages in clinical staff is making it increasingly difficult to address workforce challenges in the short term and a merger was described by one table as not offering a 'magic bullet'.

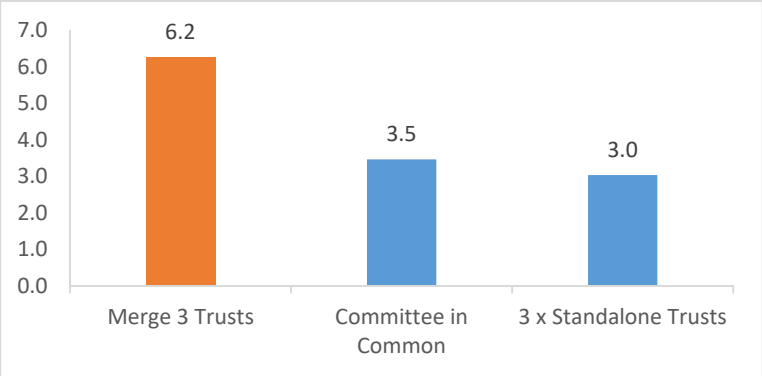
- **Sii** – The Committee in Common structure was repeatedly described as introducing an additional tier of management that made decision-making slow and accountability unclear. Whilst this was perceived as necessary as a temporary measure to start to respond to the challenges faced as a health system, it was not seen as a workable model for long term implementation of the necessary service changes. Three standalone organisations would have easier and quicker decision making but would be unable to engage and deliver wider decision-making for system changes, including for those changes proposed in the PCBC. A merger would offer opportunities to make the decision making clearer and cleaner with one Board and one set of statutory duties as well as a simpler structure, accountability and ability to implement change.
- **Di** – The existing Committee in Common structure has been scored lowest on the basis that the structure is seen as confusing in practice and as leading to a lack of clarity over roles, responsibilities and accountability. This can slow the pace of service transformation that is required and may undermines the ability to hold individuals to account for operaitonal performance over the long term. It was noted that the structure was also only agreed as a temporary arrangement with the CMA so any decision to prolong it indefinitely could lead to a challenge from the CMA and substantial problems in delivering this model given the lack of support from management or staff. By contrast the three standalone entities is better understood by people and issues of localism are addressed and so it scores better than the Committee in Common structure but is still scored low on the basis that the three NHS Trusts are likely to struggle to recruit a highly experienced management team and there would be complexities in unpicking the Committee in Common structure to return to three standalone organisations. Finally a merger does have deliverability challenges and will likely take over 12 months to implement however it is a relatively well tested approach and there are recent precedents for NHS acute mergers, so risks can be foreseen and mitigated where possible. On balance therefore all options are seen as difficult to deliver but the merger would be the easiest to implement.
- **Dii** – The Committee in Common structure has scored the lowest of the options as is more resource intensive to operate, slow paced, creates misaligned incentives between the three NHS Trusts (as they retain individual operational performance targets and control totals) and will not meet future organisational needs. By contrast the three standalone entities would meet local requirements and the management structure would be simpler at a Trust level. It has scored low on the basis that management of system change required would remain difficult due to a lack of joined up leadership, lack of a common culture and management could be adverse to change and sharing resources. A merger was seen as addressing someo of these difficulties and therefore the best option to provide the capacity to deliver the scale and pace of the organisational goals.

- **Fi** – The model of three standalone NHS Trusts has been shown not to be capable of delivering a financially sustainable health system that can deliver against national performance standards in view of the demographic challenges faced by NHS organisations nationally. A Committee in Common introduced some ability to share resources but maintains the separate statutory duties of the organisations so results in pressure on the Managing Directors and Finance Directors for each NHS Trust to manage against their individual system control totals. A merger was identified as having substantial costs in the short term but these were seen as offering value for money insofar as they should generate opportunities for transformation of services and financial savings.
- **Fii** – A Committee in Common would have the same issues as it is currently facing and would not be financially sustainable in the longer term. Three standalone NHS Trusts would not be sustainable in the present or in the longer term. A merger would provide more opportunities however it is not fully sustainable until there is a fixed system in place.

3.3.3 Preferred option

As shown above the preferred option is for the three NHS Trusts to merge into a single NHS Trust. The figure below summarises the relative scores for each option and shows significant support for a merger compared to the other shortlisted options.

Scores Summary



4 Next steps

In this section we have set out the next steps following the identification of a preferred option and these inform some of the recommendations set out in section 1.

4.1 Boards agreement of preferred option and approach

Following the consensus reached in the Workshop, the Boards of the three NHS Trusts will be informed of the preferred option and it will be recommended that they approve the choice of a preferred option as well as the approach followed. This decision can then be shared with NHS Improvement to formally start the next stages of the process.

