

Transactions guidance for trusts undertaking transactions, including mergers and acquisitions

Appendices

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We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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Appendix 1: Legal and regulatory requirements for transactions

Introduction

This appendix provides information about the legal aspects of the following transactions:

- merger – section 56
- acquisition – section 56A
- three-way merger or acquisition
- dissolution of an NHS trust and transfer of assets – schedule 4
- dissolution of a foundation trust – section 57A
- commercial transfer – ordinary legal powers.

Trust special administration is not covered in this guide, neither does it cover the separation of foundation trusts under section 56B. We plan to update the guidance to cover separation of foundation trusts next year.

This appendix also describes the roles and responsibilities of executive directors, non-executive directors (NEDs) and governors when taking transaction-related decisions.

All references to legislation are to the National Health Service Act 2006 (the NHS Act 2006) unless otherwise stated.

This appendix explains the legal requirements, limitations and processes for these types of transactions. NHS providers should not view it as comprehensive legal advice and are advised to seek bespoke advice as necessary.

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

Merger – section 56

Section 56 of the NHS Act 2006 provides for mergers of NHS foundation trusts and for mergers of NHS trusts and foundation trusts. A merger involves the dissolution of each trust and the establishment of a new foundation trust.

A merger under section 56 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 trusts involved in a merger is an NHS trust, the Secretary of State's powers under schedule 4 to dissolve NHS trusts and transfer their property and liabilities cannot be exercised.¹ A merger cannot therefore take place in conjunction with a schedule 4 transaction.

At the time of writing, there have been two mergers, resulting in the establishment of Essex Partnership University NHS Foundation Trust² and Manchester University NHS Foundation Trust.³

Application

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

- a proposed constitution for the new foundation trust
- evidence that a majority of the council of governors of each merging foundation trust 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 the new foundation trust
- acknowledgement of the risk rating given to the transaction by NHS Improvement

¹ Section 57(5) of the NHS Act 2006

² <http://www.legislation.gov.uk/ukxi/2017/374>

³ <http://www.legislation.gov.uk/ukxi/2017/932>

- a letter of support from the Secretary of State if one of the merging trusts is an NHS trust. NHS Improvement will seek the support of the Secretary of State on the trust's behalf.

The transaction risk 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.

We have a legal duty to grant the merger application if all the above requirements are met.

Grant of Merger and Statutory Order

An NHS Improvement committee takes the decision to grant the merger shortly before the planned date of the merger. The decision is confirmed in a document called a Grant of Merger which we issue. A new foundation trust is established on the effective date of the grant which is typically the first day of a month (even if this falls at a weekend). This is for ease of accounting.

Upon the merger being granted, the Chief Executive of NHS Improvement (acting as Accountable Officer of Monitor) will sign a Statutory Order⁴ (the Order) to transfer specified property and liabilities of the old trusts to the new foundation trust and to dissolve the old trusts⁵ on a specified date. It will also provide for continuity from the old trusts to the new foundation trust and for other related matters.

We draft the Order in the weeks before the merger and will liaise with the trusts' legal advisers when we do this. The Order does not need to be laid before Parliament but the Department of Health's (DH) involvement is required to register and publish it. Our legal team co-ordinates this with DH. The need for an Order makes a merger a slightly more complex transaction compared with an acquisition.

In practice, the establishment of the new foundation trust (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 enables a seamless transition from the old trusts to the new foundation trust. Accordingly, neither the merging trusts nor the new foundation trust exist as a 'shell' entity for any period of time.

⁴ A statutory instrument.

⁵ Sections 57(2) and 64(5)(b) of the NHS Act 2006.

Once the Grant of Merger is issued and the Order is made no further legal steps are needed to make the merger effective. The new foundation trust will be listed on our online foundation trust directory and the Grant of Merger will be published on the directory along with the constitution of the new foundation trust. The Order will be published on [legislation resources](#).

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 liabilities⁶ and private finance initiative (PFI) liabilities.

