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NHS England

Assuring and supporting complex change

Statutory transactions, including mergers and acquisitions

Appendices

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Contents

Appendix 1: Strategic case KLoEs, good practice and red flags

Our strategic case (SC) review comprises three domains – strategic rationale, underlying transaction risk and FBC readiness.

Our review team will explore a number of key lines of enquiry (KLoEs) to determine a rating for each domain and an overall rating. These KLoEs are detailed in the tables below, together with some non-exhaustive examples of good practice and red flags that would likely indicate a red or amber–red rating for that particular KLoE.

Table 1: Strategic rationale

KLoE	Example good practice	Example red flags
S1. Are the ICS and provider challenges that the proposed transaction is seeking to address, as well as opportunities, clearly articulated?	There has been a systematic process to understand and evidence relevant challenges with service delivery in the trusts and ICS. The proposal clearly explains the root causes of major challenges faced by the trusts and ICS. While the wider challenges are set out as context, it is clear which challenges are specifically addressed by the transaction.	There is no clear link between the root causes of challenges and transaction rationale.
S2. Is the transaction rooted in the ICP's integrated care strategy and ICB's five year joint forward plan, and does the ICB support it?	The transacting trusts and system partners have a clear and common view on how the transaction supports the delivery of these strategies and plans. ICBs (across multiple ICSs where materially impacted), support the transaction.	Lack of support from system partners. Evidence that the SC is inconsistent with the integrated care strategy or five year joint forward plan.
S3. Has a detailed, robust options appraisal process been followed that demonstrates why	The SC provides a clear description of: • how the identified challenges have informed the options appraisal	There is limited analysis of alternative options or chosen criteria and weightings are not backed

KLoE	Example good practice	Example red flags
the preferred option is optimal for the ICS?	• how system partners have been engaged in developing options • the range of options considered, including other forms of collaboration, and why the chosen option is preferred to other options. The shortlisting process should be explained, including by setting out why other options have been discarded. There should be a clear methodology and criteria for weighting options and arriving at a conclusion. The criteria should be well reasoned and backed by clear rationale. Shortlisting criteria should include the 'fit' of the organisations, with reference to existing networks and relationships. Appraisals of shortlisted options should include assessments demonstrating the impact on patients, finances, workforce and other stakeholders, where relevant. The options appraisal should have been considered by a balanced panel, including system partners. Panel members should have an appropriate range of skills and experience.	by clear and reasonable rationale. There is a clearly superior alternative to the chosen option that has not been duly considered.
S4. Is the strategic case well-reasoned and does it articulate how the transaction will deliver material benefits to the population?		
S4a. Are patient benefits a core motivation for the transaction?	A focus on patient benefits has been integral to the development of the SC. We have developed further guidance on patient benefits, which we will share on request.	Potential patient benefits have not been considered in sufficient depth.
S4b. Does the case demonstrate that the clinical strategy and integration plans, if successfully delivered, are likely to deliver material benefits to patients?	There is an explicit link between the clinical challenges identified and the clinical strategy. It is clear how the transaction addresses clinical challenges and maximises opportunities to improve care.	Insufficient clinical leadership or ownership of patient benefit plans in the development of the transaction's clinical strategy.

KLoE	Example good practice	Example red flags
	High-level plans reflect national policy and best practice. Clinical leaders have led the development of the clinical vision, strategy and potential patient benefits. We have developed further guidance on patient benefits, which we will share on request.	
S4c. Does the strategic case articulate high-level financial benefits that outweigh the cost of the transaction in the medium term?	The SC highlights the areas where the trust considers that financial benefits are likely to be realised, even if the detailed quantification is to be worked up at FBC stage. The proposal evidences consideration of whether changes to services are likely to lead to financial costs and benefits. Forecast transaction and integration costs appear reasonable at a high level. There is likely to be a net benefit from the transaction for the ICS in the medium to long term.	Insufficient evidence that financial benefits are likely to outweigh costs in the medium term. The ICB is not prepared to manage any transaction funding required within its financial envelope.
S4d. Are there likely to be any other significant benefits arising from the transaction?	The trust has considered how the transaction proposal links into wider estates and workforce strategies, and whether there are opportunities to deliver benefits in these or any other areas. Other benefits could be in relation to workforce or environmental sustainability, for example.	
S5. Does the transaction proposal form part of an ICB strategy that delivers ICS sustainability in the medium term? [Where applicable]	See Section 8.1 of the statutory transactions guidance	It is not clear that the proposed transaction provides the best strategic solution to addressing ICS sustainability issues.

Table 2: Underlying transaction risk

KLoE	Example red flags
R1. Are there any current or emerging unmitigated quality risks in the transacting organisations that are likely to have a material impact on the transaction?	Insufficient evidence of robust action plans and/or reasonable progress to address material quality concerns that could impact the transaction.
R2. Are there current or emerging risks that are likely to result in material financial deterioration in the short term?	Evidence of an underlying financial problem (that may or may not be evident from the reported I&E position). Evidence of material weaknesses in financial governance that could result in financial deterioration post transaction.
R3. Are there any current or emerging risks that could materially impact successful delivery of the transaction and its benefits related to: • current leadership and governance • culture in any of the transacting organisations • staff engagement and support for the transaction • other relevant factors	Material concerns raised about the quality of leadership and/or governance. Significant vacancies at board level or new/inexperienced board members. Existing cultural issues give rise to material concern about the ability of the organisations to come together successfully. Evidence that there is limited support for the transaction from staff at any of the transacting organisations.

Table 3: FBC readiness

KLoE	Example good practice	Example red flags
F1. Is there a clear understanding of the key risks of the transaction at a high level? Has a sufficient, robust due diligence programme been planned to identify risks in further detail?	An indicative risk assessment has been carried out to understand where the trust needs to perform detailed due diligence and which elements should be undertaken internally and externally. Where due diligence will be undertaken internally, there is a clear process for ensuring staff will have capacity to do the work and understand what is required and what needs to be documented.	Due diligence plans lack an appropriate scope or delivery programme based on a robust initial risk assessment.

KLoE	Example good practice	Example red flags
	Robust due diligence programmes have been developed in relation to: • clinical matters • finance • culture • IT • legal • operational, including HR and estates matters • commercial. The rationale for the choice of any external due diligence provider is clearly articulated and well-reasoned. An appropriate timeline has been planned, which includes sufficient time to incorporate the findings from due diligence into detailed integration plans. See Appendix 6 for indicative due diligence scopes.	
F2. Is there a clear process for developing detailed plans for the delivery of patient and population benefits? • Is there a clear, well-resourced programme of work to develop patient benefits detail for the FBC? • Are steps being taken to consider transformative and ambitious opportunities from the transaction to maximise patient benefits?	Plans are being co-developed by clinicians from both organisations. Clinicians are given sufficient and dedicated time to do this. Plan development is supported by dedicated PMO resource and professionals as relevant, eg business intelligence, IT and finance. There is evidence that the patient benefits requirements for FBC stage are well understood and there is a clear programme of activity to meet these requirements. Clinical service leads will be engaged as part of this programme. The trusts have set out how they will look for and examine a broad range of opportunities, to ensure that the proposals are ambitious.	There is limited evidence that the trusts will be able to develop sufficiently detailed and robust plans for delivering patient and population benefits by FBC stage. The proposals put forward at this stage do not demonstrate sufficient ambition, eg there are opportunities for benefits to other system partners that are not being explored.
F3. Is there a clear process f**or** developing detailed plans for the	The SC articulates the next steps the trusts will take to develop detailed plans for the delivery of synergies, including through engaging	High-level plans for synergies are unambitious, eg focusing

KLoE	Example good practice	Example red flags
delivery of financial benefits? • Is there a clear, well-resourced programme of work to develop financial benefits detail for the FBC? • Are steps being taken to ensure the opportunity for financial benefits is being maximised?	clinicians to articulate the financial benefits of clinical transformation where relevant. A finance team member is embedded in integration teams to work up the costs and financial benefits of clinical changes. Where relevant, demand and capacity modelling is planned to understand the impact of the target operating model on beds, theatres and workforce. The SC sets out how the trusts will look for and pursue a broad range of opportunities, including through use of benchmarking and discussion with peers.	only on quick wins such as back office consolidation or procurement savings, rather than savings arising from service reconfiguration.
F4. Are there appropriate structures and processes in place to support the development of the business case, including: • effective transaction governance • identified transaction and integration workstreams • dedicated programme management resource with transaction expertise • plans for engaging patients, public and other stakeholders, including governors	The governance structure includes appropriate and experienced executive sponsors and clinical leadership of integration planning. A dedicated board subcommittee has been set up to focus on the transaction. There is at least monthly reporting up to board and the transaction subcommittee, highlighting the progress of each workstream against an overall timeline and key risks/issues that require executive support to resolve. A dedicated integration function has been set up to develop more detailed plans if the SC is approved. Resource plans for this have been developed to the level of individual roles. Where staff are already in post, they are named in the structure chart. Where roles are currently vacant, the role grading is provided. It is clear how key integration roles will be backfilled to provide BAU continuity. Resource plans clearly demonstrate consideration of what skills are required within the integration function. There is an appropriate balance of internal staff who can implement the planned changes and external expertise, which is brought in only when specialist input is required. (Planning being carried out by trust staff can result in greater	There is insufficient board-level scrutiny of the transaction. It is not clear how issues will be escalated and resolved. There appears to be insufficient experienced resource dedicated to developing the business case and detailed plans. There appears to be insufficient ownership of the transaction delivery plans by internal staff.

KLoE	Example good practice	Example red flags
	ownership of plans and increase the chance of successful delivery.) The SC articulates how the interdependencies between workstreams have been considered and how cross- workstream issues will be managed going forward. Enabling business partners are embedded within workstreams. The level of stakeholder engagement to date has helped to articulate the benefits of the transaction to interested parties. There is a clear programme in place for further engagement if the SC is approved.	
F5. Are there clear plans to engage with staff in the period leading up to the proposed transaction date, and think about culture development?	The SC clearly explains what engagement there has been to date, the major issues highlighted from that engagement and the detailed programme for future staff engagement and cultural due diligence.	There is limited clarity on how staff will be engaged leading up to the transaction. There are insufficient plans to assess the culture of both organisations and start thinking about the culture of the enlarged organisation.
F6. Where successful completion of the transaction and benefit delivery is dependent on other factors (eg capital funding, action by system partners), are there clear plans in place to secure these?	NB There should be no assumption that central funding will be available for transactions.	Evidence that financing required for the transaction to proceed is unlikely to be secured.
F7. Have the trusts involved sought legal advice on the transaction, with no indicators of risk that the transaction could not legally proceed?		

Appendix 2: FBC KLoEs and good practice

Our full business case (FBC) review comprises three domains – quality and patient benefits delivery, integration delivery and finance.

Our review team will explore a number of key lines of enquiry (KLoEs) to determine a rating for each domain and an overall rating. These KLoEs are detailed in the tables below, together with some non-exhaustive examples of good practice.

Table 1: Quality and patient benefits delivery

KLoE	Example good practice
Q1. Does the case feature a clear narrative which links the strategic rationale for the transaction, the overall vision for the merged organisation and the clinical strategy to detailed service-level plans?	We have developed a separate good practice guide for planning patient and population benefits – this is available through our FutureNHS transactions site, which we will provide access to for trusts undertaking transactions.
Q2. Have the trusts adequately explored opportunities for benefits to patients, service users and the public?	
Q3. Has there been a robust prioritisation process for improvement and integration and is there also a clear programme of work to plan for lower priorities?	
Q4. Does the case include detailed service-level proposals as well as cross-cutting benefits that are likely to lead to demonstrable improvements in quality of care for patients and the public? • Is there clear articulation of the challenges faced by existing services and how they impact patients? • Is the case accompanied by proposals for improvements to services and patient pathways that will address these challenges?	

• Do proposals set out and evidence how these improvements will benefit which patients, in what way and by how much?	
Q5a. Have clear and comprehensive implementation plans been developed for patient benefits in the submitted proposals?	
Q5b. Are the proposals likely to be successfully implemented within a reasonable timeframe?	
Q6. Has thorough clinical due diligence been undertaken which provides a sufficient understanding of the quality risks associated with the transaction and inherent in the transacting organisations?	See Appendix 6 for indicative due diligence scopes.
Q7. To what extent are existing quality risks that are likely to have a material impact on the transaction mitigated?	Robust plans, with clear ownership, are in place to mitigate areas of significant risk.
Q8. To what extent are there mitigations to potential quality risks arising from the transaction? • Do current and planned quality governance arrangements provide confidence that ongoing quality risks will be appropriately managed? • Are there appropriate mitigations in place in relation to the quality risks of the transaction identified through due diligence and other means? • Has there been robust and effective planning of the new clinical governance structure, and is there a safe transition plan in place?	See Appendix 4 for indicative quality governance scope and good practice.

Table 2: Integration delivery

KLoE	Example good practice
I1. Is there a comprehensive overall plan setting out the required actions to complete the transaction, integrate the organisations and transform services? • Does the plan contain the expected elements? • Are the milestones deliverable within the stated timeframes? • Does the plan have a sufficient level of detail?	See Appendix 3 for guidance on PTIP content.
I2. Is a well-planned culture development and staff engagement programme in place? • Is there an adequate understanding of the cultures of both organisations, resulting from thorough cultural due diligence? • Is there a robust and detailed plan to develop the desired culture for the enlarged organisation? • Has communication and staff engagement been effective and are there robust plans for future engagement?	We have developed a separate good practice guide in relation to culture and staff engagement – available through our FutureNHS transactions site, which we will provide access to for trusts undertaking transactions.
I3. Is a well-planned digital integration programme in place? • Is there an adequate understanding of the risks and opportunities of digital integration from robust IT due diligence? • Has there been robust planning in relation to the digital requirements of the new clinical and operating model? • Are there safe and deliverable plans in place for the transition of key systems? • Are the costs of transition (including capital) and funding sources clear?	We have developed a separate good practice guide in relation to digital integration – available through our FutureNHS transactions site, which we will provide access to for trusts undertaking transactions.
I4. Has there been a robust consideration of an appropriate operating model for the	There is a clear articulation of what the future operating model will be, as well as any transitional model if applicable.

KLoE	Example good practice
enlarged organisation, based on factors including: • enabling delivery of transaction benefits • enabling strong organisational performance • achieving the desired culture for the enlarged organisation.	Trusts have sought views on the positive and negative elements of their current organisational forms. There is no right or wrong model, but trusts should have considered the pros and cons of various options – eg in relation to central decision-making and standardisation versus local autonomy and ability to manage BAU performance and oversee the delivery of transaction benefits. The current cultures of each transacting organisation have been considered. It is clear how the future model reflects the intended vision and values of the enlarged trust.
I5. How effectively will staff be able to deliver the change required to transform services after the transaction? For example: • Do staff have the tools, capacity and knowledge to deliver change programmes? • Does the culture and governance of the existing organisations support an environment in which staff feel empowered and enabled to deliver change?	Staff feel ownership to help design and deliver elements of the transaction relevant to their role. Governance processes support effective decision-making in relation to transformation. Staff are supported to be involved in the change through being given appropriate training and having sufficient time freed up.
I6. Has there been an appropriate level of planning for any other enablers that are critical to successful delivery of the transaction?	NB as part of this test we will follow-up on any key interdependencies identified at strategic case stage under strategic case KLoE F6 (FBC readiness).
I7. Have any red flag issues previously raised been adequately addressed?	
I8. Has a robust programme of due diligence been carried out, consistent with the plan set out at strategic case stage?	See Appendix 6 for indicative due diligence scopes.
I9. Are there any major transaction risks, raised from due diligence or other sources, that are not covered by other KLoEs, and have these been mitigated appropriately?	

KLoE	Example good practice
I10. Are there effective structures and processes in place to manage integration and support the delivery of benefits? • Is the transaction governance structure operating effectively, supported by dedicated resource where appropriate? • Is there an effective ongoing process for managing transaction risk, including those identified through due diligence? • Is there sufficient capacity and robust processes in place to mitigate the risk of BAU deterioration due to focus on the transaction? • Are there effective processes in place to monitor the delivery of benefits?	**Transaction governance and resource:** • The plans contain details of how information flows effectively from workstream level up to the trust board, usually through a transaction committee or equivalent. It should be clear how this will operate post-transaction too. • All relevant internal stakeholders should be represented in governance arrangements, showing a clear multidisciplinary input. For some forums external input may be appropriate, eg from relevant ICB leaders. • There should be executive-level sponsorship for all workstreams. **Managing transaction risk:** • There are clear processes for the escalation of issues. • There is a transaction risk register that shows significant risks that arise as a result of the transaction. • Transaction risks are allocated to transaction workstreams, such that there is clear ownership of each, with progress against mitigating actions tracked. **Capacity:** • Trusts have undertaken a robust process to identify transaction resource needs and put these in place. This should be in relation to supporting the programme of work up to the transaction date and also for the implementation of benefits in the longer term. • Many trusts avoid significant use of external resource as it can reduce the ownership of plans felt by staff. Where external resource is used, trusts need to set out how they will ensure ownership of the necessary work by trust staff once the temporary resource is no longer available, including by taking steps to ensure effective, lasting knowledge transfer to the relevant teams to enable ongoing delivery of benefits.