4.2 Develop Strategic Case

Following a decision on the preferred option from the three NHS Trust Boards, JEG would proceed to develop a Strategic Case to meet the requirements of the latest NHSI Transactions Guidance[1]. This will consider the existing operational, quality, cultural and financial issues, and set out why the merger proposed as the preferred option will be the best way to address these and improve or maintain patient outcomes. This would include:

- A strategic case evaluation;
- Proposed execution plan to deliver the transaction including governance and management and an outline Post Transaction Implementation Plan (PTIP);
- Meeting the legal and regulatory requirements;
- Performance and risk assessment including an assessment of access and outcomes performance against operational targets, with recovery plans for failing targets;
- Preliminary due diligence;
- Financial assessment of the impact of the transaction; and
- A decision to proceed to develop a more substantive 'Business Case', which is the final document to be produced under the latest NHSI Transcations Guidance.

Timelines are still to be agreed with NHS Improvement but it is expected that a Strategic Case would take two to three months to complete (so completing early or late March 2018), followed by a four week review period for NHS Improvement. This would enable the three NHS Trusts to proceed to the more detailed (and resource intensive) assessment of benefits, detailed financial forecasting and implementation planning required for a 'Business Case'. NHSI indicate in the Transactions Guidance that the new Business Case stage will typically take ten months to develop followed by two months for approvals. Whilst there may be opportunities to accelerate the timeline therefore it is not at this stage envisaged that the three NHS Trusts would formally merge before April 2019. If the three Trust Boards approve the Strategic Case and decides to proceed to the 'Business Case' stage of the transactions process it will need to develop a detailed assessment of the competition impacts and patient benefits case. This will form the basis of a submission to the Competition and Markets Authority (CMA) and the timelines for this run parallel with the Business Case timelines set out above. There will need to be a decision on whether to proceed with a Phase I or Phase II review in consultation with NHSI and the CMA. This will be driven by the strength of the benefits case.

[1] Transactions guidance – for trusts undertaking transactions, including mergers and acquisitions, NHS Improvement, November 2017

4.3 Cascade decision-making

Following a decision by the Board on the preferred option, it is proposed that the decision and a summary of approach followed should be formally shared with all staff in the three NHS Trusts. It will be important to be clear on the stage of the process and on the steps still to be taken prior to the preferred option being finally approved and then implemented. This will include NHS Improvement approval of the Strategic Case and Business Case as described below. A communication strategy will be agreed by the JEG and cascaded through the three NHS Trusts.

Appendix 1: Workshop attendees and scoring

This Appendix sets out the:

- Attendees at the Future Organisational Form Workshop on 14 December 2017 with table facilitators identified in grey italics; and
- Average scoring for the Workshop and scoring by breakout table.

Workshop attendees by breakout table

Table 1	Table 2	Table 3	Table 4
• Clare Panniker, JEG CEO • Mike Green, SFT NED • Yvonne Blucher, SFT MD • Denise Townsend SFT Nursing • Clare Culpin, BTFT MD • Colin Grannell, MEHT NED • Ellie Makings, MEHT Medical • Veronica Watson, MEHT Finance • Jo Cripps, CCGs and STP • *David Bevan, KPMG*	• Tom Abell, JEG Deputy CEO • Mary Foulkes, JEG HR • David Parkins, SFT NED • Gabrielle Ridings SFT NED • Parm Phipps MEHT NED • John Henry, SFT Estates • Steph Watson, BTFT Finance • Lyn Hinton, MEHT Nursing • Naresh Chenani, NHSI • Andrew Stride, MEHT Trust Sec • *Sue Day, KPMG* • *Ankeeta Ghosh KPMG*	• Celia Skinner, JEG Medical • Nigel Beverley, BTFT NED • Tony Le Masurier, SFT NED • Rita Greenwood, BTFT • Adrian Buggle, SFT Finance • Dawn Patience, BTFT Nursing • James Day, MEHT Trust Sec • Lisa Hunt, MEHT MD • Ron Capes, SFT Governor • *Danny Hariram, JEG Programme*	• Diane Sarkar, JEG Nursing • James O'Sullivan, JEG Finance • Tim Young, SFT NED • Gail Partridge, SFT NED • Cathy O'Driscoll SFT HR • Barbara Riddell, BTFT NED • Karen Hunter, MEHT NED • Steven Beeson, MEHT Finance • Brinda Sittapah, SFT Trust Secretary • Robert Lee-Bird, MEHT Patient Council • *Mike Foster, Independent Programme Support*

Average scoring (as applied in section 3.3.2 and based on the consensus of the Workshop attendees)