The trusts must specify in their merger application letter which property and liabilities they propose to transfer to the new foundation trust. It is likely that the trusts will wish to specify that all of their property and liabilities should transfer (except perhaps for employment contracts – see below for more detail). However, the decision as to which property and liabilities actually transfer rests with NHS Improvement.⁷ While it is unlikely that we will disagree with the trusts' wishes, it is possible that we will consider that certain property and liabilities should go elsewhere. We have the power to transfer the remaining property and liabilities to other trusts or to the Secretary of State via the Order.

As the transfer of liabilities is effected by the Order (legislation), the trusts do not need to obtain the consent of third parties such as lenders and suppliers which would otherwise be required. Depending on the specific terms of the contract, third parties may be able to invoke contractual rights, including termination rights, which are triggered by the merger. In general, however, third parties should carry on as normal and deal with the new foundation trust in place of the dissolved trusts.

Transaction agreement or merger agreement

The parties may find it beneficial to formally agree certain commercial matters relating to the merger. An agreement, known as a transaction agreement or merger agreement, can be used to document the agreed commitments, assurances and processes, and to identify key assets and liabilities. The trusts may wish to first enter into heads of terms (a non-binding document) before proceeding to agree the

⁶ Section 57(4) of the NHS Act 2006.

⁷ NHS Improvement has a duty to specify which property and liabilities are to transfer per section 57(1).

more detailed agreement. The agreement is not, however, the legal instrument by which the merger is effected nor by which the property and liabilities transfer – the legal instruments are the Grant of Merger and the Order.

There may be other parties to the agreement such as commissioners who may commit to providing some financial support for the transaction. Where one of the merging trusts is an NHS trust, NHS Improvement (TDA) may be a party in light of our role as ‘vendor’ of NHS trusts. We will not usually be a party to an agreement if the merging trusts are foundation trusts.

Entering into an agreement may require approval from each foundation trust’s council of governors. If the agreement amounts to a ‘significant transaction’ as described in the merging foundation trusts’ constitution(s), more than half of the members of each council of governors will need to vote in favour of it at a governors’ meeting. If a transaction requires both types of governor approval (that is, approval of the merger application and approval to enter into a significant transaction), a foundation trust may arrange for both to be approved at the same time.

Interim board

The boards of the merging trusts fall away in consequence of the dissolution of the trusts. The constitution of the new foundation trust comes into effect on the day the merger takes effect (Day 1). On or after Day 1 the new foundation trust’s governance structures, including its council of governors and board, can be established. This process can take several months. Until then, the directors of the merging trusts have control of the new foundation trust and authority to exercise the new foundation trust’s functions pursuant to section 56(11) of the NHS Act 2006.

The default position under legislation is that all the directors of each trust transfer to the new foundation trust, on the same terms and conditions, 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 having two sets of directors running the new foundation trust, a subset of directors is chosen from the directors of each trust. This 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 foundation trust board; that is, a chair, NEDs, chief executive, finance director, medical director, nursing director and other executive directors.

It is likely that some or all of the directors from the transacting trusts will not wish or be able to continue in their roles or continue them in the same way with the new foundation trust and therefore will not be appointed to the interim board.

Executive directors who are not appointed to the interim board will need to resign, accept severance packages or be redeployed into non-director roles; otherwise they will automatically transfer to the new foundation trust and gain control along with the interim board. It is unlikely that the trusts can make the directors redundant at this point given the ongoing requirement⁸ for their work and roles up until the point of dissolution of the trust. 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 the effective date; otherwise they will automatically transfer to the new foundation trust and gain control along with the interim board.

The interim board should be in place by the start of our risk assessment process (stage 2: business case) to lead the governance of the transaction and to engage with us, in particular at the 'board-to-board' meeting when NHS Improvement staff and board members meet representatives of the trusts. In the pre-merger period, the interim board has no legal powers over either of the merging trusts⁹ and it should not purport to take any decisions on behalf of the as-yet-unformed foundation trust.