KLoE	Example good practice
	Processes to monitor benefits: • There are robust governance and processes for monitoring benefits. This should include, for example, ongoing management resource and capability, executive sponsorship, multidisciplinary involvement and processes for escalation and resolution of issues. • There should be an agreed set of quantitative and qualitative measures in place to assess delivery of benefits.
I11. Will the board of the enlarged trust and senior management have the capability, capacity and experience to deliver the transaction successfully and lead the trust? • Is there an appropriate mix of skills, knowledge, diversity and experience, including integration experience, to lead the new organisation? • Is there any available intelligence suggesting a risk of loss of key members of the board or senior management? Are there credible succession plans in place? • Is there a good working relationship between the board and local stakeholders? • Has there been sufficient consideration of how the board and management will have sufficient capacity to manage competing priorities? • Is there a clear rationale for any proposed changes to the board, committee structures and governance processes for the enlarged organisation, and have such changes been properly planned and communicated?	**Board skills, knowledge, diversity:** • The board has considered whether its existing skillset will remain appropriate for the enlarged trust and its range of services. The NHS Leadership Academy has published guidance on building effective trust boards. • Trust plans show that the trusts have considered, for example, the size of the board, the executive/non-executive director split, structured induction processes and opportunities for board members to build their capability. • Diversity: The board should ideally represent the population it serves. If it does not, the trust should have a sense of this and whether it has plans to change this. The Commissioner for Public Appointments provides guidance on this, including how to generate interest in positions, where to advertise, encouraging applications from under-represented groups and managing the interview process. • Trusts have considered the skills of existing executive and non-executive directors and mapped these to the needs of the enlarged trust, as well as the shorter-term needs for transaction execution. There should be plans in place to address any gaps, including through temporary appointments where appropriate. • The risk of the loss of corporate memory has been factored into appointment considerations. **Succession planning:**

KLoE	Example good practice
	• The guidance here sets out steps for creating a robust plan, including identifying the critical roles, identifying readiness of successors, creating a plan, mitigating risks and regularly reviewing the plan. • It is worth noting that if the success of a transaction depends on a small number of key individuals, it could indicate concerns about the resilience of the organisation as a whole. **Board and local stakeholders:** • Trusts should demonstrate that they have engaged with (not just informed) local stakeholders in a transparent manner from early in the transaction process, provided them with sufficient and timely information and taken their views into account. **Board and management capacity:** • Board members should be able to articulate how delivery of transaction benefits will be managed alongside other priorities, and how they will ensure they are able to make time for integration work. • The board should have considered any support needs as it progresses with transaction execution and then integration and benefit delivery, such as buddying. **Changes to governance:** • There should be a clear justification for any significant changes to board and committee structures and processes and communicate these in an informative and timely manner.
I12. Are the council of governors (CoG) appropriately sighted on the organisation(s) and the transaction? • Is there an appropriate level of interaction between the board and CoG? • Does the CoG understand its responsibilities in relation to the organisation(s) and the transaction?	Trust boards and CoGs should be aware of the following: • CoGs should not unreasonably withhold their consent for a significant transaction to go ahead. They should consider the implications of withholding consent in terms of the key risks the transaction was designed to address. • Governors need to be assured that the process the board undertook in reaching its decision was appropriate, and that the

KLoE	Example good practice
• Have sufficient steps been taken to ensure there will be a fully-functioning CoG post-transaction?	interests of the 'public at large' (ie not just the individual organisation) were considered. • In the context of the NHS's new operating model, this means that CoGs may well be expected to provide consent for decisions that benefit the broader public interest while not being of immediate advantage to, or creating some level of risk for, the individual organisation. Trust boards should assure themselves that governors are aware of the above, as well as other relevant guidance and legislation concerning their role. The board should be able to demonstrate to the CoG that transaction proposals have been subject to robust non-executive scrutiny. The board should keep the CoG sighted on key transaction developments, in a transparent manner, from an early stage. The board(s) should be listening to feedback and be able to provide evidence that it is being given due consideration. Trusts should be able to demonstrate that they have taken steps to ensure a representative post-transaction CoG, covering the three constituencies (public, appointed and staff). This may include benchmarking to comparator local trusts, analysis of geographical distribution of members and patients, and assessing strengths and weaknesses of different composition options. Guidance for governors is available here.
I13. Is there a clear articulation of how system partners will work together to ensure the successful delivery of the transaction and the realisation of anticipated benefits?	Good practice in this area is likely to develop as ICS architecture continues to evolve. Benefits of the transaction can be for the wider population as well as trusts' patients, so broader working across the ICS will be increasingly necessary. We will expect a clear articulation of the role of the system (ICB/ICP leadership, other providers in the ICS, primary care, etc) in delivering transaction benefits, eg clarity about who is delivering what and an ICS-wide oversight mechanism to hold

KLoE	Example good practice
	organisations and individuals to account for delivery.
I14. Have all regulatory and legal requirements (including NHS England self-certification) been met? • Has an appropriate consultation process been undertaken, if required? • Have trusts complied with the Public Sector Equality Duty (PSED) in relation to the transaction? • If a revised/new constitution is applicable for the enlarged organisation, has it been provided and does it meet all legal requirements? • Are there sufficient plans in place to obtain appropriate governor approval? • Are there plans in place to grow a representative membership? • Will the post-transaction trust board maintain a register of interests and are no material conflicts of interest anticipated for the post-transaction board? • Have commissioners confirmed any changes to commissioner requested services (CRS) arising from the transaction?	NB guidance in relation to the council of governors is included under I12 above.
I15. Have any material risks raised by legal due diligence been appropriately mitigated?	

Table 3: Finance

KLoE	Guidance notes
F1. Do the deliverable financial benefits of the transaction outweigh the costs of the transaction over the medium term?	See Section 8.1 of the statutory transactions guidance.
F2. Have the trusts adequately explored opportunities for financial benefits?	Has there been a robust process to identify potential synergies/financial opportunities?

	Are there potential benefits identified which have been considered but excluded from the forecast plan? Are there any clear benefits that have not been considered?
F3. Is the risk of material short-term financial deterioration sufficiently mitigated?	See Section 8.1 of the statutory transactions guidance.
F4. To what extent is the expected year 1 financial deterioration mitigated in the medium term?	See Section 8.1 of the statutory transactions guidance. This KLoE is only required if we anticipate a material financial deterioration in year 1.
F5. Are there any material changes to our assessment at strategic case stage of whether the transaction proposal forms part of an ICB strategy that delivers ICS sustainability in the medium term?	See Section 8.1 of the statutory transactions guidance.

Appendix 3: Submission guidance

Indicative content guidance for a strategic case (SC)

The SC needs to set out the strategic rationale for the transaction, outline the risk environment and set out the next steps should the proposal proceed to the next stage.

Table 1 below provides suggested content for the SC. This guidance is only indicative and based broadly on the structure of our assurance approach; trusts and ICSs should determine the SC structure and scope based on their own needs and the characteristics of the transaction.

Table 1: Indicative strategic case content

Area	Suggested content
Strategic rationale	• ICS and provider challenges that the transaction is seeking to address. • The link between the proposed transaction, integrated care strategy and five year joint forward plan. • The anticipated benefits of the transactions – including for patients, the wider population, workforce, finances, etc. The case must demonstrate that patient benefits are central to the transaction's purpose. • A summary of how system partners have been engaged in developing the proposals, and how feedback has been considered and incorporated into plans. • An options appraisal demonstrating that a range of options has been considered, describing the shortlisting process and setting out clearly why the chosen option is optimal for the ICS(s). • Where relevant, an explanation of how the transaction supports an ICB strategy to achieve financial sustainability.
Underlying risk	• Any material current/emerging quality, financial, governance or other risks that are relevant to the successful execution of the transaction and delivery of the planned benefits. • Details of how these are being mitigated or expected to be mitigated, where appropriate.

Area	Suggested content
FBC readiness	• A timeline for the key activities needed to develop a robust FBC. • Outline of the due diligence programme to be undertaken, including a risk assessment supporting a risk-based approach, clarity on scope and details of what will be undertaken internally versus externally (and why). • An initial view of material risks that may arise in relation to the transaction's successful execution. • A description of the process that will be undertaken to develop the detail needed for an FBC and PTIP, including: – how detailed benefit proposals and implementation plans will be developed (including resourcing, securing adequate clinical involvement, the process to ensure opportunities have been adequately explored) – the governance structure that will ensure adequate oversight of transaction development – the programme management structure and resourcing – plans for engaging staff and other stakeholders – plans for understanding the cultures of each organisation and the programme of work to consider cultural development for the enlarged organisation. • Reference to interdependencies (including with other assurance processes such as service change and capital) and how these will be managed. • A summary of any relevant legal advice received.

Indicative content guidance for a full business case (FBC) and post-transaction integration plan (PTIP)

The FBC is a formal document setting out the detailed case for change. The FBC should detail the benefits that will derive from the transaction, identify key risks and set out the resources and processes in place to ensure a safe landing and the achievement of intended benefits.

The PTIP needs to explain the process of bringing the transacting parties together, from their current state to the integrated single entity post-transaction. The PTIP should be regarded as a 'living' document which provides a valuable reference point for how the trusts will achieve a safe transition but also continue to integrate and deliver the intended benefits post-merger.

Robust due diligence is critical to the development of the PTIP. Each area of the PTIP should clearly build on relevant due diligence and demonstrate how the findings from this exercise have informed the design and planning of structures and processes at the enlarged trust, as well as how key risks have been mitigated. For example, plans for new quality governance structures should clearly demonstrate they are based on robust clinical due diligence and articulate how clinical risks have been addressed.

Put simply, the FBC describes the 'what' for a transaction; the PTIP describes the 'how'.

Table 2 provides suggested content for both documents. It is designed to capture the key elements of our assurance process, but also to illustrate the difference between the purpose of an FBC and PTIP. This guidance is only indicative; trusts and ICSs should determine the FBC and PTIP structure and scope based on their own needs and the characteristics of the transaction. Trusts should also make reference to the key lines of enquiry set out earlier in Appendix 2, and ensure that the cases and supporting documents adequately respond to them.

The information required does not necessarily need to be provided within the FBC or PTIP – for example, detailed patient benefit delivery plans or a strategy for cultural development may exist as separate documents. This does not present a problem for our assurance work as long as the FBC and PTIP have a coherent narrative and reference key documents as necessary.

Table 2: Indicative FBC and PTIP content

Area	Full business case (FBC)	Post-transaction integration plan (PTIP)
Quality and patient benefits		
Patient and wider benefits	• A clear narrative linking trust and ICS challenges with the overall vision for the enlarged trust and clinical strategy. • Details of the expected benefits for patients and the wider population, including key assumptions and dependencies. This should incorporate detailed service-level or cross-cutting proposals, although trusts may instead choose to	• Clear, thoughtful and comprehensive patient or population benefit implementation plans for each proposal, demonstrating: – how these benefits will be realised including senior clinical leadership/ownership, KPIs, risks, mitigations, and timelines – description of how benefits delivery will be prioritised and the

Area	Full business case (FBC)	Post-transaction integration plan (PTIP)
	reference through to separate documents. • Description of how benchmarking and other information has been used to explore opportunities for benefits. • A high-level overview of the prioritisation process (with detail in the PTIP). • Summary of any quality and equality impact assessment implications. **More detailed guidance is available and will be shared with trusts undertaking transactions.**	timescales for each level of priority – any dependencies on future funding sources or approvals requirements, eg for a capital build, refurbishment or digital infrastructure – plans for any further consultation that may be required to support service reconfigurations and steps being taken to manage this process – delivery risks and mitigations. • Clarity on roles and responsibilities for implementation, including the role of system partners where applicable.
Quality risks	• Summary of key quality risks and mitigations relevant to the transaction, eg arising from clinical due diligence, recent CQC inspections, etc. This should include existing quality risks and those that may arise as a result of the transaction. • Summary of proposed quality governance structure and processes for the enlarged organisation.	• Detailed rationale for proposed quality governance structure and processes for the enlarged organisation, based on clinical due diligence. • Plans for how quality governance systems will be integrated where applicable (eg patient experience, complaints and serious incident reporting arrangements). • Plans for addressing relevant quality issues raised in due diligence, CQC inspections or other sources. • Clear differentiation between day 1 mitigating actions required for safe transition and those requiring ongoing post-transaction governance. • Key quality governance policies and processes to be harmonised.
Integration delivery		
Implementation timeline		• Timing and status of key transaction workstreams and objectives or milestones material to the plan to integrate the organisations and

Area	Full business case (FBC)	Post-transaction integration plan (PTIP)
		deliver the benefits. This should include key milestones pre-transaction and at day 1 and, for example, day 100, as well as other dates relevant to the critical path.
Structure, governance and roles	• Proposed governance structure for the combined organisation including interim/shadow board and its subcommittees, and rationale for changes from current structure. • Appointment plans for key senior roles, with a clear plan to recruit to any unfilled positions by day 1 (or mitigations if they cannot be filled). • Proposed operating model for the enlarged organisation, including the rationale for this choice and other options considered. • Consideration of board and management capacity to manage the transaction in addition to competing BAU priorities. • Outcome of assessment of knowledge, skills and diversity of proposed enlarged board and plan to address any gaps. • Details of the programme structure and resources for the pre-transaction phase.	• Details of how roles and reporting lines will be structured in the enlarged organisation. • Roles/responsibilities for PTIP delivery within the board of directors and post-transaction management team. • Details of how the programme structure and resources will change for the post-transaction phase to support integration and benefits delivery. • Details of any additional governance measures implemented to oversee integration and benefits delivery. • Outline of the role ICS governance will play in supporting and overseeing benefits delivery. • Key HR policies and processes to be harmonised
Risk management	• Summary of key transaction risks including their magnitude, nature, likelihood and mitigation, and escalation strategy, including alignment to transaction workstreams and executive-level sponsorship. This should include reference to existing organisational/ICS risks as well as those arising from the transaction, including as identified in due diligence.	• Allocation of post-transaction risks to workstreams with clear ownership and progress tracking. • Description of the process and governance structures in place for managing post-transaction risks. Key risk management policies and processes to be harmonised.

Area	Full business case (FBC)	Post-transaction integration plan (PTIP)
	• Description of the process and governance structures in place for managing transaction risks.	
Legal and regulatory	• Summary of any legal risks identified arising from the transaction, with mitigations. • Details of consultation processes undertaken, if required. • Compliance with Public Sector Equality Duties (PSED) in relation to the transaction. • Summary of any major changes from the previous constitution. • Summary of any changes in commissioner requested services (CRS). • Where applicable, arrangements for obtaining governor approval. • Arrangements for the post-transaction trust board to maintain a register of interests and confirmation that there are no material conflicts. • Where applicable, plans for growing a representative council of governor membership, including timetable for elections.	•
Cultural integration	• Details of any internal or external cultural assessments undertaken. • Consideration of any cultural concerns raised by staff engagement, check-in/pulse surveys or recent CQC inspections. • Details of the outcome of work undertaken to understand current cultural differences and consider what is required for the enlarged organisation. This should include: – a shared vision and set of values and behaviours – clarity on where the aim is to align cultures and where there is	• Cultural change management strategy providing detailed and robust plans for developing the desired culture for the enlarged organisation, including details of: – plans for embedding a single vision, set of core values and behaviours, and gathering feedback and responding to concerns – ongoing actions to address any identified cultural concerns • How success of cultural development will be measured and assessed.

Area	Full business case (FBC)	Post-transaction integration plan (PTIP)
	benefit to keeping them distinct (and why). **More detailed guidance is available and will be shared with trusts undertaking transactions.**	• Resourcing plans ensuring availability of experienced staff representative of various grades and services.
Engagement	• An overview of how staff have been communicated with and engaged regarding the proposals and how issues raised have been addressed. • Details of consultation and engagement activities with other key stakeholders such as trust governors and local MPs, including details of feedback and how this has been incorporated into proposals. **More detailed guidance is available and will be shared with trusts undertaking transactions.**	• Continued engagement requirements for staff, patients, system partners and other groups.
Digital integration		• Details of work carried out to understand current systems across transacting organisations. • The opportunities that the transaction creates for improving digital infrastructure and/or reducing cost. • Proposals for integrating (or not) key systems, including performance reporting, health records, risk management, staff records and financial ledger. To include clarity on what must be implemented for day 1. • IT integration prioritisation with phased implementation plan; considering the urgency of integration and resources available. • Resourcing plans for integration delivery alongside BAU, including delivery of staff training needs in a timely manner. • Key digital policies and processes to be harmonised.

Area	Full business case (FBC)	Post-transaction integration plan (PTIP)
		More detailed guidance is available and will be shared with trusts undertaking transactions.
Change management	• An assessment of current organisational capability for managing the complex change that will be needed for integration, and how any gaps are being addressed.	• Details of how the required change programme will be managed and resourced.
Finance		
Transaction benefits and costs	• Details of financial benefits expected to derive from the transaction, including assumptions and dependencies. • Analysis/benchmarking carried out to support benefits identification, including the rationale for any opportunities not pursued. • Details of the costs expected to be incurred to complete and implement the transaction, including the assumptions and methodology used to calculate them and timings (annual phasing). • A summary of what the transaction's financial impact means for the overall financial position of the enlarged organisation in the medium term, and for the ICS. • Details of how any funding requirement will be met from trust or ICS resources.	• Financial benefits realisation plan describing how they will be delivered – timing and prioritisation, resourcing, risks, how benefits will be measured, etc. • Key financial governance policies and processes/financial controls to be harmonised

Appendix 4: Indicative quality governance review scope

Domain 1: Leadership and behaviours

KLoE	What good looks like
QG1. Is there a robust understanding of the services offered by the new organisation?	• Boards conduct a self-assessment of skills and background to ensure coverage all areas of business in the enhanced organisation. • Board and quality committee development sessions support understanding of new enhanced organisation. • Non-executive director (NED) induction covers outline of new services. • Members understand their portfolios and have the skills to deliver them.
QG2. Does the board give the quality agenda sufficient attention? Is this well-balanced against other priorities?	• Quality is covered by the full board. • NEDs not sitting on the quality committee have access to monthly quality/performance reporting, which is discussed formally in reasonable detail at every board meeting. • Quality/performance reporting allows for granular visibility of poor performing areas/services. • NEDs find opportunities to engage with staff and patients/service users to gain 'soft intelligence' regarding challenges within the organisation.
QG3. How will the quality agenda continue to be balanced post-transaction?	• Balance of discussion reflects the new span of services, but with appropriate focus on key risks and challenges. • Agendas allow for bottom-up escalation of significant risks as well as strategic/top-down focus.
QG4. Is there high quality assurance-focused discussion and challenge in forums where quality is discussed?	• There is a culture of challenge and asking questions. • Regular self-assessments to test skills and capabilities; and succession plans are in place to ensure they are maintained. • Members have attended training sessions covering the core elements of quality governance and continuous improvement.

	• The capabilities required in relation to delivering good quality governance are reflected in the make-up of membership.
QG5. Does the board play an active leadership role in quality, including setting a tone for a compassionate and just culture?	• The board takes a proactive approach to improving quality. • The board's behaviour and challenge embeds the trust's risk appetite. • There is a programme of leadership visits to the clinical areas, and this is fed into the governance processes. • Board members are identified as executive sponsors for local quality issues. • Divisional management can demonstrate visibility and support of the board in their quality improvements.
QG6. Do board/senior management understand current and future quality risks? Has the organisation's risk appetite been clearly defined and used to inform the risk management strategy?	• Explicit discussion of the board's risk management appetite which links to the identification and escalation mechanism. • Board/senior management have a detailed understanding of quality risks and actions being taken to address them. • Clear alignment of the Board Assurance Framework and quality strategy • Surveillance or performance tracking system enables timely intervention to address deteriorating or poor performance. • Directorate/service risk registers reflect operational risks.
QG7. Are actions taken in a timely way in response to identified risks, quality concerns or issues?	• There is clear evidence of action to mitigate risks and resolve clinical audit concerns. • Action plans address the material issue and lead to sustainable change. • There is evidence of rapid resolution of significant risks and the board requesting assurance that actions are embedded. • The board is assured that actions once delivered are having the desired effect on performance. Failure to complete actions without good reason is not accepted.

Domain 2: Data and reporting

KLoE	What good looks like
QG8. Will the new board be presented with effective quality information?	• An integrated performance report (IPR) should allow comparison and triangulation across quality, performance, workforce, productivity and finance metrics. • Planned reports are appropriately focused, drawing board attention to key issues • There is a clear strategy behind plans to integrate data across the two organisations, which links to the board's identified risk appetite. • The IPR includes a monthly 'dashboard' of the most important metrics for review by the board. Qualitative commentary is provided to explain quantitative information. • The dashboard is analysed and challenged as appropriate.
QG9. How will the board be assured of the robustness of the quality information?	• There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness. • Each directorate/service has a well-documented, well-functioning process for clinical governance that assures the board of the quality of its data. • Electronic systems are used where possible, generating reliable reports with minimal ongoing effort. • Issues with data quality raised by internal audit or clinical due diligence are clearly addressed in the PTIP. • There is a comprehensive clinical audit programme.