Areas		Criteria	Committee in Common	3 x Standalone Trusts	Merge 3 Trusts
Quality	i	Delivery of overarching clinical strategies for the region	4.3	2.3	7.0
	ii	Improved outcomes & experience for service users and their families	4.0	3.3	7.3
Sustainability	i	Sustainability of workforce and operations	3.8	2.3	6.3
	ii	Effective decision-making	3.0	5.8	7.3
Deliverability	i	Regulatory and political barriers	2.8	4.0	5.0
	ii	Pace, capacity to deliver and track record of working elsewhere	3.0	3.5	5.8
Finance	i	Affordable in the short term	3.8	2.3	4.5
	ii	Financially sustainable in the longer term	3.3	1.3	6.8

Breakout Table 1 scoring

Areas		Criteria	Committee in Common	3 x Standalone Trusts	Merge 3 Trusts
Quality	i	Delivery of overarching clinical strategies for the region	5	3	7
	ii	Improved outcomes & experience for service users and their families	5	3	7
Sustainability	i	Sustainability of workforce and operations	3	0	6
	ii	Effective decision-making	3	5	7
Deliverability	i	Regulatory and political barriers	2	3	5
	ii	Pace, capacity to deliver and track record of working elsewhere	2	3	7
Finance	i	Affordable in the short term	4	2	7
	ii	Financially sustainable in the longer term	3	0	6

Breakout Table 2 scoring

Areas		Criteria	Committee in Common	3 x Standalone Trusts	Merge 3 Trusts
Quality	i	Delivery of overarching clinical strategies for the region	4	3	7
	ii	Improved outcomes & experience for service users and their families	4	4	8
Sustainability	i	Sustainability of workforce and operations	5	5	7
	ii	Effective decision-making	3	5	7
Deliverability	i	Regulatory and political barriers	4	5	4
	ii	Pace, capacity to deliver and track record of working elsewhere	3	3	3
Finance	i	Affordable in the short term	3	1	2
	ii	Financially sustainable in the longer term	4	2	7

Breakout Table 3 scoring

Areas		Criteria	Committee in Common	3 x Standalone Trusts	Merge 3 Trusts
Quality	i	Delivery of overarching clinical strategies for the region	3	1	7
	ii	Improved outcomes & experience for service users and their families	3	1	7
Sustainability	i	Sustainability of workforce and operations	3	1	6
	ii	Effective decision-making	3	5	8
Deliverability	i	Regulatory and political barriers	3	5	6
	ii	Pace, capacity to deliver and track record of working elsewhere	1	3	7
Finance	i	Affordable in the short term	5	3	6
	ii	Financially sustainable in the longer term	3	1	8

Breakout Table 4 scoring

Areas		Criteria	Committee in Common	3 x Standalone Trusts	Merge 3 Trusts
Quality	i	Delivery of overarching clinical strategies for the region	5	2	7
	ii	Improved outcomes & experience for service users and their families	4	5	7
Sustainability	i	Sustainability of workforce and operations	4	3	6
	ii	Effective decision-making	3	8	7
Deliverability	i	Regulatory and political barriers	2	3	5
	ii	Pace, capacity to deliver and track record of working elsewhere	6	5	6
Finance	i	Affordable in the short term	3	3	3
	ii	Financially sustainable in the longer term	3	2	6

Mid Essex, Southend and Basildon Hospitals

Future Organisational Form Programme Governance

Mid Essex	Southend	Basildon

Trust Board

s
Councils of Governors / Patient Council (MEHT)

JWB

- Overseeing the project and holding the programme board to account for delivery for the delivery of project and timescales (integration and post implementation)
- Communicates vision
- Promotes joint working and shared culture
- Decision-making and resolution of critical issues
- Communication and key stakeholders

Programme Board

Chair of Programme Board NED representative (BTUH) Nigel Beverly	NED representative (SUHT) Mike Green	NED representative (MEHT) Colin Grannell
CEO Clare Panniker	Deputy CEO / CTO Tom Abell (SRO)	Group Director POD / Project Director Danny Hariram
DoS Charlotte Williams	CFO James O'Sullivan	CMO Celia Skinner

- Communicates vision
- Promotes joint working and shared culture
- Review deliverables/drives programme
- Approve internal/external communication
- Prioritisation, objectivity and focus.
- Execute delivery of the plan and oversight of programme delivery group.

Market Assessment Owen O'Sullivan/Veronica Watson	Clinical Strategy Jenny Davis	Legal James Day	Governance Andrew Stride/Brinda Sittapah	Business Case Owen O'Sullivan	Integration Owen O'Sullivan	Business Management Veronica Watson	• Development, testing and implementation of transformation and integration plans
Clinical Operations & Performance Dr Rebecca Martin	Clinical Quality Dr Rebecca Martin	Programme Support/ Governance Adetutu Adeyeye	HR & OD Thenjiwe Ndiweni/ Cathy O'Driscoll/Jane Toplis	Estates Simon Myles	IT Alan Tuckwood	Finance Planning w/cap & FRP Veronica Watson	