There is no defined process for the appointment of directors to the interim board. It is for the trusts to decide how to establish the interim board. 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, governors from each merging foundation trust should be involved and the need for appropriate representation from each trust considered. The trusts may wish to invite an NHS Improvement

⁸ Some roles are a requirement of statute per schedule 7 of the NHS Act 2006.

⁹ The interim board could meet as a committee-in-common with the directors exercising authority delegated to them by their own trust. NHS Improvement has issued guidance on committees-in-common.

representative to sit on any interview panel. We can provide informal views on which director(s) are appointable but decisions will remain with the trusts.¹⁰

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 the new foundation trust.¹¹ This is because the legislation is clear that the interim board only has temporary control of the new foundation trust 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 those under the old trusts or the new foundation trust. This can give rise to employment law complications in the event that the interim board members are not appointed as the substantive directors. This is discussed further below.

Once the new foundation trust'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 substantive directors to be appointed.

Members and governors

The trusts will need to determine the new foundation trust'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 foundation trusts 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 makeup of the new foundation trust. For example, the public constituencies should cover the enlarged geographical areas.

A foundation trust's membership will automatically fall away in consequence of the foundation trust being dissolved. Merging foundation trust(s) can however approach their existing members to ask whether they wish to be members of the new foundation trust. The members of a dissolving foundation trust cannot automatically be made members of the new foundation trust due to the requirement in schedule 7

¹⁰ <https://improvement.nhs.uk/resources/options-structuring-foundation-groups/>

¹¹ Despite the fact that employment contracts may well be permanent contracts.

of the NHS Act 2006 that individuals must apply for membership of a public constituency of a foundation trust. Public members of the dissolving foundation trusts must be given the choice whether or not to be a member of the new foundation trust. If they choose not to be a member, it must be made clear that they will be deemed to have applied for membership of the new foundation trust to meet the legal requirement for an application. The same approach will probably need to be taken for any patient/service user members unless the new foundation trust wishes to invite its future patients/service users to become members without an application being made.¹² The trusts will need to check that the individuals are eligible to join as members of the new foundation trust according to rules laid out in the new foundation trust's proposed constitution. Membership established in this way will only exist in shadow form until the new foundation trust is established on Day 1.

Alternatively, the trusts may decide to let the membership fall away and to recruit members from scratch after the new foundation trust is formed. 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.

NHS trusts do not have members. This means that the new foundation trust may need to take extra steps to recruit members from populations served by the NHS trust, to ensure that the members of the new foundation trust 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 foundation trust status, these shadow members can be asked if they wish to be a member of the new foundation trust and their shadow membership can be deemed an application for membership vis-à-vis the new foundation trust.

The trusts will also need to determine the configuration of the new foundation trust's council of governors. The proposed council will need to reflect the makeup of the new foundation trust, its new constituencies and partner organisations. The merging foundation trusts' councils of governors automatically fall away in consequence of the foundation trusts being dissolved and therefore governors of the merging foundation trusts cannot automatically become governors of the new foundation trust. Moreover, schedule 7 of the NHS Act 2006 requires governors to be chosen by election or appointment (by the new foundation trust). Governors of the merging

¹² This is permitted under paragraph 6(3) of schedule 7 of the NHS Act

foundation trusts may of course stand for election to be a governor of the new foundation trust provided they meet the new foundation trust's constitutional requirements.

Constitution

The trusts must submit a proposed constitution for the new foundation trust 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 their governors. The constitution should be modelled on the Model Core Constitution published by [NHS Improvement](#). As per usual, the proposed constitution 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 the new foundation trust and NHS England has published guidance¹³ on what is appropriate for a foundation trust 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.

Trusts should note that these constitutional amendments are not being made pursuant to the procedure under section 37 of the NHS Act 2006: amendments to the constitution require board and governor approval. The constitution is submitted to NHS Improvement in a 'draft' form and it takes effect if we grant the merger. The trusts will nevertheless want to ensure governor and board approval of the proposed constitution.

Licensing and enforcement action

The licences of the old foundation trusts fall away on dissolution and the Order will specifically state that they no longer have effect. NHS trusts must comply with the equivalent of certain licence conditions but they do not have licences as such.