Domain 3: Structures and processes

KLoE	What good looks like
QG10. Are there defined lines of accountability into directorates and services from day 1 onwards?	• There is clear understanding of roles and responsibilities, line management and the scope of accountability at every level in the new structures. • Clinical business unit leadership responsibilities are linked through to a clear performance and accountability framework that in turn links to escalation criteria in the risk strategy. • There are plans for key senior posts, including executive leaders of quality, quality committee chair and head of quality governance to be recruited into by day 1, and clear mitigations should this not be achieved.

KLoE	What good looks like
QG11. Will there be clear and effective governance processes that allow issues to be escalated when issues are identified?	• There is a lean and effective governance framework that allows a clear line of sight from the clinical services to the trust board, which includes clear quality governance meetings at a clinical business unit level. • There is a culture of transparency so that people are comfortable about raising concerns and the Freedom To Speak Up guardian is well known.
QG12. What additional governance measures is the trust putting in place over and above BAU to ensure a safe transition to the new organisation?	• The PTIP clearly sets out additional governance measures, informed by risks identified in the clinical due diligence or by other means. • The trusts have put in place additional OD programmes to manage cultural or process differences associated with, for example, multi-site governance.

Appendix 5: Indicative financial governance review scope

Domain 1: Leadership and behaviours

KLoE	What good looks like
FG1. Does the board give the financial agenda sufficient attention?	• The finance agenda receives appropriate attention at board meetings (public and private) and board seminars, to provide sufficient visibility of financial matters. • Non-executive directors (NEDs) not sitting on the finance committee have access to the monthly finance report. • NEDs find opportunities to engage with staff to gain 'soft intelligence' regarding pressures within the organisation, eg chairs of the audit and finance committees periodically meet members of staff from the finance department to gauge sentiment.
FG2. Is there a high quality of discussion and challenge in forums where financial performance (including CIP delivery) is discussed?	• There is a culture of challenge and asking questions. Board members should be satisfied that they are provided with an appropriate level of assurance with regards to the matter at hand, ensuring that responses are not limited to reassurance. • Board members can clearly articulate financial risks, including risks to achieving the annual financial plan, and mitigations. • Board and finance committee members have an appropriate mix of skills and experience. Financial training is provided to executive directors and NEDs where required. • Executives other than the finance director are engaged in financial discussion.
FG3. Is timely, appropriate action taken in response to identified finance risks?	• Board members and senior managers have a detailed understanding of financial challenges and actions being taken to address them. • Actions agreed in meetings are recorded and followed up in subsequent meetings. Failure to complete actions without good reason is not accepted.

Domain 2: Reporting

KLoE	What good looks like
FG4. Does reporting to the board and finance committee clearly present the financial position and risks?	• Finance reports clearly show: – a reconciliation between the reported and underlying position – the use of reserves – current and historical cash position and rolling 12-month cash forecast – BPPC compliance and debtor/creditor days – divisional variances against budget, and forecast outturn – agency and bank spend versus budget, and forecast outturn – progress with CIP delivery, and forecast outturn. • The above are accompanied by narrative giving insight into the underlying drivers of trends (explaining, not describing). Reports clearly set out the 'so-what', risks and mitigations, and a clear forecast. • The board finance report includes a more concise dashboard summary of the key issues/risks than the finance committee report. • Planned format of finance reports for the enlarged organisation represents the expected practice above. There is clear separation between CIP and synergy reporting, to avoid issues of double counting.

Domain 3: Financial planning and delivery

KLoE	What good looks like
FG5. Is there a robust process in place to develop the Y1 financial plan?	• The plan is based on a clear understanding of the underlying position of both trusts. • Evidence of cross-trust working to develop the plan in an integrated manner. • Evidence that service and financial planning are integrated, with extensive service/divisional input into the planning process. • The planning process seeks a robust understanding of resource requirements by speciality, including for service developments enabled by the transaction. This should be used to inform the activity baseline as well as highlighting potential synergies. • Appropriate resource is dedicated to costing the estates requirements, digital enablers and other infrastructure underpinning the transaction strategy.

KLoE	What good looks like
	• Cash as well as income and expenditure impact has been considered. • Assumptions are aligned with NHSE planning guidance, or any exceptions are clearly justified. • Evidence that planning is based on appropriate data and metrics. • The plan has been properly scrutinised and signed off by the Finance Committee(s) (or equivalent) and Board(s).
FG6. Does the trust have an effective finance and support function (PMO or equivalent) to support delivery of efficiency programmes?	• The finance team and programme support functions are viewed favourably by the users of those teams and are perceived as adding value.
FG7. Is there real ownership of financial performance and improvement among staff responsible for delivery?	• Divisional management feels accountable for financial performance and efficiency/transformation schemes. • All staff see themselves as having a role in financial delivery rather than viewing it as the job of the finance team.
FG8. Are there effective escalation procedures when issues are identified (including non-delivery of financial plan/CIPs)?	• Material financial risks and issues can be tracked from divisional reports through to the finance committee and, if necessary, the board.
FG9. Are there any current material weaknesses in financial controls that could impact the transaction's success? **Are there adequate plans for controls in the enlarged organisation?**	• Sources of assurance on financial control, including internal and external audit, have not raised any material concerns.

Appendix 6: Due diligence guidance and indicative scopes

This appendix covers the scope for a range of due diligence activities that would typically be undertaken as part of a transaction. The exact scope will depend on many factors, including the size, type and complexity of the transaction and the nature of the risks involved.

The purpose of due diligence is to identify areas of risk, so that trusts can decide whether to proceed with the transaction and, if so, take action to mitigate these risks as part of integration planning. It should not be treated as a tick-box exercise; it is a critical part of gaining a thorough understanding of the organisations involved in the transaction.

The due diligence programme for a transaction should be informed by a risk assessment that seeks to identify which areas require the most focus so that resources can be prioritised. Trusts will need to consider the value of assurance for each of the areas listed below against the time and money cost of completing the work.

Third-party providers can be used to deliver due diligence work, but this is not essential. Insight and understanding can be obtained in other ways, eg through a management support agreement, joint appointments or less formally. Experience from across the NHS suggests that these approaches, perhaps with some supplementary and targeted third-party assurance, offer a more comprehensive and less expensive way of understanding culture, issues and risks.

There is some benefit to carrying out elements of due diligence in-house: this can help increase understanding and ownership of any issues identified. Those completing the diligence must understand the purpose of the work and be given the tools and time to be able to carry it out effectively.

Due diligence must be completed early enough that the outputs can feed into integration planning. We will expect the full business case (FBC) and post-transaction

integration plan (PTIP) to reference relevant due diligence findings and how they will be addressed.

Please note that this guidance is not exhaustive and trusts should make their own judgement about the extent of the due diligence needed, depending on their view of the risks inherent in the transaction.

Indicative clinical due diligence

Clinical due diligence requirements can be met and resourced internally and externally.

Governance systems

The due diligence should include a review of current and proposed systems of corporate governance and reporting. Examples of information for review include:

- board committee structures
- subcommittees (in particular, the level of scrutiny and operational effectiveness)
- key risks as identified on the 'board assurance framework'/corporate risk register and assurance that these are effectively mitigated with action plans for effective control
- performance management of quality priorities and their alignment to strategic objectives
- the level of devolvement of governance arrangements to business units
- how information flows from operational business to corporate governance structures/trust board and back
- quality performance information, for example:
  - clinical audit plan
  - patient safety/incident reports
  - serious incident performance (including Never Events)
  - responsive action plans and assurance reports demonstrating learning from investigations
  - infection control reporting
  - safeguarding reports
  - national surveys

  - ward-to-board quality and key performance reporting, including hospital standardised mortality rates, patient/user experience (Friends and Family Test), incidents, complaints, staffing levels, sickness absence, training and appraisals
  - Commissioning for Quality and Innovation (CQUIN) performance
  - quality account
- work performed to implement the NHS Outcomes Framework
- patient outcomes monitoring process, including implementation and effectiveness of early warning systems, and the risks to meeting performance targets
- analysis of patient outcomes performance and resultant recommendations and action plans to address issues
- consideration of plans to manage the patient outcomes monitoring process in the new organisation
- processes for collation and monitoring of acuity/staffing, reviewing most recent National Quality Board publication of data where available
- peer review processes
- details of any governance arrangements for integrated care working and how this feeds into the trust's own processes
- details of any current independent enquiries into clinical issues at the trust
- outstanding action plans for third-party inspections
- processes for the management of clinical negligence claims (identification of alleged clinical medical negligence claims as part of legal due diligence – see below); links to the serious incidents process and performance as reported by the NHS Litigation Authority
- trust's management of coroner's inquests
- links to the serious incident/claims process and any active 'Prevention of future death' reports and how these are being processed
- clinical records management and information governance systems and processes.

Patient and user experience:

- systems for capturing complaints, patient advice and liaison service (PALS), litigation and any trends analysis performed (to include those named in

complaints to enable consideration of any necessary supporting action, eg clinical practice)

- review of complaints, trends identified, demonstrable learning action plans/re-open rates (that is, organisation culture of response)
- numbers referred and upheld by Parliamentary and Health Service Ombudsman
- any ICB/ICP/GP/primary care-specific concerns
- patient experience surveys and patient feedback
- how users and stakeholders are involved in defining priorities for quality account.

Regulatory and compliance:

- compliance with our Oversight Framework governance indicators, and plans to address areas of underperformance
- Care Quality Commission (CQC) registration (and any conditions applied), reports of recent CQC review visits and resultant action plans/outstanding actions, results of CQC healthcare intelligence monitoring including respective action plans/outstanding actions
- compliance and/or implementation plans to comply (and status) with National Institute for Health and Care Excellence (NICE) guidance
- evidence of compliance with key mandatory training, eg safeguarding, resuscitation and demonstrable compliance with local policies (workforce)
- statutory and mandatory training attendance figures (workforce)
- mandatory safeguarding training levels (particularly level 2 – key staff with enhanced responsibilities) and evidence of compliance
- details of any issues regarding Mental Capacity Act Deprivation of Liberty Safeguards applications (issues may be reflected in CQC issues)
- pharmaceutical manufacturing/Medicines and Healthcare Products Regulatory Agency (MHRA) licence and action plan to address any conditions
- external assessments/statutory requirements
- contractual key performance indicator (KPI) performance by service.

Clinical leadership:

- quality governance leadership, roles and responsibilities; for example:
  - Caldicott guardian

  - director of infection prevention and control
  - safeguarding lead
- current structures, roles and responsibilities, strategies, action plans and proposed structures, roles and responsibilities, issues including vacancies/potential vacancies that could affect patient safety
- policy frameworks in important areas, eg for staffing levels and grades required to manage units with graded acuity
- structures for how the leadership accesses the views of junior staff in quality improvement (as per recommendations made in the Berwick report into patient safety).

Operational management:

- clinical audit programme, including action planning and reporting
- clinical audit training plans and resources
- results of recent national and local clinical audits, and any resultant action plans/outstanding actions
- current structures, strategies, action plans and proposed structures, roles and responsibilities, including supporting IT infrastructure for recording and reporting (data validation)
- process for assessing staffing levels, ongoing review of staffing levels, areas of concern and how these are being managed
- review of clinical staff turnover
- analysis of numbers of permanent staff and agency staff
- escalation procedures for when staffing pressures arise
- staff survey: areas of concern and action plan
- issues including vacancies/potential vacancies which could impact on safety
- involvement in clinical networks and arrangements to manage this.

Safeguarding:

- safeguarding adults: structure, policy, annual report, current issues (eg current case reviews)
- safeguarding children: structure, policy, annual report, number of children on plans, any serious case reviews including outstanding actions, any issues
- action plans since last review.

Infection control processes:

- structure and management, policies and procedures, annual report and action plan, any issues
- examination of surveillance for the other Health Protection Agency data (eg methicillin-sensitive *Staphylococcus aureus* (MSSA) and vancomycin-resistant enterococcus (VRE)).

Policy management process:

- policy management including review and archiving process, priorities for review
- freedom of information policy and requests
- alerts and cascading process and effectiveness
- evidence of compliance.

Research:

- research being undertaken; any research and development strategies
- policy for managing, reporting and monitoring the introduction of new interventional procedures and how it links into the clinical effectiveness pathway.

Pharmacy:

- structure, medicines management function and responsibilities, policies and procedures including practice in relation to controlled drugs and also safe storage of drugs
- annual report
- accountable officer for controlled drugs, sample control drugs exception reports
- training and education in place, nurse prescribing training and accreditation.

Workforce:

- information on support provided by training and development, clinical supervision systems, preceptorship, mentorship and competency frameworks
- revalidation process and numbers of medical staff being deferred or not put forward for revalidation
- numbers of medical staff being managed under 'maintaining high professional standards'

- numbers of staff being investigated by the Nursing and Midwifery Council, General Medical Council (GMC) and Health and Care Professions Council
- training and supervisory issues being reported in GMC or university deanery reports, including action plans to address these issues
- appraisal rates.

Medical equipment:

- equipment age profile
- condition
- obsolescence status
- routine maintenance status / contracts
- cyber security risks
- compliance with regulations, eg alerts / safety notices

Indicative human resources and pensions due diligence

Human resources

The information below should be reviewed in addition to the information in the workforce section of the indicative clinical due diligence above.

HR and pensions due diligence should consist of a review of:

- culture, including (for example):
  - values and behaviours
  - management practices and working norms
  - how decision-making works
  - how staff are motivated
  - how people are held to account
  - consideration of sub-cultures as well as overarching observations
- list of all transferring staff and analysis of management and staff by number, grade, salary, pension and other benefits entitlements
- staff handbook
- details of union representation
- analysis of HR KPIs such as sickness, absence and staff turnover

- details of ongoing HR-related legal disputes (identified in legal due diligence)
- training programmes and training records
- job planning
- occupational health and wellbeing
- performance management systems
- education and training activities
- listing of all contractors and secondments
- details of any disciplinary action against employees
- details of any employment tribunal cases
- staff consultation and TUPE[1] arrangements
- mapping of HR policies and procedures between organisations.

Pensions (may not all be required if just NHS Pension scheme):

- summary of the main pension and other post-retirement benefit arrangements, early retirement allowances, retirement indemnities, termination indemnities, death-in-service benefits, jubilee awards and summary of employee participation
- analysis of the funding and balance sheet position
- summary of past cash and accounting costs and analysis of budgeted/ projected costs with a view to commenting on whether they are realistic
- main financial risks associated with the plans
- separation issues and costs.

Indicative financial due diligence scope

Historical and projected trading results

Financial due diligence should cover three years of historical data, the outturn year (including year to date) and two years of financial projections.

Historical financial due diligence could consist of a review of the following:

- summary of results
- analysis of revenue and profitability by hospital/unit

[1] Transfer of undertakings (protection of employment) Regulations 2006 (SI 2006/246).

- revenue, direct costs and margins, gross profit, overheads, earnings before interest, tax, depreciation and amortisation (EBITDA)
- explanation of historical trends by hospital/unit, including:
  - pricing trends with payers and tariffs
  - contractual arrangements
  - volume and operation type (including analysis of day and outpatients)
  - bed numbers, occupancy and utilisation
  - trends in average length of stay
- overview of direct and indirect costs including employee and agency costs (and associated KPIs)
- to the extent possible, analysis of the fixed versus variable nature of the cost base
- impact of seasonality
- summary of any cost saving initiatives included in the budget and projections
- adjusted/underlying EBITDA and rent (EBITDA[R]), explanation of adjustments including any standalone adjustments, non-recurring revenues and costs (including redundancy costs), accounting policy changes
- view on last 12 months, pro forma and run-rate EBITDA
- any central or public sector charges/income applied that may change post-transaction
- overview of projections made for the forecast years, review of the main assumptions in the projections
- summary of the conclusions on the achievability of the projections incorporating the views of the commercial and operational due diligence work.

Current year trading and full-year outturn:

- summary of current year budget/forecast
- summary of the budget/forecast, key lines in the profit and loss account, comparison with historical results and current year outturn
- key assumptions
- analysis of year-to-date trading (including comparison with budget and previous year)
- views on the achievability of the current year forecast, including any vulnerabilities and upsides.

Balance sheet review

For historical years and the latest available date:

- statement of net assets
- significant trends, change in accounting policies, any assets with a book value significantly different from market value
- any non-trading items, basis of valuation in the accounts and alternative market valuation (if available)
- significant off balance sheet items (including any guarantees).

Fixed assets:

- summary by type of asset and by location/activity
- summary of owned and leased property and land
- basis of valuation, depreciation rates, profits/losses on disposals
- fixed asset impairment/write-downs
- fixed assets held under finance leases
- nature of any intangible assets, valuation, amortisation policy, own costs (research and development, other) capitalised
- capital expenditure plans and capital commitments.

Working capital:

- key ratios and trends
- analysis of inventory, reserves/provisions
- analysis of trade debtors – ageing (with comparatives), bad debt reserves and experience
- analysis of trade creditors – ageing (with comparatives).

Other assets and liabilities:

- summary of other assets and liabilities, unusual items, significant fluctuations
- analysis of provisions
- litigation pending, claims not settled (overlap with legal due diligence)
- details of any security, retention of title or other restrictions relating to fixed and current assets.

Financing:

- analysis of net interest-bearing debt by component and maturity
- summary of property lease commitments
- other financing (including financial instruments).
- Future PFI-related risks, eg balloon payments

Cash flow review

For the historical years, budget for the outturn year and projections for forecast years:

- summary cash flow statement

- analysis of historical capital expenditure, by type and unit
- monthly trends in working capital
- cash flow seasonality including intra-month swings.

Cost improvement plans:

- analysis of historical performance and delivery
- current year performance
- future cost improvement plans
- mitigation plans.

Other matters:

- key accounting policies (eg revenue recognition) and any significant changes in the past three years
- accounts, relevant management letters and audit reports for the preceding two to three years
- bank account details
- management information
- content and frequency of board/executive committee management reports
- accuracy/integrity of management information
- reconciliation of historical results to audited accounts
- normalising adjustments and the trust's normalised/underlying position
- analysis of the historical accuracy of budgeting
- overview of budgeting, re-forecasting and medium-term planning process
- group organisation, including legal structure, key locations and premises, management and organisational structure
- headcount overview and full-time equivalency overview by function and by division
- overview of remuneration policies.

Charities:

- details of any endowment funds received
- details of any NHS umbrella charities and associated subsidiary charities established together with amounts held
- copy any deeds and deeds of variation from predecessor organisation

- details of arrangements to manage charitable funds internally.

Indicative contract due diligence scope

Contract due diligence should consist of a review of the following:

- healthcare
- supplies
- partnerships
- other agreements
- details of all proposed and current tenders to bid for and issue.

Indicative legal due diligence scope

Legal due diligence should consist of a review of the following:

- asset register and maintenance records
- all relevant non-property leasing agreements
- insurance
- material contracts (both NHS and otherwise), including consideration of any change in control provisions
- regulatory compliance
- clinical negligence claims
- judicial reviews
- other litigation and non-clinical disputes
- intellectual property rights
- criminal litigation
- coroner's inquests.

Indicative commercial due diligence

Commercial due diligence should consist of a review of the following:

Trust review:

- overview of the services and geography covered by the trust to include:
  - procedures and service volumes by type, revenue, profitability and capacity

  - review of the geographical catchment area as defined by referral patterns from GPs and others
  - analysis to understand what services are being paid for by which commissioners and the geographical reach of particular services
- assessment of the benefits of the acquisition of the target NHS organisation:
  - how does the geographical and service combination benefit each trust?
  - what service synergies can be achieved through extending previously not-offered services to the new trust and vice versa?
  - what services could be rationalised across the two organisations and what cost reduction opportunities may be presented?