¹³ www.england.nhs.uk/nhsidentity/identity-guidelines/naming-principles/

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. The new foundation trust will not automatically be placed in special measures as a result of the old trust(s) being in special measures.

The new foundation trust is required to apply for a licence.¹⁴ The licence must be held from Day 1 for the new foundation trust to lawfully provide NHS services. To grant the licence, we must be satisfied that the directors and governors of the new foundation trust pass the fit and proper person test and the foundation trust is registered with the Care Quality Commission (CQC). These are the two standard licensing criteria. The interim board (chief executive) will be asked to make a prospective licence application on behalf of the new foundation trust which takes effect on Day 1. The licence application must be supported by a self-certification confirming that interim directors of the new foundation trust are fit and proper. Since there are no governors on Day 1, the new foundation trust does not fail the fit and proper person criteria as regards the governors. We will seek assurance from CQC that plans are in place to register the new foundation trust from Day 1. If the merger is granted, we will sign the licence and it will take effect on Day 1.

NHS Improvement's licence register will be updated accordingly.

Commissioner requested services

The new foundation trust's commissioners will be encouraged to revisit commissioner requested services (CRS) designations in light of the merger.

CQC registration and other regulatory requirements

The new foundation trust must be registered with CQC from Day 1 so that any regulated activity is performed lawfully. The new foundation trust does not have a CQC rating until its first inspection as any previous trusts' ratings fall away on their dissolution.

The new foundation trust will need a new organisational code from NHS Digital.

The trusts will need to ensure that there is a smooth transition of insurance cover, including Clinical Negligence Scheme for Trusts (CNST), Liabilities to Third Parties

¹⁴ Foundation trusts are not exempt from licensing.

Scheme (LTPS) and Property Expenses Scheme (PES) cover with NHS Resolution.¹⁵

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

The new foundation trust 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

There is precedent for the application of Transfer of Undertakings (Protection of Employment) (TUPE) regulations in section 56 mergers. In all mergers to date, all employees of the dissolving trusts have transferred to the new foundation trust. Trusts are responsible for seeking their own legal and HR advice on compliance with TUPE.

NHS Improvement has the power to include staff transfer provisions in the Order if, for instance, there is any doubt as to whether TUPE applies. We 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 the new foundation trust.

Executive directors are employees of the trusts and their employment contracts will transfer to the new foundation trust by TUPE (or by the Order). Please refer to the section about the interim board for information about executive directors who do not intend to transfer.

NEDs are office holders rather than employees. As such they will not transfer under TUPE or any staff transfer provisions of the Order. However, their terms of appointment – their contract with the trust – will transfer to the new foundation trust along with all other contracts held by the trusts via the Order. Please refer to the

¹⁵ NHS Resolution is the operating name for the NHS Litigation Authority.

¹⁶ By virtue of section 67A of the Finance Act 2003 (as amended by section 216 of the Finance Act 2012).

section about the interim board for information about NEDs who do not intend to transfer.

Elections

The membership and constituencies of the new foundation trust come into effect on Day 1 and elections for the governors can be held after this. Elections will need to be held in accordance with the Model Election Rules as set out in the new foundation trust's constitution and they take at least 40 days to complete. The 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 the new foundation trust 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 the new foundation trust to determine the nominations process and crucially whether the substantive roles will be offered to the interim directors or whether they will be opened up to 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, re-deployment or termination. This risk should be addressed by the trusts in the pre-merger phase with the benefit of employment law and HR advice as needed. Trusts must remember that the statutory requirements for establishing the new foundation trust board must be discharged in a manner consistent with the employment law rights of the individual interim directors. NHS Improvement 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.

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 duties¹⁷ and are 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, the new foundation trust 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 Improvement 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:

¹⁷ Section 275 of the NHS Act 2006 (Interpretation).

- 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 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 obligations thereunder in relation to engaging the local authority on merger plans.

Acquisition – Section 56A

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

At the time of writing there have been six acquisitions: three foundation trust–foundation trust acquisitions and three foundation trust–NHS trust acquisitions. Note that it is not possible for an NHS trust to acquire a foundation trust under section 56A.

Application

The target trust and the acquiring foundation trust must make a joint written application to NHS Improvement 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 foundation trust amended on the assumption that it is acquiring the target trust
- evidence that the majority of the council of governors of each foundation trust 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 risk rating given to the transaction by NHS Improvement
- a letter of support from the Secretary of State if the target is an NHS trust. NHS Improvement will seek the support of the Secretary of State on the trust's behalf.

The transaction risk 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.

We have a legal duty to grant the acquisition application if all the above requirements are met.

Grant of Acquisition

An NHS Improvement committee takes the decision to grant the acquisition shortly before the planned date of the acquisition. The decision is confirmed in a document called a Grant of Acquisition which we issue and publish on our online foundation trust directory.

The acquisition takes place on the effective date of the grant which is typically the first day of a month (even if this falls at a weekend). This is for ease of accounting.

On the effective date of the grant, the target trust is dissolved and subsumed into the acquiring foundation trust which continues in existence. All property (including contracts) and liabilities (including criminal liabilities) of the target trust automatically transfer to the acquiring foundation trust by virtue of section 56AA. It is not legally possible to split the target trust's property and liabilities between multiple acquirers as part of this process. In particular, where the target is an NHS trust, the Secretary of State cannot exercise his/her powers under schedule 4 to dissolve NHS trusts

and transfer their property and liabilities.¹⁸ 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 enables a seamless transfer of the target trust to the acquiring foundation trust and means that the target trust does not exist as a 'shell' entity for any period of time.

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

Transaction agreement

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

Other parties to the agreement such as commissioners may commit to providing some financial support for the transaction. Where the target is an NHS trust, NHS Improvement (TDA) may be a party in light of our role as 'vendor' of NHS trusts. We will not usually be a party to an agreement if the transacting trusts are foundation trusts.

Entering into an agreement may require approval from each foundation trust's council of governors. If the agreement amounts to a 'significant transaction' as described in the merging foundation trusts constitution(s), more than half of the members of each council of governors will need to vote in favour of it at a governors' meeting. If a transaction requires both types of governor approval (that is, the approval of the acquisition application and the approval to enter into a significant transaction), the foundation trust may arrange for both to be approved at the same time.

¹⁸ Section 57(5) of the NHS Act 2006.

Board

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

The post-transaction board will need to be thought about and discussed early in terms of its structure and size, the individuals who might fill the roles and the process for filling any vacant or new roles. The general expectation is that individuals on the board of the acquiring trust will stay on post transaction.

On or after Day 1, the revised board can be established in accordance with the structure set out in the constitution. This process can take several months if, for example, there is an open competition to recruit to new director posts. 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. Until then, the existing directors of the acquiring foundation trust have control of the enlarged foundation trust and the authority to exercise the functions of any unfilled director roles pursuant to section 56A(11) of the NHS Act 2006.

It is likely that some or all of the directors from the transacting trusts will not wish or be able to continue in their roles or continue them in the same way.

Executive directors who are not continuing their roles in the enlarged foundation trust will need to resign, accept severance packages or otherwise agree to terminate their employment contracts; otherwise they will automatically transfer to the acquiring foundation trust under TUPE. This will need careful management from an HR perspective. We can support directors who are displaced as a result of an acquisition.

NEDs who are not continuing their roles in the enlarged foundation trust will need to terminate their appointments in accordance with the agreed terms before the effective date. Otherwise, by default, their appointments will transfer to the acquiring foundation trust by virtue of section 56AA (transfer of contracts) and they will take up vacant NED posts on the enlarged foundation trust's board. If there are no vacant posts, the NEDs will have no role in the enlarged foundation trust. The trusts should therefore make appropriate plans before the transaction.

Members

The trusts will need to determine the enlarged foundation trust'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 foundation trusts 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 makeup of the enlarged foundation trust. For example, the public constituencies should cover the geographical areas served by the enlarged foundation trust which may be wider than before. The constituencies come into effect on Day 1 when the foundation trust's constitution comes into effect.