Demand:

- macro assessment of the development for services in the catchment area:
  - population analysis trends and dynamics, historical and expected future development, including where available and appropriate, specific population health needs
  - GP referral network – historical and expected development
  - how the models of treatment are likely to develop – in particular, the balance of inpatient and outpatient procedures
  - what other service delivery models are likely to affect the demand for services (eg primary care initiatives, community hospitals, etc)?

Competition:

- overview of the local supply base which competes for patients (other NHS trusts and, where appropriate, private providers)
- understand the size and focus of the providers – what services are offered, what are their expansion strategies?
- market share of patients by service area
- what does the combined entity look like in terms of the competitive position?

Business plan:

- provide a view on the key revenue drivers underpinning the business plan
- indicative operations due diligence
- review and comment on certain key areas of hospital operations, including:
  - non-staff costs

  - staff costs
  - organisational capabilities (management and staff)
  - capital expenditure plans (historical and forecast) and estates strategy, linking into the financial analysis above
  - operational relationships with NHS and private medical insurance healthcare providers
  - supplier relationships
- review and comment on relationship-building measures with NHS consultants
- where reviews have been conducted or improvement projects initiated, review and comment on efficiency of patient journey and clinical pathways through the hospitals and interdependency with IT systems
- where available, review management information, and completeness and timeliness of KPIs versus comparative data. This work would link into the financial analysis above. Example KPIs that could be considered include:
  - in-house KPIs relating to initial coding/billing of procedures
  - conversion rate of referrals to procedures
  - length of stay by procedure
  - utilisation by theatre
  - tests per procedure, test costs
  - outpatient clinic utilisation
  - consultant efficiency/profitability (all KPIs by consultant)
  - nursing over-contract hours and unfilled duties
  - pharmacy costs per procedure
  - profit per procedure
  - billing days, debtor days, etc
- review of strategic plans for the target as well as the strategic plans and commissioning intentions of the broader local health economy
- service development strategy and plans.

Opportunities for upside:

- review and comment on management's plans for improving performance across the business

- consider potential for increase in income or efficiency through high-level review of KPIs and targeted data analysis, where such data is available and provided. Potential areas for consideration include:
  - reduction in length of stay and bed optimisation
  - increased efficiency of outpatient clinics
  - improvement in theatre utilisation or increase in day case rates
  - rationalisation of back office functions
  - consideration of administration levels
  - VAT planning and tax efficient salaries
  - transport, facilities and estates planning and clinical space optimisation
  - procurement opportunities
  - planned diagnostics
  - consideration of nursing levels or scheduling (including specialist nurses)
  - reduction in pharmacy costs or waste levels
  - faster recovery of debts or more accurate billing and management of working capital.

Note: upsides are likely to be in a range and will require further detailing to be specific.

Indicative estates/property due diligence

Estates/property due diligence should consist of a review of:

- list of properties, to include details of any relevant charges such as rates, insurance, value, length of ownership
- freehold title deeds
- lease agreements (head lease, sub-lease, when they expire, etc)
- reverse lease premiums
- rent agreements
- restrictive covenants for both land and buildings
- rights of way
- mortgage deeds
- ground rents
- concessionaire contracts
- contiguous boundary assessment

- details of any capital projects committed to, eg local improvement finance trust (LIFT), PFI schemes (see below for specific due diligence for PFI arrangements)
- planning applications
- existing licences and permits, and details of any applications outstanding
- backlog maintenance
- soft and hard facilities management
- latest six facet surveys
- sustainability strategy.

PFI specific:

- details of any estate, soft and hard facilities management and equipment PFI arrangements
- PFI contractual and legal relationships
- finance schedules for PFI impact on historical, current and future income and expenditure, balance sheet, capex, public dividend capital and invoice timing
- details of the design, construction and maintenance of PFI assets
- details of relevant supporting contracts and variations.

Indicative IT due diligence

IT due diligence would consist of a review of the following:

- overall view of adequacy of core IT systems, both clinical and non-clinical
- extent to which the current systems provide management with timely and accurate information to run the business on a day-to-day basis and to support business planning over the next one to two years
- evaluation of the status of IT projects in process and the adequacy of plans, budgets and staffing, and the risk of failure (in particular, projects relating to the integration of acquired businesses)
- review of the adequacy of IT governance, business continuity and disaster recovery plans
- review of IT carve-out requirements, including technical service agreements, ongoing projects as well as shared infrastructure
- IT strategy, policies and procedures
- IT governance structures, staffing and reporting lines

- listing of all IT infrastructure
- review of data extraction and systems migration (if applicable)
- IT security and regulatory compliance
- data protection
- user support services
- IT project pipeline.

Indicative taxation due diligence

- In connection with withholding taxes, payroll taxes, social security contributions and sales taxes (VAT), discuss with the target organisation's management and its advisors:
  - the procedures for administering the taxes concerned
  - the extent to which the transacting NHS organisation has complied with relevant statutory, regulatory or other legal requirements, the key issues in the transacting NHS organisation's tax position, and the key judgements made in preparing tax returns
  - any material potential exposures of which they are aware.

Indicative environmental due diligence

- Overview of key environmental, health and safety (EHS) risk issues relevant to the trust, current EHS management arrangements and commentary on level of controls in place.
- Overview of key EHS regulatory requirements, commentary on compliance record (last three years), compliance issues, significant incidents and any significant expenditure anticipated in respect of regulatory requirements.
- Discussion of any actual and potential EHS exposures (eg contaminated land liabilities, etc).
- Commentary on anticipated EHS regulatory developments affecting the trust.
- Hazardous substances.
- General environmental issues.

Health and safety due diligence

- Written statement of health and safety policy.

- Health and safety management structure.
- Individual responsibilities, including job descriptions that include health and safety duties.
- Safety committees.
- Health and safety rules.
- Reporting, recording and investigating accidents and incidents.
- Risk assessments.
- Manual handling operations.
- Hazardous substances.
- Information and training to employees and non-employees.
- First aid information.
- Fire and other serious and imminent dangers.
- Monitoring and auditing health and safety arrangements.
- Details of any claim, complaint, prosecution, investigation or enquiry concerning health and safety matters.

Carve-out specific due diligence

NB This refers to transactions where part of a continuing entity is transferred or absorbed by another and therefore relates to commercial transfers rather than statutory transactions. It is included here for completeness.

- Analysis and disaggregation of:
  - balance sheet and assets and liabilities
  - income and expenditure
  - estate
  - contracts
  - HR and workforce
  - cost improvement plan allocation
  - IT
  - business plans and strategic activity.
- Underlying assumptions of the carve-out.
- Identify significant operational changes required for the business to operate on a standalone basis (with costs identified), the nature of the changes required,

the related timing and the technical service agreements that are being proposed. This would include:

  - IT/telephony (scope discussed in IT section above)
  - finance
  - pensions
  - insurance
  - HR
  - procurement
  - shared sites and property
  - commercial impact of any significant change of control clauses.
- Consider one-time/transitional costs associated with the above (capex and opex).
- Provide ongoing programme management assistance as necessary to co-ordinate development of all transitional plans to deal completion.
- Consider the scope and activities of a Legacy Management Office or equivalent function that can independently manage matters that arise post transaction, for example, any assets, liabilities, staff or estates that may sit with the wrong entity.

Appendix 7: Board certification

All trusts undertaking material and significant transactions must complete this certification as part of the transaction review process. It needs to be submitted to us alongside the FBC, to demonstrate the board's confidence that the requirements of the transactions guidance have been met.

For a merger, both parties should jointly make the board certification.

Where boards are not able to make certain statements below, they should explain why.

Where a potential transaction is deemed to be material, as defined in Section 2 of our guidance Statutory transactions, including mergers and acquisitions, we may, as part of our overall assessment of the transaction, request evidence in relation to some of the statements below.

The trust board(s) is (/are) satisfied that it has (/they have):

General

- considered a detailed options appraisal before deciding that the transaction delivers benefits for patients and the trust
- conducted appropriate enquiry about the probity of any partners involved in the proposed transaction, taking into account the nature of the services provided and the likely reputational risk
- received appropriate external advice from independent professional advisers with relevant experience and qualifications
- taken into account the good practice advice in NHS England's transaction guidance or commented by exception where this is not the case
- considered the implications of the proposed transaction on the Oversight Framework segment.

Quality and patient benefits delivery

- developed detailed plans to deliver demonstrable and achievable benefits to patients and the wider population
- ensured that plans are ambitious for patients by considering a range of potential opportunities for benefits, including through reference to benchmarking data and views of system partners

- engaged and collaborated with system partners to ensure transaction plans are aligned to ICB priorities
- carried out a robust prioritisation process to determine which services require integration sooner, including a clear programme to integrate lower priority services at a later date
- conducted an appropriate level of clinical due diligence relating to the transaction, which has enabled an understanding of quality risks associated with the transaction or inherent in the transacting organisations
- identified and mitigated to the extent possible quality risks, both pre-existing and arising from the transaction
- involved senior clinicians at the appropriate level in transaction planning, including involvement in the creation of patient benefits proposals
- assured itself that senior clinicians have been fully engaged and involved in developing the business plan and all the changes and improvements to clinical services, including integration and new configurations or models of delivery, and that there is no clinical practice reason to object to the plans
- effective governance arrangements that safeguard quality, for the purpose of monitoring and continually improving the quality of healthcare provided by the enlarged trust to its patients, including:
  - ensuring required standards are achieved (internal and external)
  - investigating and taking action on sub-standard performance
  - planning and managing continuous improvement
  - identifying, sharing and ensuring delivery of best practice
  - identifying and managing risks to quality of care
  - establishing robust quality governance procedures for the enlarged organisation.

Integration delivery:

- developed a comprehensive plan to complete the transaction, integrate the organisations and transform services, including mitigations to associated risks
- developed robust cultural integration and staff engagement plans that will enable the establishment of an integrated culture
- developed robust digital integration plans that will ensure the safe, effective transition of key systems
- developed a robust operating model for the enlarged organisation, based on careful consideration of a range of options

- ensured that staff have the capacity and capability to deliver the transaction and the benefits associated with it
- conducted a robust programme of non-clinical due diligence that is consistent with the plan set out at strategic case stage and has enabled the identification and mitigation of material risks
- complied with all necessary regulatory and legal requirements
- addressed any legal issues arising from the transaction, including those associated with the transfer of staff
- in the case of a contract for a specified period, ensured appropriate legal protection in relation to staff, including on termination of the contract
- complied with any consultation requirements
- established the reporting lines, processes and accountabilities to deliver the planned benefits of the proposed transaction
- ensured that the board and senior management of the enlarged trust have the capability, capacity and experience to deliver the transaction successfully and lead the enlarged trust
- engaged with system partners to determine how all parties will work together to ensure the successful delivery of the transaction and the realisation of benefits.

Finance:

- developed a plan in which the deliverable financial benefits of the transaction outweigh the costs over the medium term
- ensured that plans are ambitious by considering a range of potential opportunities for financial benefits, including through reference to benchmarking data
- identified robust mitigating actions against short-term financial deterioration
- prepared a robust medium-term financial plan
- made provision for the transfer of all relevant assets and liabilities
- resolved any accounting issues relating to the proposed investment or divestment and its proposed treatment
- reviewed the working capital requirements of the enlarged trust, taking into account the new and existing working capital facilities, and is satisfied that the working capital available to the enlarged trust is sufficient to meet the trust's requirements for at least 12 months from the transaction date

- established financial reporting procedures that provide a reasonable basis on which to reach proper judgement as to the financial position and prospects of the enlarged trust.

Appendix 8: Management letter of representation

NHS England
Skipton House
80 London Road
London SE1 6LH

[Date – as close as possible to date of decision]

Re: Transaction review – management representations

This letter of representation is provided in connection with your review of [name of NHS foundation trust/NHS trust]'s ('the trust') [name or brief description of transaction, eg acquisition of X] ('the transaction'), for the purpose of assessing the impact of the transaction on the trust's compliance with the NHS England Oversight Framework ('the transaction review') as detailed in the guidance: *Assuring and supporting complex change - Statutory transactions, including mergers and acquisitions* (October 2022).

The trust's board of directors ('the board') tabled and agreed this letter at its meeting on [date]. I have been authorised to write to you on its behalf. The board confirms that the representations it makes in this letter are in accordance with the definitions set out in the appendix to this letter.

Representations

The board confirms to the best of its knowledge and belief at the date of this letter, having made all such enquiries as it considered necessary for the purpose of informing itself, that:

Financial forecasts and [name of main transaction plan submitted for review, eg full business case for the transaction (FBC)]

1. Measurement methods and significant assumptions used by the board in preparing the financial forecasts provided to NHS England have been disclosed and are reasonable.

2. The financial forecasts and [FBC title] incorporate all known changes to service provision at [both of the trusts directly involved in the transaction/the trust] and the board has disclosed all known material risks to changes to service provision.

3. The assumptions underlying the financial forecasts are consistent with the board's knowledge of the business and [both trusts'/the trust's] operating environment.

4. The underlying financial position as disclosed in the financial forecasts and [FBC title] is consistent with the board's knowledge of the business and reflects all known material normalising items.

5. All material events and material changes subsequent to the submission of the financial forecasts and [FBC title] have been disclosed to NHS England.

6. The board has disclosed all material risks and uncertainties arising or potentially arising from the transaction impacting [both trusts'/the trust's] business plan, including key strategic, operational (including IT) and financial risks.

Relevant information

7. The board has:

    a. Disclosed to you all information of which it is aware having made reasonable enquiries that are both relevant and material to the transaction review such as records, documents and other matters. For the avoidance of doubt, this includes all reports and peer review information (or latest draft where reports have not been finalised), commissioned either internally or externally and covering governance arrangements or the quality of services at [both trusts/the trust] within the last two years; and

    b. Provided you with additional information requested in the guidance: *Assuring and supporting complex change - Statutory transactions, including mergers and acquisitions*.

Internal control

8. The board acknowledges its responsibility for such internal control as it determines necessary for the conduct of the trust's business and the preparation of information, including that provided to NHS England, which is free from material misstatement, whether due to fraud or error. In particular, the board acknowledges its

responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

9. The board has disclosed to you the results of any assessment of the risk that the information it has reported to you may be materially misstated as a result of fraud.

10. There have been no instances of material fraud or suspected fraud that the board is aware of, other than those already reported to NHS England as part of the transaction review process, that involve:

    a. management and, where appropriate, those charged with governance

    b. employees who have significant roles in internal control, or

    c. other employees where the fraud could have a material effect on the information provided to NHS England.

Legal compliance

11. The board has disclosed to you all known material instances of non-compliance or suspected non-compliance with laws and regulations which affect the matters considered as part of the transaction review.

12. The board has disclosed to you all known material actual or possible litigation and claims which affect the matters considered as part of the transaction review.

Other matters

13. The board has actively considered all information provided to NHS England and has not identified any other matters it deems material to the transaction review.

Yours faithfully

Signed for and on behalf of the board:

Title:

Date:

Trust:

Appendix: Definitions (for letter of representation)

Material matters: Material omissions or misstatements of items are material if they could, individually or collectively, influence NHS England's view on the impact of the transaction on the trust's compliance with the NHS England Oversight Framework. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size and/or nature of the item could be the determining factor.

Fraud: Fraudulent reporting involves intentional misstatements including omissions of amounts or disclosures in the information provided to deceive the user of the information.

Error: An error is an unintentional misstatement in the information provided. Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts.

Appendix 9: Example application letter

The suggested and optional wording below can be used by trusts planning a section 56 merger or section 56A acquisition.

[Trust headers]

[Addresses]

Proposed [merger/acquisition etc] of [trust names] ("the Parties")

In accordance with section [56/56A etc] of the National Health Service Act 2006 ('the Act') and the enclosed [merger/transaction agreement, etc] dated [date] between the Parties, this letter is the joint application of the Parties to NHS England for their [merger by way of their dissolution and the establishment of a new NHS Foundation Trust to be named [name]/[acquisition details]].

The Parties request that NHS England:

1) Grants this joint application pursuant to section [56/56A etc] of the Act to confirm that it is satisfied that the Parties have taken such steps as are necessary to prepare for the [merger/acquisition] taking effect on [date].

2) [Makes the grant of application pursuant to section [56/56A] of the Act/Makes the dissolution and transfer order pursuant to section 57 of the Act in the form appended to this letter].

3) [If applicable:] Grants [new trust name] an NHS provider licence under section 87 of the Health and Social Care Act 2012 upon its establishment as an NHS foundation trust.

In compliance with section [56/56A etc] of the Act, the Parties enclose:

4) [Merger:] Copies of minutes of meetings of their respective Councils of Governors evidencing the approval of more than half the members of both their councils of governors to this application.

5) [Acquisition]: A copy of minutes of the meeting of the [acquiring trust] Council of Governors evidencing the approval by more than half of the members of the Council of Governors to this application.

6) A copy of the proposed constitution of [acquiring trust/new trust].

7) [Merger]: A specification of the property and liabilities proposed to be transferred to the new FT

The Parties acknowledge that, in accordance with their guidance '*Assuring and supporting complex change: Statutory transactions, including mergers and acquisitions'* NHS England has rated the transaction '[Amber/Green]'.

Yours sincerely

Appendix 10: Legal and regulatory requirements for transactions

This appendix provides guidance on the legal and regulatory aspects of the following types of transactions:

- merger – section 56 (Section 10.1 of this appendix)
- acquisition – section 56A (Section 10.2)
- three-way merger or acquisition – section 56 and 56A (Section 10.3)
- dissolution of an NHS trust and transfer of assets – schedule 4 (Section 10.4)
- dissolution of an NHS foundation trust – section 57A (Section 10.5)
- separation of an NHS foundation trust – section 56B (Section 10.6)
- commercial transfer – ordinary legal powers (Section 10.7)
- statutory transfer of property and liabilities (Section 10.8).

It also provides guidance on the roles and responsibilities of executive directors, non-executive directors (NEDs) and governors when taking transaction-related decisions (see Section 10.8).

The general legal requirements, limitations and processes applicable to each type of transaction are discussed in turn; however, it is not a substitute for legal advice and providers should seek independent legal advice tailored to their particular circumstances. Trust special administration is not covered. Separate guidance is available on the trust special administration process.

All references to legislation are to the National Health Service Act 2006 (the NHS Act 2006) unless otherwise stated. Amendments to the legislation introduced by the Health and Care Act 2022 have been taken into account.

NHS foundations trusts are referred to as 'FTs'. 'NHS trust' is used when it is legally necessary to make a distinction between NHS trusts and FTs. Where the distinction is not relevant, the term 'trust(s)' is used and covers both FTs and NHS trusts.

Please contact NHS England if you are planning one of these transactions to discuss how we can support you further, including by providing template legal documents. The

following templates are available for mergers and acquisitions which we can provide on request:

- Heads of Terms
- Transaction Agreements
- Confidentiality and Information Barrier Agreement.

10.1 Merger – section 56

Section 56 of the NHS Act 2006 provides for mergers of an FT and an NHS trust or an FT and another FT. A merger involves the dissolution of each trust and the establishment of a new FT ('New FT').

A section 56 merger cannot create a new NHS trust and it is not legally possible for two NHS trusts to merge under this process.

Where one of the merging trusts is an NHS trust, the powers of the Secretary of State and NHS England to dissolve the NHS trust and transfer its property and liabilities under schedule 4 cannot be exercised.[2] A merger cannot therefore take place in conjunction with a schedule 4 transaction.

At the time of writing, there have been four mergers.

Application

Merging trusts must make a joint written application to NHS England. The application must include supporting documents to show that the requirements of section 56 and other regulatory requirements have been met. They are:

- a proposed constitution for New FT
- evidence that a majority of the council of governors of each merging FT has approved the application; that is, a majority of all governors in post at the relevant time and not just a majority of those voting at the governors' meeting
- a specification of the property and liabilities proposed to be transferred to New FT
- acknowledgement of the transaction rating given by NHS England (for significant transactions only).

The transaction rating must be green or amber to proceed as this confirms we are satisfied that the trusts have taken the necessary steps to prepare for the merger.

Grant of Merger and Statutory Order

We must grant the application if:

[2] Section 57(5) of the NHS Act 2006.

- we are satisfied that the necessary steps to prepare for the merger have been taken (as evidenced by a green or amber transaction rating); and

- the grant is approved by the Secretary of State.

The decision to grant a merger will be taken by an NHS England committee shortly before the planned effective date. The decision is confirmed in a document called a Grant of Merger which we will issue. New FT is established on the effective date of the grant under the terms of the new constitution. For ease of accounting, the effective date is typically the first day of a month even if it falls on a weekend.

Upon the merger being granted, the Chief Executive of NHS England will sign a statutory order[3] (the Order) to transfer specified property and liabilities of the old trusts to New FT and to dissolve the old trusts[4] on a specified date. It will also provide for continuity from the old trusts to New FT and for other related matters.

We draft the Order in the weeks before the merger and will engage the trusts' legal advisers as part of the process. The Order does not need to be laid before Parliament but we will liaise with the Department of Health and Social Care (DHSC) to arrange for the Order to be registered and published.

In practice, the establishment of New FT (per the Grant of Merger) and the dissolution of the old trusts and transfer of property and liabilities (per the Order) are timed to happen simultaneously. This provides legal certainty and a seamless legal transition from the old trusts to New FT. As such, neither the merging trusts nor New FT exist as a 'shell' entity for any period of time.

Once the Grant of Merger is issued and the Order is made, no further legal steps are needed to make the merger effective. New FT will be listed on our online FT directory and the Grant of Merger is published on the directory along with the constitution of New FT. The Order will be published on the government legislation website.

Transfer of property and liabilities

The property to be transferred to New FT includes assets such as estates, equipment, intellectual property and contractual rights, and the transferring liabilities include civil liabilities, criminal liabilities[5] and private finance initiative (PFI) liabilities.

[3] A statutory instrument.
[4] Sections 57(2) and 64(5)(b) of the NHS Act 2006.
[5] Section 57(4) of the NHS Act 2006.

As part of the merger application, trusts must specify which property and liabilities they propose to transfer to New FT. It is likely that the trusts will specify that all their property and liabilities should transfer (except perhaps for employment contracts – see below for more detail); however, the decision rests with NHS England to determine which property and liabilities will transfer.[6] While it is unlikely that we will disagree with the trusts' wishes, it is possible that we decide to transfer certain property and liabilities elsewhere. We have the power to transfer remaining property and liabilities to other trusts or to the Secretary of State.

As the transfer of liabilities is effected by a statutory Order, the trusts do not need to obtain consent from the third parties to whom the liabilities are owed, such as lenders and suppliers. Depending on the specific terms of a contract, third parties may be able to invoke contractual rights which are triggered by the merger, including termination rights. In general however, third parties should carry on as normal and deal with New FT in place of the dissolved trusts.

Transaction agreement or merger agreement

The trusts may find it beneficial to agree in writing certain commercial and governance matters relating to the merger. An agreement, known as a transaction agreement or merger agreement, can be used to document commitments, assurances and processes and to identify key assets and liabilities. The trusts may wish to agree heads of terms (a non-binding document) before proceeding to enter into a more detailed transaction agreement. The agreement is not the legal instrument by which the merger is effected and nor is it the means by which the property and liabilities transfer – the relevant legal instruments are the Grant of Merger and the Order.

If there are other parties who have a vested interest in the transaction, such as a commissioner who is providing financial support, they can also be made parties to the agreement.

Entering into an agreement may require approval from each FT's council of governors. If the agreement amounts to a 'significant transaction' as described in the FT's constitution(s), more than half the members of each council of governors will need to vote in favour of it at a governors' meeting. The vote can be taken at the same time as the governors vote to approve the merger application.

Interim board

[6] NHS England has a duty to specify which property and liabilities are to transfer per section 57(1).

The constitution of New FT comes into effect on the date that the merger is completed ('Day 1'). Immediately prior this, the trusts will have been dissolved and, in consequence, the boards of the merging trusts will have fallen away.

On or after Day 1, New FT's governance structures, including its council of governors and board, can be established in accordance with the constitution. This process can take several months. Until then, pursuant to section 56(11), the directors of the merging trusts have control of New FT and the authority to exercise its functions.

Under legislation, the default position is that **all** the directors of the trusts transfer to New FT and gain interim control in the period after the merger. However, it is usually not feasible or desirable to carry forward so many individuals. In practice, to avoid the complication of effectively having two sets of directors running New FT, a subset of directors is chosen prior to the merger. The subset is known as the interim board. The interim board should be an appropriate mix of executive and non-executive directors, and should meet all the statutory requirements for the future board – that is, it should have a chair, other NEDs, a chief executive, a finance director, a medical director, a nursing director and other executive directors.

There is no defined process for the appointment of directors to the interim board. It is for the trusts to decide how to establish it. This could be through nomination of particular directors from each trust, a process of competition between directors or a combination of approaches. We do not endorse any particular approach. Regardless of the process adopted, the governors from each merging FT should be involved and there should be appropriate representation of directors from each trust. The trusts may wish to invite an NHS England representative to sit on interview panels. We can provide informal views on which directors are appointable but decisions will remain with the trusts.

As such, executive directors who are not appointed to the interim board will need to resign, accept severance/redundancy packages or be redeployed into non-director roles; otherwise they will automatically transfer to New FT and gain control along with the interim board members. If that happens, the New FT will need to resolve their employment status. These issues will need careful management from an HR perspective in terms of handling and employment law, and trusts are advised to seek bespoke legal/HR advice. We can support directors who are displaced as a result of a merger.

NEDs who are not appointed to the interim board will need to terminate their appointments in accordance with the agreed terms before Day 1.

The interim board should be in place by the start of our FBC review. It will then lead the trusts through the transaction process and will interface with NHS England, in particular at the Challenge Meeting. In the pre-merger period, the interim board has no legal powers over either of the merging trusts[7] and it should not purport to take any decisions on behalf of New FT.

The trusts will have to carefully manage the expectations of the directors on the interim board and should not give any guarantees about the prospect of future permanent employment with New FT. This is because the legislation is clear that the interim board only has temporary control of New FT until the substantive directors are appointed in accordance with the structure set out in the constitution. Being appointed to the interim board does not mean that each director's terms and conditions of employment automatically become time limited or diminished in any way vis-à-vis the old trusts or New FT. This can give rise to employment law complications in the event that the interim board members are not appointed as the substantive directors. Please see the section 'Substantive board' below for further guidance.

Once the New FT's substantive board has been established, the interim board should hand over and disband as soon as possible. There is no specified time limit but we recommend that the interim board should not remain in place for longer than five months after the merger. This timescale allows for governor elections to be held after the merger and for the substantive directors to be appointed.

Members and governors

The trusts will need to determine New FT's public, staff and patient/service user/carer constituencies. In doing so, the trusts should be mindful of section 61(2) of the NHS Act 2006, which requires FTs to have regard to the need for those eligible for membership to be representative of their service users. We will expect the new constituencies to reflect the make-up of New FT. For example, the public constituencies should cover the enlarged geographical areas and new classes may be appropriate within the staff constituency to reflect a wider range of services.

An FT's membership will automatically fall away in consequence of it being dissolved. Merging FTs can approach their existing public members to see whether they wish to become members of New FT – they cannot automatically be made members due to the requirement in schedule 7 of the NHS Act 2006 that individuals must apply to be members of the public constituency. If they want to become a member, it must be made

[7] The interim board could meet as a committee-in-common with the directors exercising authority delegated to them by their own trust.

clear that they will be deemed to have made an application to come into effect on Day 1. The same approach will probably need to be taken for any patient/service user members unless New FT intends to invite its future patients/service users to become members without an application being made.[8] The trusts will need to check that the individuals are eligible to join as members of the New FT according to rules laid out in its constitution. Membership established in this way will only exist in shadow form until New FT is established on Day 1.

Alternatively, the trusts may decide to let the membership fall away and to recruit members from scratch after New FT is established. Trusts should, however, be mindful of the significant time and effort it can take to establish a membership in this way and the knock-on effect on the timing of governor elections.

NHS trusts do not have members. This means that New FT may need to take extra steps to recruit members from populations served by the NHS trust to ensure that the members of New FT are representative of those who are eligible for membership (section 61(1) of the NHS Act 2006). Where NHS trusts have recruited shadow members in preparation for an application for FT status, these shadow members can be asked if they wish to be a member of New FT and their shadow membership can be deemed an application for membership vis-à-vis New FT.

The trusts will also need to determine the configuration of New FT's council of governors. The proposed council will need to reflect the make-up of New FT, its new constituencies and partner organisations. The merging FTs' councils of governors automatically fall away in consequence of the FTs being dissolved. Governors cannot automatically become governors of New FT due to the requirement in schedule 7 of the NHS Act 2006 that governors to be chosen by election or appointment (by New FT). They may stand for election to be a governor of New FT provided they meet the new constitutional requirements.

Constitution

The trusts must submit a proposed new constitution for New FT to NHS Improvement as part of their application. The trusts will probably wish to form a working group to develop the draft constitution with representatives from both trusts and the FT governors. An NHS trust party will not have an existing constitution to work from but should be fully engaged. As per usual, the constitution should be modelled on the Model

[8] This is permitted under paragraph 6(3) of schedule 7 of the NHS Act.

Core Constitution published by NHS Improvement and should include a copy of the Model Election Rules for governor elections published by NHS Providers.

The trusts are likely to want a new name for New FT and there is guidance on what is appropriate for an FT name.

The trusts must satisfy themselves that the proposed constitution complies with schedule 7 of the NHS Act 2006, taking legal advice as needed. We do not perform a detailed review of the constitution but we will want to understand, in general terms, the major changes from the old constitution(s) and the new governance structures.

Section 37 of the NHS Act 2006, which sets out the general process for amending an FT constitution, is not engaged when developing a constitution for New FT. The proposed constitution is submitted to NHS Improvement in 'draft' form and it takes effect if we grant the merger. The trusts will nevertheless want to ensure that the governors and board approve of the proposed constitution; this will likely be confirmed as part of their approval of the transaction for the purposes of making the merger application.

Licensing and enforcement action

The licences of the old trusts fall away on dissolution and the Order will specifically state that they no longer have effect.

Any enforcement actions associated with the licences (or equivalent of licences) such as section 106 enforcement undertakings or section 105 discretionary requirements will also fall away. New FT will not automatically be placed in the recovery support programme (RSP) as a result of the old trust(s) being in RSP.

New FT will be deemed to have made a licence application and to have met the licensing criteria[9]. If the merger is granted, we will issue the licence and it will take effect on Day 1. NHS England's licence register will then be updated.

Commissioner requested services

New FT's commissioners will be encouraged to revisit commissioner requested services (CRS) designations in light of the merger.

[9] section 88 of the Health and Social Care Act 2012 as amended by the Health and Care Act 2022

CQC registration and other regulatory requirements

New FT must be registered with CQC from Day 1 so that its regulated activity is performed lawfully. It will not have a CQC rating until its first inspection as any previous trusts' ratings fall away on their dissolution.

New FT will need a new organisational code from NHS Digital.

The trusts will need to ensure that there is a smooth transition of insurance/indemnity cover, including Clinical Negligence Scheme for Trusts (CNST), Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES) cover with NHS Resolution.[10]

The trusts are exempt from stamp duty land tax in respect of the transferred property and liabilities.[11]

New FT will be required to prepare the outstanding part-year accounts of the dissolving trusts and to perform all statutory duties relating to those accounts.

TUPE

It is generally accepted that the Transfer of Undertakings (Protection of Employment) (TUPE) regulations applies to section 56 mergers. In all mergers to date, all employees of the dissolving trusts have transferred to New FT. Trusts are responsible for seeking their own legal and HR advice on compliance with TUPE.

NHS England has the power to include staff transfer provisions in the Order if, for instance, there is any doubt as to whether TUPE applies. We will decide whether to exercise our power, but in practice we will be led by whether the trusts require the staff provisions in the Order and, if so, the extent to which the power should be used. We have not previously exercised our power to transfer staff in this way. In previous mergers, the trusts were content that TUPE would be effective. Staff transfer provisions may be needed if, for example, some members of staff need to transfer to entities other than New FT.

Executive directors are employees of the trusts and their employment contracts will transfer to New FT under TUPE (or by virtue of the Order). Please refer to the sub-section about the interim board above for information about executive directors who do not intend to transfer.

[10] NHS Resolution is the operating name for the NHS Litigation Authority.
[11] By virtue of section 67A of the Finance Act 2003 (as amended by section 216 of the Finance Act 2012).

NEDs are office holders rather than employees. As such they will not transfer under TUPE or any staff transfer provisions of the Order. Please refer to the sub-section about the interim board above for information about NEDs who do not intend to transfer.

New Governors

The membership and constituencies of New FT come into effect on Day 1 and governor elections can be held immediately afterwards. Elections should be held in accordance with the Model Election Rules as set out in New FT's constitution. They take a minimum of 40 days to complete. The appointed governors can be appointed on or immediately after Day 1. Once the council of governors is in place, the substantive NEDs and chair can be appointed.

Substantive board

As described above, the interim board has control of New FT in the months after the merger while the substantive board is being established. The substantive directors must be appointed in accordance with the provisions of schedule 7 of the NHS Act 2006, meaning that:

- the chair and other NEDs must be appointed by the council of governors
- the chief executive must be appointed by the NEDs and the chair and approved by the council of governors
- the executive directors are appointed by a committee of the chief executive, chair and NEDs.

It will be for New FT to determine the recruitment process and crucially whether the substantive roles will be offered to the interim directors or opened up to competition. In a competition, there is an inherent risk that the interim executive directors are not appointed to the substantive posts and, if they are not, their positions will need to be resolved by resignation, redeployment or termination. This risk should be addressed by the trusts in the pre-merger phase with the benefit of employment law advice and HR advice as needed. Trusts must remember that the statutory requirements for establishing New FT's board must be discharged in a manner consistent with the employment law rights of the individual interim directors. NHS England can provide support to executive directors displaced by a merger.

It would be usual for the substantive appointments to be made in the order listed above, that is:

1. the substantive chair and other NEDs are appointed by the council of governors

2. the substantive NEDs and chair then appoint the substantive chief executive and this appointment is approved by the council of governors
3. a committee of the substantive chief executive, chair and NEDs then appoints the executive directors.

However, recognising the need for stability in the board as soon as possible after the merger, we accept that the interim directors may exercise their statutory duties under schedule 7 of the NHS Act 2006 to appoint the substantive directors. For example, the interim NEDs may appoint the substantive chief executive before the NEDs are substantively appointed. Section 56(11) enables the interim directors to exercise "the functions of the trust"; functions includes powers and duties[12] and is therefore interpreted broadly to include the function of appointing directors.

Consultation and engagement

There is no requirement in section 56 for a consultation. However, the trusts will need to consider whether the merger triggers other consultation and engagement obligations. In particular:

- Section 242 of the NHS Act 2006 places a duty on trusts to involve the public and local authorities concerning decisions about changes to services. A merger is generally considered a change to organisational form and does not usually entail any immediate service changes. On that basis, it is unlikely that the merger of itself will trigger the section 242 duty. If service changes are to follow the merger, New FT should work with commissioners as they develop plans for service reconfiguration and should consider whether and when any public involvement under section 242 becomes necessary.
- A TUPE consultation is likely to be required. Even where NHS England transfers the staff by the Order, TUPE may continue to apply to most, if not all, the staff concerned and the trusts must ensure they comply with the consultation duties under the TUPE regulations. In summary, before the transfer happens, employers must inform their trade union or employee representatives of transfer in writing including:
  - the fact that the transfer is going to take place, approximately when and why
  - any social, legal or economic implications for the affected employees – for example, a change in location or risk of redundancies

[12] Section 275 of the NHS Act 2006 (Interpretation).

- any measures that the outgoing and incoming employers expect to take in respect of their own employees (even if this is nothing)
- the number of agency workers employed, the departments they are working in and the type of work they are doing
- the outgoing employer must provide information about any measures which the incoming employer is considering taking in respect of affected employees.

The trusts must determine how far in advance of the transfer any consultation or engagement needs to happen. Trusts should also consider the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and their obligations in relation to engaging local authorities on merger plans.

10.2 Acquisition – section 56A

Section 56A of the NHS Act 2006 provides for an FT to acquire an NHS trust or another FT. An acquisition involves the dissolution of the acquired trust and the wholesale transfer of its assets and liabilities to the acquiring FT.

There are numerous examples of FT–FT acquisitions and FT–NHS trust acquisitions. It is not possible for an NHS trust to acquire an FT under section 56A.

In practice, an acquisition is often used to combine two entities rather than as a means for an FT to 'take over' another trust. For ease of reference, we use the term 'acquirer or acquiring FT' and 'target trust or target FT' but this is not intended to signal a takeover by one of the other. The post-acquisition FT is referred to as the 'enlarged FT'.

Application

The target trust and the acquirer must make a joint written application to NHS England for the acquisition. The application must include supporting documents to show that the requirements of section 56A have been met. They are:

- a copy of the proposed constitution of the acquiring FT amended on the assumption that it acquires the target trust
- evidence that the majority of the council of governors of each FT involved has approved the application; that is, a majority of all governors in post at the relevant time and not just a majority of those voting at the governors' meeting
- acknowledgement of the transaction rating given by NHS England (for significant transactions only).

The transaction rating must be green or amber for the transaction to proceed as this confirms we are satisfied that the trusts have taken the necessary steps to prepare for the acquisition.

Grant of Acquisition

We must grant the application if:

- we are satisfied that the necessary steps to prepare for the acquisition have been taken (as evidenced by a green or amber transaction rating); and

- the grant is approved by the Secretary of State.

The decision to grant an acquisition will be taken by an NHS England committee shortly before the planned effective date. The decision is confirmed in a document called a Grant of Acquisition which we will issue and then publish on our online FT directory. For ease of accounting, the effective date is typically the first day of a month even if it falls on a weekend.

On the effective date of the acquisition, the target trust is dissolved and subsumed into the acquirer which continues in existence under the terms of its revised constitution. All property (including contracts) and liabilities (including criminal liabilities) of the target trust automatically transfer to the acquiring FT by virtue of section 56AA. It is not legally possible to split out the target trust's property and liabilities as part of this process. In particular, where the target is an NHS trust, the Secretary of State and NHS England cannot exercise their powers under schedule 4 to dissolve the NHS trust and transfer its property and liabilities to multiple entities.[13] An acquisition cannot therefore take place in conjunction with a schedule 4 transaction.

There is no gap in timing between the dissolution and the transfer. This provides legal certainty and a seamless legal transition of the target trust to the acquirer. As such, the target trust does not exist as a 'shell' entity for any period of time before its dissolution.

Legislation provides for continuity of acts and documents from the target trust to the enlarged FT.

Transaction agreement

The parties may find it beneficial to agree in writing certain commercial and governance matters relating to the acquisition. An agreement, known as a transaction agreement, can be used to document commitments, assurances and processes, and to identify key assets and liabilities. The trusts may wish to agree heads of terms (a non-binding document) before proceeding to enter into a more detailed transaction agreement. The agreement is not the legal instrument by which the acquisition is effected and nor is it

[13] Section 57(5) of the NHS Act 2006.

the means by which the property and liabilities transfer – the relevant legal instruments are the Grant of Acquisition and section 56AA.

If there are other parties who have a vested interest in the transaction, such as a commissioner who is providing financial support, they can also be made parties to the agreement.

Entering into an agreement may require approval from each FT's council of governors. If the agreement amounts to a 'significant transaction' as described in the FT's constitution(s), more than half the members of each council of governors will need to vote in favour of it at a governors' meeting. The vote can be taken at the same time as the governors vote to approve the transaction application.

Board

The board of the target trust falls away in consequence of the dissolution of the trust. The board of the acquirer continues to exist after the acquisition.

The enlarged FT's board will need to be thought about and discussed at an early stage in terms of its structure, size, the individuals who might fill the roles and the process for filling any vacant or new roles. The general expectation is that the enlarged FT's board should have appropriate representation from each trust.

On or after Day 1changes to the board can be made in accordance with the structure set out in the revised constitution. This process can take several months if there is an open competition to recruit to new director posts for example. All board appointments must be made in accordance with schedule 7 of the NHS Act 2006 as per usual, meaning that governors appoint the NEDs, the NEDs appoint the chief executive and so on. If a person is *specified* in the revised constitution as a director of the enlarged FT but has yet to be appointed, the other directors may exercise their functions in the meantime.

Executive directors of the target who do not wish to continue in post with the enlarged FT will need to resign, accept severance/redundancy packages or be redeployed into non-director roles; otherwise their employment contracts will automatically transfer to enlarged FT. If that happens, the enlarged FT will need to resolve their employment status. These issues will need careful management from an HR perspective in terms of handling and employment law, and trusts are advised to seek bespoke legal/HR advice. We can support directors who are displaced as a result of an acquisition.

NEDs who are not continuing their roles in the enlarged FT will need to terminate their appointments in accordance with the agreed terms before the effective date. If they are to continue their role, they will need to be appointed to the enlarged FT in accordance with the relevant statutory process.

Members

The trusts will need to determine the enlarged FT's public, staff and patient/service user/carer constituencies and reflect any changes in the proposed constitution. In doing so, the trusts should be mindful of section 61(2) of the NHS Act 2006 which requires FTs to have regard to the need for those eligible for membership to be representative of the trust's service users. We will expect the new constituencies to reflect the make-up of the enlarged FT. For example, the public constituencies should cover the wider geographical areas served by the enlarged FT. The staff constituencies may also need to be reconfigured to take account of different hospital sites, professional groupings or services. The constituencies come into effect on Day 1 when the FT's constitution comes into effect.

The members of the acquirer will continue as members of the enlarged FT unless they are no longer eligible as a result of changes to the constitution.

The target FT's membership falls away in consequence of it being dissolved. The FT can however approach its existing public members to see whether they wish to be members of the enlarged FT – they cannot automatically be made members due to the requirement in schedule 7 of the NHS Act 2006 that individuals must apply to become a member of the public constituency. If they want to become a member, it must be made clear that they will be deemed to have made an application to come into effect on Day 1. The same approach will probably need to be taken for any patient/service user members unless the acquirer intends to invite its new patients/service users to become members without an application being made.[14] The trusts will need to check that the individuals are eligible to be a member according to the enlarged FT's proposed constitution. Membership established in this way will only exist in shadow form until the enlarged FT is established on Day 1.

NHS trusts do not have members. This means that the enlarged FT may need to take extra steps to recruit members from populations served by the target NHS trust, to ensure that the members are representative of those who are eligible for membership (section 61(1) of the NHS Act 2006). Where NHS trusts have recruited shadow

[14] This is permitted under paragraph 6(3) of schedule 7 to the NHS Act.

members in preparation for an application for FT status, these shadow members can be asked if they wish to be a member of the enlarged FT. If so, their shadow membership can be deemed to be an application for membership of the enlarged FT.

The timing of membership recruitment is up to the trusts. An acquiring FT can reconfigure its constituencies at any time by amending its constitution under section 37 of the NHS Act 2006. It can also recruit new members at any time. An acquirer could therefore expand its public and patient constituencies and recruit members ahead of the acquisition.[15] However, it would be prudent to wait until the acquisition is complete or sufficiently advanced before recruiting new members due to cost and resources needed. The target trust's staff members cannot become members of the acquiring FT ahead of the acquisition because their employment remains with the target trust at that point. Once their employment has transferred, Day 1, they can automatically become members in accordance with the constitution without having to apply.

Governors

The trusts will need to determine the configuration of the enlarged FT's council of governors. The council will need to reflect the make-up of the revised constituencies and partner organisations. The constituencies and structure of the new council of governors come into effect on Day 1 when the enlarged FT's constitution comes into effect.

The governors of the acquirer will continue as governors of the enlarged FT unless they are no longer eligible as a result of changes to the constitution. New governors may need to be elected to fill any vacancies and to represent any newly created constituencies.

A target FT's council of governors falls away in consequence of it being dissolved. It is not possible for the governors of a target FT to transfer to the acquiring FT – schedule 7 of the NHS Act 2006 requires governors to be chosen by election or appointment (by the acquiring FT) and there is no relaxation of this rule in the context of an acquisition. Individuals who served as governors of a target FT may stand for election to the enlarged FT if they are eligible under the terms of the revised constitution.

The timing of the elections is up to the trusts. An FT can reconfigure its council of governors at any time by amending its constitution (section 37) and can hold elections thereafter. An acquirer could therefore expand its public/patient membership constituencies to take account of the area served by the target trust and to hold

[15] Subject to section 61(2) of the NHS Act 2006.

elections for governors ahead of the acquisition. However, it would be prudent to wait until the acquisition is complete before holding elections due to the cost and resources needed.

Trusts will also need to decide the partner organisations from which they will appoint the appointed governors.

All of these matters will typically be decided by a joint working group across the two trusts in the months leading up to the effect date of the transaction as part of discussions on the proposed constitution of the enlarged FT.

Constitution

The trusts must submit a proposed constitution for the enlarged FT to NHS England as part of their application. The trusts will probably wish to form a joint working group to develop the draft constitution with representatives from both trusts and the FT governors. An NHS trust party will not have an existing constitution to work from but should be fully engaged. As per usual, the constitution should be modelled on the Model Core Constitution published by NHS England and should include a copy of the Model Election Rules for governor elections published by NHS Providers.

The trusts must satisfy themselves that the proposed constitution complies with schedule 7 of the NHS Act 2006, taking legal advice as needed. We do not perform a detailed review of the constitution but we will want to understand, in general terms, the major changes from the old constitution(s).

Section 37 of the NHS Act 2006, which sets out the general process for amending an FT constitution, is not engaged when amending the FT's constitution for an acquisition. The constitution is submitted to NHS England in draft form and it takes effect if we grant the acquisition. The trusts will nevertheless want to ensure that governors and the board approve of the proposed constitution; this will likely be confirmed as part of their approval of the transaction for the purposes of making the acquisition application.

It is a legal requirement that some amendments are proposed. Trusts cannot submit a constitution without any proposed changes. Some transactions are likely to entail large constitutional changes; for example, to reflect new public constituencies and new appointed governors. In other cases, the changes may be minor.

The enlarged FT is likely to want to change its name. There is guidance on what is appropriate for an FT name.

Licence and enforcement actions

The licence of the acquirer continues in force after the acquisition. No changes are made to its licence, except to reflect any name change. In that event, NHS England's licence register will be updated accordingly.

The licence of a target trust falls away in consequence of its dissolution and any enforcement actions associated with the licence, such as undertakings or discretionary requirements, also fall away. The enlarged FT will not automatically be placed in the recovery support programme (RSP) as a result of the target trust being in RSP.

CQC registration and other regulatory requirements

The enlarged FT must continue to be registered with the CQC from Day 1 so that its regulated activity, expanded as a result of the acquisition, is performed lawfully.

The enlarged FT will keep its organisational code issued by NHS Digital.

The trusts are exempt from stamp duty land tax in respect of the transferred property and liabilities.[16]

The trusts will need to ensure that there is a smooth transition of insurance/indemnity cover, including Clinical Negligence Scheme for Trusts (CNST), Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES) cover with NHS Resolution.[17]

The enlarged FT will be required to prepare the outstanding part-year accounts of the dissolved trust and to perform all statutory duties relating to those accounts.

Commissioner requested services

The enlarged FT's commissioners will be encouraged to revisit CRS designations in light of the acquisition.

TUPE

It is generally accepted that the Transfer of Undertakings (Protection of Employment) (TUPE) regulations applies to section 56A acquisitions. Trusts are responsible for seeking their own legal and HR advice on compliance with TUPE.

[16] By virtue of section 67A of the Finance Act 2003 (as amended by section 216 of the Finance Act 2012).
[17] NHS Resolution is the operating name for the NHS Litigation Authority.

NHS England has the power to make a staff transfer order if, for instance, there is any doubt as to whether TUPE applies. We will decide whether to exercise our staff transfer power, but we will be led by whether the trusts require the staff transfer order and, if so, the extent to which the power should be used. We have not previously made a staff transfer order. In all previous acquisitions, the trusts were content that TUPE would be effective.

The target trust's executive directors are employees and their employment contracts transfer to the acquirer under TUPE unless alternative action is taken. NEDs are office holders rather than employees. For further discussion, see the sub-section entitled 'Board' above.

Consultation

There is no requirement in section 56A for a consultation. However, the trusts will need to consider whether the acquisition triggers other consultation and engagement obligations. In particular:

- Section 242 of the NHS Act 2006 places a duty on trusts to involve the public and local authorities concerning decisions about changes to services. An acquisition is generally considered a change to organisational form and does not usually entail any immediate service changes. On that basis it is unlikely that the acquisition of itself will trigger the section 242 duty. If service changes are to follow the acquisition, the enlarged FT should work with commissioners as they develop plans for service reconfiguration and should consider whether and when any public involvement under section 242 becomes necessary.
- A TUPE consultation is likely to be required. Even where NHS England transfers the staff by the Order, TUPE may continue to apply to most, if not all, the staff concerned and the trusts must ensure they comply with the consultation duties under the TUPE Regulations. In summary, before the transfer happens, employers must inform their trade union or employee representatives of transfer in writing including:
  - the fact that the transfer is going to take place, approximately when and why
  - any social, legal or economic implications for the affected employees – for example, a change in location or risk of redundancies
  - any measures that the outgoing and incoming employers expect to take in respect of their own employees (even if this is nothing)
  - the number of agency workers employed, the departments they are working in and the type of work they are doing

- the outgoing employer must provide information about any measures which the incoming employer is considering taking in respect of affected employees.

The trusts must determine how far in advance of the transfer consultation or engagement needs to happen. The trusts should also consider the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and their obligations in relation to engaging the local authority on acquisition plans.

10.3 Three-way merger or acquisition – sections 56 and 56A

At the time of writing, there has been one example of a three-way transaction which used the section 56A acquisition power.

The legislation for mergers (section 56) and acquisitions (section 56A) is written in the singular – that is, 'an NHS FT' merges with or acquires 'another NHS FT or NHS trust'. However, these sections are subject to the general rule of statutory interpretation which says that words in the singular include the plural (and vice versa) unless there is a contrary intention in the legislation. This means that 'an NHS FT' or 'another NHS FT or NHS trust' can be taken to mean more than one trust, unless there is a contrary intention.

There is one instance of contrary intention in our view. Only one FT can be an acquiring trust under section 56A. It is not therefore possible to have two or more acquiring FTs because section 56AA states that the target is dissolved and all its property and liabilities transfer to an acquirer by operation of law. It is not possible to have two surviving FTs and only one dissolved target whose assets and liabilities are then split between two or more acquirers. It is however possible to have one acquiring FT with two or more targets.

It is possible for a merger to take place under section 56 (mergers) between more than two parties so long as one party is an FT. Only one FT can be established following a merger.

As for bilateral mergers and acquisitions, the parties may wish to enter into a transaction agreement. In a three-way transaction, a single agreement between all trusts is preferable to separate agreements between the acquiring trust and each target.

All the requirements of sections 56 and 56A can be met on a multi-party basis – that is, the taking of necessary steps, amendment of constitution, governor approval, application to NHS England, Secretary of State approval, etc. Please refer to sections 10.1 and 10.2 for more detail on these requirements.

In three-way transactions, it is still the case that:

- in a section 56 merger, all trusts will be dissolved and a New FT created. The resulting entity cannot be an NHS trust even if, for example, three NHS trusts and one FT merge

- only an FT can acquire trusts under section 56A. NHS trusts cannot acquire FTs or NHS trusts
- only whole entities can participate – that is, it is not possible to have a three-way transaction involving just one part of a trust, eg one hospital site
- where one party is an NHS trust, the Secretary of State and NHS England cannot exercise their powers under schedule 4 to dissolve NHS trusts and transfer their property and liabilities.[18] A three-way acquisition or merger cannot therefore take place in conjunction with a schedule 4 transaction.

A transaction which requires the establishment of a new NHS trust can only be given effect by the Secretary of State exercising the power in section 25 to create new NHS trusts. NHS England is unable to establish new NHS trusts.

[18] Section 57(5) of the NHS Act 2006.

10.4 Dissolution of NHS trusts and transfer of assets – schedule 4

Paragraphs 28 and 29 of Schedule 4 of the NHS Act 2006 provide for the dissolution of NHS trusts and the transfer of their property, liabilities and staff to other NHS bodies, including NHS trusts and FTs. The property and liabilities can be transferred in their entirety to a single receiver or split between multiple receivers.

Using Schedule 4, an NHS trust can 'acquire' another NHS trust by acquiring all its assets and liabilities. An FT can also 'acquire' an NHS trust under Schedule 4 in this way, but it would be simpler to achieve the same result using section 56A.

There have been many examples of NHS trust dissolutions under schedule 4. FTs cannot be dissolved under Schedule 4.

Application

The board of an NHS trust can apply to the Secretary of State or NHS England to be dissolved. The application will be in the form of a short letter from the trust.

The Secretary of State and NHS England also have the power to dissolve an NHS trust if it's considered to be in the interests of the health service without the trust making an application.

Statutory orders

The Secretary of State or NHS England will consider the application letter alongside other information produced as part of the transaction review process. There is no defined legal criteria by which to judge the application, however the following will typically be taken into account:

- the transaction rating issued by NHS England which must be green or amber to proceed (for significant transactions only);
- the results of the statutory consultations - see details below;
- if the application is addressed to the SoS, DHSC will seek certain information about the transaction supplied to NHS England as part of its transaction review such as:
    - the rationale for the dissolution and evidence of options appraisal;

- assurance that all elements of the dissolving trust have been accounted for;
- assurance that all elements (property, liabilities and staff) will have a home in another NHS body post-dissolution and that there will be a legacy organisation if needs be;
- evidence of engagement and support by key stakeholders;
- patient/clinical benefits and other benefits;
- information about risks and mitigation of risks;
- financial details including funding requests and transaction costs.

If the application is approved, the Secretary of State or NHS England will make an order dissolving the trust. An order made by NHS England must be approved by the Secretary of State.

A further statutory order will be made for the transfer of the dissolved trust's property, liabilities (including criminal liability) and staff. The dissolution order and the transfer order ('the Orders') are timed to come into effect at the same time so that there is no time gap between the dissolution and the transfer. This means that the dissolving trust does not exist as a 'shell' entity for any period of time.

The Orders are prepared either by DHSC or NHS England depending on who is exercising the power. . Accordingly, the process can take a little longer than a section 56A acquisition, typically two to three weeks longer. The Orders do not need to be laid before Parliament.

Consultation

Except in urgent situations, the dissolving trust is required to undertake a consultation before the Orders can be made. The requirements are set out in the National Health Service Trusts (Consultation on Establishment and Dissolution) Regulations 2010.

The dissolution of the trust requires consultation with each relevant Local Healthwatch organisation (regulation 2(5)(a)). A "relevant local Healthwatch organisation" is a local Healthwatch organisation for the area of a local authority in which there is situated any hospital or other establishment or facility managed by the dissolving trust.

The transfer of property and liabilities on dissolution of the trust requires consultation with each relevant Local Healthwatch organisation and staff interests (regulation 3(1)(a)). "Staff interests" means such persons or bodies as the trust may recognise as

representing persons who are employed by or for the purposes of that trust, and who are, in its opinion, likely to be affected by a transfer order.

The dissolution consultation and the transfer consultation are separate legal requirements but the regulations allow them to be combined. A consultation can be timed to occur alongside other transaction processes so as not to lengthen the overall timetable.

The results of the consultation must be reported to the Secretary of State or NHS England before the Orders can be made. We will advise trusts of the person to whom the results should be reported and the timescales for this.

Employment

The transfer order is likely to include provisions for the transfer of staff and employment rights and liabilities. These provisions do not displace TUPE which may also continue to apply. Accordingly the trust will need to consider a full and proper engagement with all trade unions and staff-side organisations in accordance with TUPE. Trusts will need to seek advice on the application of TUPE from legal and HR advisers. Please see the details on TUPE included in the sections on mergers, acquisitions and FT dissolution elsewhere in this appendix.

Board

The board of the dissolving trust falls away in consequence of it being dissolved. The boards of the receiving trust(s) are unaffected.

Early thought and discussion may be needed about the structure and size of the board of the receiving trust(s) and whether any changes should be made to reflect the acquired sites or services, as well as the process for filling any vacant or new roles. Individuals on the board of the receivers continue in post after the transaction.

It is likely that some or all of the directors of the dissolving trust will not wish or be able to continue in their roles or continue them in the same way with a receiving trust.

Executive directors of the dissolving trust who are not continuing their roles with a receiving trust will need to resign, accept severance/redundancy packages or otherwise agree to terminate their employment contracts; otherwise they will transfer to a receiving trust under TUPE and the staff transfer provisions of the transfer order. This will need careful management from an HR perspective. We can support directors who are displaced as a result of a dissolution.

NEDs from the dissolving trust who are not continuing their roles in a receiving trust will need to terminate their appointments in accordance with the agreed terms before the effective date. If they are to continue their role, they will need to be appointed to the receiver in accordance with the relevant statutory process.

10.5 Dissolution of an NHS foundation trust – section 57A

Section 57A provides for FTs to be dissolved. There have been no section 57A dissolutions to date because the pre-2022 Act dissolution regime was legally uncertain in our view and difficult to put into practice. The Health and Care Act 2022 clarifies how the dissolving FT's property and liabilities will be dealt with.

It is not legally possible for an NHS trust to be dissolved under section 57A – see the section 'Dissolution of NHS trusts and transfer of assets' above.

Application

An FT may apply to NHS England to be dissolved.

The application must include supporting documents to show that the requirements of section 57A have been met. They are:

- evidence that the majority of the council of governors has approved the application; that is, a majority of all governors in post at the relevant time and not just a majority of those voting at the governors' meeting
- acknowledgement of the transaction rating given to the transaction by NHS England (for significant transactions only).

The transaction rating must be green or amber for the transaction to proceed as this confirms we are satisfied that the FT has taken the necessary steps to prepare for the dissolution.

Grant of Dissolution and Statutory Order

We must grant the dissolution if we are satisfied that the FT has taken the necessary steps to prepare for the dissolution (as evidenced by a green or amber transaction rating). NHS England is not required to obtain the approval of the Secretary of State for the grant.

Where an application is granted, we must make a statutory instrument, an Order, which:

- dissolves the FT;
- transfers the property and liabilities (including criminal liabilities) to another FT, an NHS trust or the Secretary of State; and
- provides for the transfer of any employees of the dissolved FT

- The decision to grant a dissolution will be taken by an NHS England committee shortly before the planned effective date. The decision is confirmed in a document called a Grant of Dissolution which we will issue. For ease of accounting, the effective date is typically the first day of a month even if it falls on a weekend.
- Upon the dissolution being granted, the Chief Executive of NHS England will sign an order19 (the Order) to dissolve the FT and to transfer the specified property, liabilities and staff on the effective date. It will also provide for continuity from the dissolved FT to the receiver/s and for other related matters.
- We draft the Order in the weeks before the dissolution and will engage with the trust's legal advisers as part of this process. The Order does not need to be laid before Parliament but we will liaise with DHSC to arrange for it to be registered and published. The dissolution of the FT and the transfer of its property, liabilities and staff will be timed to happen simultaneously. This provides legal certainty and a seamless legal transition. As such, the dissolving FT will not exist as a 'shell' entity for any period of time.
- Once the Grant of Dissolution is issued and the Order is made, no further legal steps are needed to make the dissolution effective. The Order will be published on the government legislation website.

Transfer of property and liabilities

The property to be transferred includes assets such as estates, equipment, intellectual property and contractual rights, and the transferring liabilities include civil liabilities, criminal liabilities[20] and private finance initiative (PFI) liabilities. The FT will also need to consider the destination of any charitable funds.[21]

The Order may transfer all of the property and liabilities to a single receiver or it may split them between multiple receivers. Section 57A does not require the dissolving FT to specify where the property and liabilities should transfer. We will work with the dissolving FT, as well as any proposed receivers, to determine where the property and liabilities should go. The decision ultimately rests with NHS England however. NHS England may require the dissolving FT to prepare a schedule of transferring property and liabilities to sit behind the Order if multiple receivers are involved.[22] It would be

[19] A statutory instrument.
[20] Section 57A(4)(b) of the NHS Act 2006.
[21] https://www.gov.uk/government/publications/nhs-charities-guidance/nhs-charities-guidance
[22] For an example of a dissolution and transfer order that refers to a separation schedule, see The Mid Staffordshire NHS Foundation Trust (Dissolution and Transfer) Order 2014 S.I. 2014/2849.

possible for the dissolving FT to commercially transfer some services and property to particular receivers ahead of dissolution, see section 10.7 below on commercial transfers.

As the transfer of liabilities is effected by a statutory Order, the FT does not need to obtain consent from the third parties to whom the liabilities are owed, such as lenders and suppliers. Depending on the specific terms of a contract, third parties may be able to invoke contractual rights which are triggered by the dissolution, including termination rights. In general however, third parties should carry on as normal and deal with the receiver/s in place of the dissolved FT.

One of the receivers should be the designated 'legacy organisation' for the purposes of dealing with residual liabilities, incorrectly assigned property and any matters relating to the dissolving FT which cannot be attributed to any of the receivers. These matters could include liabilities relating to staff who left the FT before it dissolved, for example. This model has been seen in the dissolution of South London NHS Trust and Mid Staffordshire NHS Foundation Trust following, in each case, a trust special administration process.

Transaction agreement

The dissolving FT may wish to enter into a transaction agreement with potential receivers to govern certain matters leading up to the dissolution. Third parties who have a vested interest in the transaction, such as a commissioner who is providing financial support for the transaction, may also be a party.

Board

The board of the dissolving FT falls away in consequence of it being dissolved. The boards of the receiving trust(s) are unaffected.

Early thought and discussion may be needed about the structure and size of the board of the receiving trust(s) and whether any changes should be made to reflect the acquired sites or services, as well as the process for filling any vacant or new roles.

It is likely that some or all of the directors of the dissolving FT will not wish or be able to continue in their roles or continue them in the same way with a receiving trust. Executive directors of the dissolving FT who are not continuing their roles with a receiving trust will need to resign, accept severance/redundancy packages or otherwise agree to terminate their employment contracts; otherwise they will transfer to a receiving trust under TUPE and the staff transfer provisions of the transfer order. This will need

careful management from an HR perspective. We can support directors who are displaced as a result of a dissolution.

NEDs from the dissolving FT who are not continuing their roles in a receiving trust will need to terminate their appointments in accordance with the agreed terms before the effective date. If they are to continue their role, they will need to be appointed to a receiver in accordance with the relevant statutory process.

Members and Governors

The FT's membership will automatically fall away in consequence of it being dissolved. Individual members can apply to become a member of any receiving FTs in the usual way.

The FT's council of governors automatically falls away in consequence of it being dissolved. Governors cannot automatically become governors of any receiving FT due to the requirement in Schedule 7 of the NHS Act 2006 that governors must be chosen by election or appointment. They may stand for election to be a governor of another FT provided they meet the constitutional requirements.

Licensing and enforcement action

The licence of the dissolving FT falls away on dissolution and the Order will specifically state that it no longer has effect.

Any enforcement actions associated with the licence such as section 106 enforcement undertakings or section 105 discretionary requirements will also fall away. Receiving trusts will not automatically be placed in the recovery support programme (RSP) as a result of the dissolving FT being in RSP.

Commissioner requested services

Commissioners will be encouraged to revisit commissioner requested services (CRS) designations in light of the transfer of services to other trusts.

CQC registration and other regulatory requirements

Receiving trusts must ensure that they are appropriately registered with the CQC to perform any new services and activities that they are taking over from the dissolving FT.

The dissolving FT will need to ensure that there is a smooth transition of insurance/indemnity cover, including Clinical Negligence Scheme for Trusts (CNST),

Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES) cover with NHS Resolution.[23]

The dissolving FT will need to investigate liability for stamp duty land tax in respect of the transferred estate.[24]

The designated legacy trust will be required to prepare the outstanding part-year accounts of the dissolved FT and to perform all statutory duties relating to those accounts.

Staff Transfer

The employees of the dissolving FT will need to transfer to one of the receiving parties. The transfer of staff will likely follow service lines, eg a nurse who works at site A where maternity services are provided will transfer to the receiver which acquires site A and the maternity service. There will however be some members of staff who are not assigned to a particular service, eg finance, catering and HR staff. Due diligence will be required to establish the distribution of staff and decisions will need to be made as to where they transfer. NHS England is required to include staff transfer provisions in the Order. The provisions will give certainty as to the destination of the FT's staff. As a general principle, TUPE is likely to apply to a dissolution but any uncertainty about the application of TUPE regarding staff members or groups of staff performing functions that are not clearly attributable to any receiver will be dealt with in the Order. Trusts are responsible for seeking their own legal and HR advice on compliance with TUPE.

The staff transfer provisions will provide for the employment contracts of the executive directors to transfer to agreed receivers unless alternative action is taken. NEDs are office holders rather than employees. As such they will not transfer under TUPE or any staff transfer provisions of the Order.

Consultation and engagement

There is no requirement in section 57A for a consultation. However, the dissolving FT will need to consider whether the separation triggers other consultation and engagement obligations. In particular:

- Section 242 of the NHS Act 2006 places a duty on trusts to involve the public and local authorities concerning decisions about changes to services. A dissolution is generally considered a change to organisational form and does not usually entail

[23] NHS Resolution is the operating name for the NHS Litigation Authority.
[24] See section 67A of the Finance Act 2003 (as amended by section 216 of the Finance Act 2012).

any immediate service changes. On that basis, it is unlikely that the dissolution of itself will trigger the section 242 duty. If service changes are to follow the dissolution, the receiving trusts should work with commissioners as they develop plans for service reconfiguration and should consider whether and when any public involvement under section 242 becomes necessary.

- A TUPE consultation is likely to be required. Even where NHS England transfers the staff by the Order, TUPE may continue to apply to most, if not all, the staff concerned and the trusts must ensure they comply with the consultation duties under the TUPE Regulations. In summary, before the transfer happens, employers must inform their trade union or employee representatives of transfer in writing including:
  - the fact that the transfer is going to take place, approximately when and why
  - any social, legal or economic implications for the affected employees – for example, a change in location or risk of redundancies
  - any measures that the outgoing and incoming employers expect to take in respect of their own employees (even if this is nothing)
  - the number of agency workers employed, the departments they are working in and the type of work they are doing
  - the outgoing employer must provide information about any measures which the incoming employer is considering taking in respect of affected employees.
- The trust should consider the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and their obligations in relation to engaging local authorities on dissolution plans.

10.6 Separation of an NHS foundation trust – section 56B

Section 56B of the NHS Act 2006 provides for the separation of an FT into two or more FTs.

A separation involves the dissolution of an FT and the establishment of new FTs (New FT/s). There are no statutory limits on how many New FTs can be established as a result of a separation. A separation cannot result in new NHS trusts.

It is not legally possible for an NHS trust to be separated under this section.

According to the explanatory notes to section 56B, the separation power can be used when, for example, an FT formed following a merger becomes too large to manage itself. Separating FTs may therefore be larger organisations wanting to downsize into smaller and more manageable organisations. The separation power could be used to establish hospital sites as FTs in their own right or it could be used to separate an FT along service lines, eg a general hospital and a specialist hospital or an adult hospital and a children's hospital. Section 56B does not restrict the circumstances in which an FT can make an application for separation. It would be a decision for the FT as to whether and when to apply.

At the time of writing, there have been no separations. They are likely to be complex in practice as there will be a need to identify the property, liabilities, services and staff to be assigned to each New FT and the need to establish governance structures for each New FT. This guidance sets out how the process is likely to implemented; however, it is untested and will need to be carefully worked through with the separating FT and its legal advisers.

Application

The separating FT must make a written application to NHS England. The application must include supporting documents to show that the requirements of section 56B and our other regulatory requirements have been met. They are:

- a proposed constitution for each New FT
- evidence that a majority of the council of governors of the FT has approved the application; that is, a majority of all governors in post at the relevant time and not just a majority of those voting at the governors' meeting
- specifications of the property and liabilities proposed to be transferred to the New FTs

- acknowledgement of the transaction rating given by NHS England (for significant transactions only).

The transaction rating must be green or amber to proceed as this confirms we are satisfied that the FT has taken the necessary steps to prepare for the separation.

Grant of Separation and Statutory Order

We must grant the application if:

- we are satisfied that the necessary steps to prepare for the separation have been taken (as evidenced by a green or amber transaction rating); and
- the grant is approved by the Secretary of State.

The decision to grant a separation will be taken by an NHS England committee shortly before the planned effective date. The decision is confirmed in a document called a Grant of Separation which we will issue. The New FTs are established on the effective date of the grant (Day 1) under the terms of their respective constitutions. For ease of accounting, the effective date is typically the first day of a month even if it falls on a weekend.

Upon the separation being granted, the Chief Executive of NHS England will sign an order[25] (the Order) to transfer the specified property and liabilities of the separating FT to the New FTs and to dissolve the separating FT on the effective date.[26] It will also provide for continuity from the separating FT to the New FTs and for other related matters.

We draft the Order in the weeks before the separation and will engage with the trust's legal advisers as part of this process. The Order does not need to be laid before Parliament but we will liaise with DHSC to arrange for it to be registered and published. The establishment of the New FTs (per the Grant of Separation) and the dissolution of the separating FT and transfer of its property and liabilities (per the Order) will be timed to happen simultaneously. This provides legal certainty and a seamless legal transition from the separating FT and the New FTs. As such, neither the separating FT nor the New FTs exist as a 'shell' entity for any period of time. All New FTs will be established at the same time.

[25] A statutory instrument.
[26] Sections 57(2) and 64(5)(b) of the NHS Act 2006.

Once the Grant of Separation is issued and the Order is made, no further legal steps are needed to make the separation effective. The New FTs will be listed on our online FT directory and the Grant of Separation will be published on the directory along with the constitutions of the New FTs. The Order will be published on the government legislation website.

Transfer of property and liabilities

The transferring property includes assets such as estates, equipment, intellectual property and contractual rights, and the transferring liabilities include criminal liabilities[27] and private finance initiative (PFI) liabilities. The separating FT will need to identify all known property and liabilities, either individually or by type, through detailed due diligence. The FT will also need to consider the separation of any charitable funds.[28]

The separation application will need to specify the property and liabilities which are proposed to be transferred to each New FT. The legislation does not specify any particular proportion; however, the split of assets and liabilities should be sufficient to set up each New FT as an operationally viable organisation. A separating FT could not propose to leave all its assets to one FT and all its liabilities to the other FT, for example. Equally, it would not be possible to propose that all the substantial assets and liabilities transfer to one FT, leaving the other FT with no resources. But the separating FT could apportion certain assets and liabilities to one FT with the remainder going to the other FT. While it is unlikely that we will disagree with the trust's wishes (provided that they are reasonable), it is possible that we decide that the property and liabilities should be split in a different way. The decision rests with NHS England to determine where the property and liabilities will transfer. We would discuss any such proposals with the FT at the earliest opportunity in the transaction review process.

NHS England will require the separating FT to prepare a separation schedule to sit behind the Order.[29]

The separating FT will probably want all its property and liabilities to transfer to one of the New FTs; however, it is legally possible to allocate some property and liabilities to be transferred to another FT, an NHS trust or the Secretary of State. NHS England has the power to transfer the 'remaining' property and liabilities to other trusts or to the Secretary of State.

[27] Section 57(4) of the NHS Act 2006.
[28] https://www.gov.uk/government/publications/nhs-charities-guidance/nhs-charities-guidance
[29] For an example of a dissolution and transfer order that refers to a separation schedule, see The Mid Staffordshire NHS Foundation Trust (Dissolution and Transfer) Order 2014 S.I. 2014/2849.

As the transfer of liabilities is effected by a statutory Order, the separating FT does not need to obtain consent from the third parties to whom the liabilities are owed, such as lenders and suppliers. Depending on the specific terms of the contract, third parties may seek to invoke contractual rights, including termination rights, which are triggered by the separation, eg on the basis of a material adverse change (MAC) clause. The separating FT may want to obtain assurances from its high value contracting partners that they will not exit their contracts. In general, however, third parties should carry on as normal and deal with the New FTs in place of the dissolved FT and the Order will ensure legal continuity of acts and documents.

One of the New FTs should be the designated 'legacy organisation' for the purposes of dealing with residual liabilities, incorrectly assigned property and any matters relating to the separating FT which cannot be attributed to any of the New FTs. These matters could include liabilities relating to staff who left the FT before it separated, for example. This model has been seen in the dissolution of South London NHS Trust and Mid Staffordshire NHS Foundation Trust following, in each case, a trust special administration process.

Transaction agreement or separation agreement

It will not be possible for the separating FT and the proposed New FTs to enter into a transaction agreement in the lead up to the separation; however, there may be a need for other arrangements between the separating FT and third parties who have a vested interest in the transactions, such as a commissioner who is providing financial support for the transaction.

Proposed directors and interim boards

The board of the separating FT falls away in consequence of it being dissolved. On or after Day 1, the New FTs' governance structures, including the councils of governors and boards, can be established. This process can take several months. Until then, the "proposed directors" of each New FT have control and authority to exercise the FT's functions pursuant to section 56B(5) of the NHS Act 2006.

The legislation does not define who a "proposed director" is. A reasonable interpretation would suggest that it means a person who is intended to take up post in the New FT substantively, subject to being appointed in accordance with the usual statutory process. A proposed director could be:

- a director of the separating FT who is proposed to be a director of one of the New FTs

- another employee within the separating FT, eg a deputy medical director who is proposed to become the medical director of one of the New FTs
- an individual who is completely new and who has never held a position within the separating FT, eg a proposed new chair
- individuals who are proposed to be appointed as directors jointly across the New FTs.

The separating FT will need to establish interim boards for each New FT comprising of individuals who are the proposed directors of that FT. Each interim board should be an appropriate mix of executive and non-executive directors and should meet all the statutory requirements for the future FT board – that is, it should have a chair, other NEDs, chief executive, finance director, medical director, nursing director and other executive directors.

There is no defined process for the appointment of proposed directors to the interim boards. We do not endorse any particular approach. It is for the FT to decide how to establish the interim boards. This could be through a process of nomination from among existing directors, an internal or external competition, or a combination of methods. The FT should consider how the governors should be involved in the selection process (at least in the case of the proposed NEDs and chair). The FT may wish to invite an NHS England representative to sit on any interview panel. We can provide informal views on which individuals are appointable but the decisions will remain with the FT.

The need for continuity and corporate memory from the separating FT to each New FT should be considered. It may not be appropriate, for example, for one interim board to be comprised of all directors of the separating FT while the other interim board is comprised of entirely new individuals. It may be sensible to have joint appointments across the New FTs initially.

Proposed directors coming from outside the FT will need to be sufficiently informed about the transaction, business case, LTFM, etc to be able to engage in the transaction process. The separating FT may need to put safeguards in place around sharing of information with such individuals.

The separating FT will have to carefully manage the expectations of the proposed directors on the interim boards and should not give any guarantees about the prospect of a permanent role with the New FT. This is because the legislation is clear that the interim boards only have temporary control until the substantive directors are appointed in accordance with the structure set out in the constitutions. Being appointed to an

interim board does not mean that the director's existing terms and conditions of employment automatically become time limited or diminished in any way. As such, their employment contracts will transfer to one of the New FTs in accordance with the Order. This can give rise to employment law complications in the event that the proposed directors are not then appointed as the substantive directors. This is discussed further below – see the section 'Substantive board' below.

The interim boards should be in place by the start of our FBC assurance process. They will lead the FT through thetransaction process and will interface with us, in particular at the Challenge Meeting when NHS England staff and board members meet representatives of the New FTs.

In the pre-separation period, the interim boards have no legal powers and should not purport to take any decisions on behalf of the separating FT. Functions of the FT will continue to be exercised by its board.

Once the New FTs' substantive boards have been established, the interim boards should hand over and disband as soon as possible. There is no specified time limit but we recommend that the interim board should not remain in place for longer than five months after the separation. This timescale allows for governor elections to be held after the separation and for substantive directors to be appointed.

These issues will need careful management from an HR perspective in terms of handling and employment law, and trusts are advised to seek bespoke legal/HR advice. NHS England can support directors who are displaced as a result of a separation.

Members and governors

The interim boards will need to determine the New FTs' public, staff and patient/service user/carer constituencies. In doing so, they should be mindful of section 61(2) of the NHS Act 2006 which requires FTs to have regard to the need for those eligible for membership to be representative of their service users. We will expect the new constituencies to reflect the profile of the New FTs.

The interim boards will need to consider how and when to establish the membership and when to hold elections for the council of governors. This can only happen after Day 1. The sequencing of these events, as required by law, means that the board cannot be fully established for some months after Day 1.

The separating FT's membership will automatically fall away in consequence of it being dissolved. However, it can approach existing members, prior to separation, to ask

whether they wish to be a member of one or more of the New FTs. They cannot automatically be made members of the New FTs due to the requirement in schedule 7 of the NHS Act 2006 that individuals must make an application. There is no rule against individuals being members of more than one FT but members must be eligible under the constitution of each New FT that they wish to join. If the New FTs have a Rest of England and Wales constituency, this will enable all existing members to be members of all New FTs if they choose to. So the choice for members is to (1) be a member of one of the New FTs, (2) be a member of more than one New FT and (3) end their membership, which would happen automatically when the separating FT dissolves.. If they wish to become a member of one of the New FTs, it must be made clear that they will be deemed to have made an application.

Membership established in this way will only exist in shadow form until the New FTs are established on Day 1 at which point the application is deemed to be made and accepted. It should enable each New FT to have a reasonably substantial membership on Day 1 from which to elect governors. The same approach will need to be taken for any patient/service user members, unless the New FT wishes to invite its future patients/service users to become members without an application being made.[30]

Alternatively, the FT may decide that members will need to be recruited afresh by the New FTs after they are established. Trusts should however be mindful of the significant time and effort it can take to establish a membership from scratch and the knock-on effect of this on the timing of governor elections and therefore on the appointment of the substantive board members.

With regards to the staff members, the New FTs can choose to automatically enrol their staff as members of the staff constituency on Day 1. We recommend this approach.

The interim boards will also need to determine the configuration of the New FTs' councils of governors. The proposed councils will need to reflect the make-up of each New FT, its new constituencies and partner organisations. The separating FT's council of governors automatically falls away in consequence of it being dissolved. The governors cannot automatically become governors of the New FTs due to the requirement in Schedule 7 of the NHS Act 2006 that governors must be chosen by election or appointment. They may stand for election to be a governor of a New FT provided they meet the new constitutional requirements.

[30] This is permitted under paragraph 6(3) of schedule 7 of the NHS Act.

Constitutions

The separating FT must submit a proposed constitution for each New FT to NHS England as part of its application. It will probably wish to form a working group to develop the draft constitutions. As per usual, the constitution should be modelled on the Model Core Constitution published by NHS England and should include a copy of the Model Election Rules for governor elections published by NHS Providers.

Each New FT will need a name. There is guidance on what is appropriate for an FT name.

Each interim board must satisfy itself that the proposed constitution complies with schedule 7 of the NHS Act 2006, taking legal advice as needed. We do not perform a detailed review of the constitutions but we will want to understand, in general terms, the new governance structures.

The FT should note that the procedure under section 37 of the NHS Act 2006 (amendments to FT constitutions) does not apply. The constitutions are submitted to NHS England in draft form as part of the separation application and they take effect on Day 1 if we grant the separation.

Licensing and enforcement action

The licence of the separating FT falls away on dissolution and the Order will specifically state that it no longer has effect.

Any enforcement actions associated with the licence such as section 106 enforcement undertakings or section 105 discretionary requirements will also fall away. The New FTs will not automatically be placed in the recovery support programme (RSP) as a result of the separating FT being in RSP.

Each New FT is deemed to have made a licence application and to have met the licensing criteria[31]. If the separation is granted, we will issue licences and they will take effect on Day 1. NHS England's licence register will then be updated.

Commissioner requested services

The New FTs' commissioners will be encouraged to revisit commissioner requested services (CRS) designations in light of the separation.

CQC registration and other regulatory requirements

[31] Section 88 of the Health and Social Care Act 2012 as amended by the Health and Care Act 2022

The New FTs must be registered with CQC from Day 1 so that their regulated activity is performed lawfully. They will not have a CQC rating until their first inspection as the previousrating falls away on dissolution.

The New FTs will need a new organisational code from NHS Digital.

The separating FT will need to ensure that there is a smooth transition of insurance/indemnity cover, including Clinical Negligence Scheme for Trusts (CNST), Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES) cover with NHS Resolution.[32]

The separating FT will need to investigate liability for stamp duty land tax in respect of the transferred estate.[33]

The designated legacy FT will be required to prepare the outstanding part-year accounts of the separating FT and to perform all statutory duties relating to those accounts.

Staff transfer

The employees of the separating FT will need to transfer to one of the New FTs. The transfer of staff will likely follow service lines, eg a nurse who works at site A where maternity services are provided will transfer to the New FT which acquires site A and the maternity service. There will however be some members of staff who are not assigned to a particular service, eg finance, catering and HR staff. Due diligence will be required to establish the distribution of staff and decisions will need to be made as to where they transfer. Networking of staff within services is relatively common and extensive. One option will be to share staff and services after the separation under a combined workforce model.

As a general principle, TUPE is likely to apply to separations; however, there may be some uncertainty regarding staff members or groups of staff performing functions that are not clearly attributable to either of the New FTs. Trusts are responsible for seeking their own legal and HR advice on compliance with TUPE.

NHS England has the power to include staff transfer provisions in the Order. It is likely that we will exercise our staff transfer powers to provide certainty as to the destination

[32] NHS Resolution is the operating name for the NHS Litigation Authority.
[33] See section 67A of the Finance Act 2003 (as amended by section 216 of the Finance Act 2012).

of all staff. The staff transfer provisions will provide for employment contracts of the executive directors to transfer to the New FT of which they are a proposed director.

NEDs are office holders rather than employees. As such they will not transfer under TUPE or any staff transfer provisions of the Order. NEDs who are not appointed as proposed directors of a New FT will need to terminate their appointments in accordance with the agreed terms before Day 1.

New Governors

The membership and constituencies of the New FTs come into effect on Day 1 and elections for the governors can be held after this provided that the membership has been established (see above). Elections will need to be held in accordance with the Model Election Rules as set out in the New FT's constitution and they take at least 40 days to complete. The appointed governors can be appointed on or immediately after Day 1.[34] Once the council of governors is in place, the substantive chair and NEDs can be appointed.

Substantive board

As described above, the interim boards have control of the New FTs in the months after the separation while the substantive boards are being established. The substantive directors must be appointed in accordance with the provisions of schedule 7 of the NHS Act 2006, meaning that:

- the chair and other NEDs must be appointed by the council of governors
- the chief executive must be appointed by the NEDs and the chair and approved by the council of governors
- the executive directors are appointed by a committee of the chief executive, chair and NEDs.

It will be for the New FTs to determine the recruitment process and crucially whether the substantive roles will be offered to the proposed directors or whether they will be opened up to competition. In a competition, there is an inherent risk that the proposed directors are not appointed to the substantive posts and, if they are not, their positions will need to be resolved by resignation, redeployment or termination. This risk should be addressed by the FT in the pre-separation phase with the benefit of employment law and HR advice as needed. Trusts must remember that the statutory requirements for establishing the New FT boards must be discharged in a manner consistent with the

[34] If appointed on Day 1, the appointed governors will need to be fit and proper for the FT to be granted a licence.

employment law rights of the individual directors. NHS England is able to provide support to directors who are displaced by a separation.

It would be usual for the substantive appointments to be made in the order listed above, that is:

1. the substantive chair and other NEDs are appointed by the council of governors
2. the substantive NEDs and chair then appoint the substantive chief executive and this appointment is approved by the council of governors
3. a committee of the substantive chief executive, chair and NEDs then appoints the executive directors.

Recognising the need for stability in the board as soon as possible after the separation, we accept that the proposed directors may exercise their statutory duties under schedule 7 of the NHS Act 2006 to appoint the substantive directors. For example, the interim NEDs may appoint the substantive chief executive before the NEDs are substantively appointed. Section 56B(5) enables the proposed directors to exercise "the functions of the trust"; functions includes powers and duties[35] and is therefore interpreted broadly to include the function of appointing directors.

Consultation and engagement

There is no requirement in section 56B for a consultation. However, the separating FT will need to consider whether the separation triggers other consultation and engagement obligations. In particular:

- Section 242 of the NHS Act 2006 places a duty on trusts to involve the public and local authorities concerning decisions about changes to services. A separation is generally considered a change to organisational form and does not usually entail any immediate service changes. On that basis, it is unlikely that the separation of itself will trigger the section 242 duty. If service changes are to follow the separation, the New FTs should work with commissioners as they develop plans for service reconfiguration and should consider whether and when any public involvement under section 242 becomes necessary.
- A TUPE consultation is likely to be required. Even where NHS England transfers the staff by the Order, TUPE may continue to apply to most, if not all, the staff concerned and the trusts must ensure they comply with the consultation duties

[35] Section 275 of the NHS Act 2006 (Interpretation).

under the TUPE Regulations. In summary, before the transfer happens, employers must inform their trade union or employee representatives of transfer in writing including:

  - the fact that the transfer is going to take place, approximately when and why
  - any social, legal or economic implications for the affected employees – for example, a change in location or risk of redundancies
  - any measures that the outgoing and incoming employers expect to take in respect of their own employees (even if this is nothing)
  - the number of agency workers employed, the departments they are working in and the type of work they are doing
  - the outgoing employer must provide information about any measures which the incoming employer is considering taking in respect of affected employees.

- The trust should consider the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and their obligations in relation to engaging local authorities on separation plans.

10.7 Commercial transfer – ordinary legal powers

Commercial transfers are reviewed by NHS England under the guidance Assuring and supporting complex change: Commercial transfers rather than the guidance for statutory transactions. However, they are included in this Appendix for completeness.

NHS trusts and FTs have legal powers to acquire and dispose of property such as equipment, contracts, estate and intellectual property by entering into commercial agreements – that is, sale and purchase agreements or novation agreements. Commercial transfers can be useful where only a part of a trust is being divested and acquired, eg a bundle of services for a particular geography or one hospital site. They are however time-consuming and can be expensive to execute given the need to identify and then convey each asset and contract, etc.

As a general principle, property and liabilities which relate to each other should transfer to the same receiver. Receivers should not seek to cherry pick the assets. For example, a receiver taking on a particular service from a divesting trust should take on the property, contracts, liabilities and staff associated with that service.

Commercial transactions in conjunction with a statutory transaction

It is possible to use a commercial transfer in conjunction with a statutory transaction as part of an overall transaction structure. For example, some assets and contracts could transfer out of an NHS trust to a receiving trust before it is acquired at a later date by the same or another trust. Alternatively, two trusts could merge and the resulting FT could then acquire assets from another trust. A transaction structure of this nature will need to be carefully timed and sequenced, and this will naturally be more complex than simply doing one or the other. We will expect to see a strong strategic rationale and the parties will need to be careful to ensure that the property and liabilities end up in the right hands.

If commercial transfers are to precede a statutory transaction, the transfers must not be of such scale as to deprive the statutory transaction of any real effect. That is, trusts should not seek to carve out the vast majority of assets, services and staff so that there is nothing left to transfer at the point of the statutory transaction.

Statutory power

For NHS trusts, the relevant legal powers are set out in schedule 4 of the NHS Act 2006. Part 2 of schedule 4 confers on NHS trusts a broad power to do anything necessary or expedient for the purposes of its functions (paragraph 14(1)). Paragraph

14(2) states that they may, in particular, acquire and dispose of property and enter into contracts. In exercising the power, the NHS trust will need to be satisfied that it is doing so "for the purpose of or in connection with" the trusts' functions. The functions will be set out in the NHS trust's Establishment Order.[36]

FTs also have a broad power to do anything necessary or expedient for the purposes of their functions (section 47(1) of the NHS Act 2006). Section 47(2) states that FTs may, in particular, acquire and dispose of property and enter into contracts. FT functions are set out in the NHS Act 2006, including in sections 30 and 43: the provision of goods and services for the NHS.

These powers mean that commercial transactions can take place between two NHS trusts, between two FTs or between NHS trusts and FTs.

Property and liabilities

Property will need to be transferred according to the usual legal requirements for the particular type of property. Assignments of intellectual property will therefore need to be in writing and land will need to be conveyed in accordance with property law.

Contracts such as services contracts, PFI contracts and loans can be transferred by way of novation. The terms of novation agreements will need to be carefully negotiated to ensure that historical and future liabilities lie with the correct parties.

Employment liabilities will transfer under TUPE if there is a transfer of services as part of the commercial transaction.

With regards to civil liabilities, including claims for clinical negligence, personal injury and employment claims, there is a general rule of law that liabilities cannot be transferred without the consent of the party to whom the liability is owed. Obtaining the consent of third parties is likely to be a time-consuming, expensive and cumbersome exercise given the large number of parties who may have claims. In some cases, obtaining consent will not be possible where liabilities have not yet materialised.

Another way of addressing civil liabilities is for a receiving trust to indemnify the divesting trust to the value of the claims. In this way, while the liabilities will legally remain with the divesting trust, the financial burden of the liability will have transferred to

[36] The statutory instrument which sets up the NHS trust describes its functions and the composition of its board.

the receiver. This can be a more efficient way of dealing with the liabilities, provided the receiver is content to give the indemnity.

There is some doubt as to whether a receiver's CNST cover will pay out on any acquired or indemnified claims for clinical negligence. Receiving trusts should clarify this directly with NHS Resolution.

Some things cannot be commercially transferred. Criminal liabilities cannot be transferred. Public dividend capital or originating capital also cannot be transferred by contractual agreement.

Employment

Trusts have the ability to employ and to transfer staff.[37] Staff transfers that follow a transfer of services take place pursuant to TUPE. NHS England does not have the ability to transfer staff in the context of commercial transfers.

Procurement

Trusts and ICBs will want to assure themselves that any novation of NHS contracts is compliant with the applicable procurement regulations.

Significant transaction

Entering into commercial agreements may require approval from an FT's council of governors. If an agreement amounts to a 'significant transaction' as described in the FT's constitution, more than half the members of each council of governors will need to vote in favour of it at a governors' meeting.

Other requirements

The trusts will need to determine whether stamp duty is payable in respect of the transferred property.

The trusts may wish to consider whether any governance changes need to be made to reflect new services/sites that have been acquired or divested. For FTs, this may involve changes to the constitution e.g. to create new public constituencies.

[37] Schedule 4 paragraph 25 and section 47(2)(d) of the NHS Act 2006.

10.8 Statutory transfer schemes – section 69A

Section 69A was introduced by the Health and Care Act 2022 as a new form of statutory transaction. It enables NHS England to make schemes for the transfer of property, rights and liabilities from one trust to another.

Section 69A does not need to be used in conjunction with any other statutory transaction. Trusts will continue in their existing legal form both before and after the scheme.

Trusts seeking a transfer scheme must make a joint application which sets out the property, rights or liabilities to be transferred.

The things that may be transferred under a transfer scheme include—

(a) property, rights and liabilities that could not otherwise be transferred;
(b) property acquired, and rights and liabilities arising, after the making of the scheme;
(c) criminal liabilities.

NHS England may grant an application if it is satisfied that such steps as are necessary to prepare for the transfer have been taken (as evidenced by a green or amber transaction rating for significant transactions). Unlike other forms of statutory transactions, NHS England has a discretion to grant the transfer scheme rather than a duty to do so.

A transfer scheme may also make provision for other matters relating to the things which are transferred.

10.9 Roles and responsibilities – directors and governors

The decision to transact is one of the most important decisions that a trust faces. Executive directors, NEDs and governors (for FTs) need to work together to successfully execute a transaction. This section discusses their respective roles and how they fit together in the context of statutory transactions where governor approval is needed.

Roles

Executive directors are responsible for making transaction proposals, plans and strategies for the future of the trust. They should work with governors by providing them with sufficient information on a proposed transaction. They need to explain to governors why they believe the transaction is necessary and provide reasons to support that view.

NEDs should challenge the executives to justify their recommendations, deal with the risks involved and seek assurance that the executive directors' decisions are the right ones. NEDs are held to account by governors for the performance of the board.

It is now commonplace for transactions to happen after a period of strategic collaboration between two trusts where the directors are appointed to both. For statutory purposes, the directors must still take certain decisions independently and must not be conflicted. The decision by a target trust to be acquired should not therefore be taken by directors who are also directors of the acquirer. Trust boards should be mindful of the potential for conflicts and manage them as they arise. It would be prudent to ensure that a sufficient number of non-conflicted members are present and able to act on behalf of the trust in the lead up to the transaction.

Governors have a role in approving applications for statutory transaction – that is, mergers, acquisitions, dissolutions and separations involving an FT. This role is discharged in the context of the general governor role under schedule 7 of the NHS Act 2006, which is to hold the NEDs to account, both individually and collectively, for the performance of the board of directors, and to represent the interests of the FT's members and the public at large.[38] Therefore, in deciding whether to approve a transaction, governors are deciding whether the board of directors has:

- been thorough and comprehensive in reaching its decision to transact

[38] This means the public generally and not just the population served by the FT.

- obtained and considered the interests of FT members and the public at large as part of the decision-making process.

Trust boards must help governors with their decision by providing appropriate information - they have a duty to ensure that the governors are equipped with the skills and knowledge they need to fulfil their role.

The decision to proceed with a transaction is ultimately determined by the board of directors. It has the power under the FT's constitution to exercise all the powers of the FT. Provided appropriate assurance is obtained on the two points above, governors should not unreasonably withhold their approval for the transaction to go ahead.

Engagement

It is good practice for the board to engage early with the governors about transaction plans. From the outset directors and governors should agree a process for engagement on the transaction to include:

- the content and timing of information to be provided to governors and any training needs
- how the views of members will be sought and stakeholders kept informed
- how governors can get involved with the future governance model – for example, by working on the constitution for the post-transaction FT.

Governor approval

There are no legal requirements about when governor approval for a transaction application needs to be sought. However, NHS England recommends that it happens towards the very end of the process: after we have issued our transaction risk rating and after the board has decided to proceed with the transaction. At this point, the governors will have sufficient information about NHS England's view of the transaction risk and can be satisfied that the board has completed a comprehensive process of transaction planning and assurance.

Approval is usually given in person at a meeting of the council of governors by a vote. Voting procedures (including any rules on the chair's vote, casting votes or abstentions) should be determined locally and are set out in the trust's constitution. For a transaction application to proceed, the legislation requires that more than half of all members of the council in post need to approve it. If there are insufficient numbers of governors present and voting, the trust will need to seek votes separately from the absent governors.

Separate governor approval may be needed if the transaction amounts to a 'significant transaction' as described in the FT's constitution.

Governor liability

Governors may be concerned that their role in approving the transaction (or not) means that they will be held personally liable for any negative consequences flowing from that decision. We do not consider there to be any real risk of personal liability. The governors' general duty is to 'hold the NEDs, individually and collectively, to account for the performance of the board of directors'. Accountability for the transaction decision remains with the board of directors. If in doubt, governors should check with the trust secretary for details of any indemnity or insurance arrangements.

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