The members of the acquiring foundation trust will continue as members of the enlarged foundation trust unless they are no longer eligible as a result of changes to the foundation trust's constitution.

A target foundation trust's membership automatically falls away in consequence of the foundation trust being dissolved. The trusts can however approach the target's existing members to ask whether they wish to be members of the acquiring foundation trust. The members of a dissolving foundation trust cannot automatically be made members of the acquiring foundation trust due to the requirement in schedule 7 of the NHS Act 2006 that individuals must apply for membership of a public constituency of a foundation trust. Public members of the dissolving foundation trust must be given the choice whether or not to be a member of the acquiring foundation trust. If they choose not to be member, it must be made clear that they will be deemed to have made an application for membership of the acquiring foundation trust to meet the legal requirement for an application. The same approach will probably need to be taken for any patient/service user members unless the acquiring foundation trust wishes to invite its future patients/service users to become members without an application being made.¹⁹ The trusts will need to check that the individuals are eligible to join as members of the enlarged foundation trust according to rules laid out in the enlarged foundation trust's proposed constitution. Membership established in this way will only exist in shadow form until the enlarged foundation trust is established on Day 1.

¹⁹ This is permitted under paragraph 6(3) of schedule 7 to the NHS Act.

The trusts will need to check that the individuals are eligible to join as members of the acquiring foundation trust according to rules laid out in the foundation trust's proposed constitution.

NHS trusts do not have members. This means that the new foundation trust may need to take extra steps to recruit members from populations served by the NHS trust, to ensure that the members of the new foundation trust 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 foundation trust status, these shadow members can be asked if they wish to be a member of the new foundation trust and their shadow membership can be deemed an application for membership vis-à-vis the new foundation trust.

The timing of membership recruitment is up to the trusts. An acquiring foundation trust can reconfigure its constituencies at any time by amending its constitution under section 37 of the NHS Act 2006 and it can recruit new members at any time. Therefore, an acquiring foundation trust can expand its public and patient constituencies and recruit members ahead of the acquisition.²⁰ However, it would be prudent to wait until the acquisition is complete or sufficiently advanced before recruiting members and holding elections as these are expensive. Trusts should note that the target trust's staff members cannot become members of the acquiring foundation trust ahead of the acquisition because they will not have transferred at that point. They can however automatically become members from Day 1 in accordance with the constitution without having to apply.

Governors

The trusts will need to determine the configuration of the enlarged foundation trust's council of governors. The council will need to reflect the makeup of the enlarged foundation trust, its new constituencies and partner organisations. The constituencies and structure of the new council of governors come into effect on Day 1 when the new foundation trust's constitution comes into effect. New governors may need to be elected to fill any vacancies and to represent any newly created constituencies.

²⁰ Subject to section 61(2) of the NHS Act 2006.

The governors of the acquiring foundation trust will continue as governors after the acquisition unless they are no longer eligible as a result of changes to the foundation trust's constitution.

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

The timing of the elections is up to the trusts. A foundation trust can reconfigure its council of governors at any time by amending its constitution (section 37 of the NHS Act 2006) and can hold elections thereafter. Therefore, an acquiring foundation trust can expand its public/patient membership constituencies to take account of the area served by the target trust and hold elections for governors before the acquisition is completed. However, it would be prudent to wait until the acquisition is complete before holding elections as these are expensive.

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

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 foundation trust.

Constitution

The trusts must submit a proposed constitution for the enlarged foundation trust to NHS Improvement 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 their governors. The constitution should be modelled on the [Model Core Constitution](#) published by NHS Improvement. As per usual, the proposed constitution 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.

Trusts should note that these constitutional amendments are not being made pursuant to the procedure under section 37 of the NHS Act 2006: amendments to the constitution require board and governor approval. The constitution is submitted to NHS Improvement in a 'draft' form and it takes effect if we grant the merger. The trusts will nevertheless want to ensure governor and board approval 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 – that is, the trusts cannot submit a constitution that does not show any proposed changes whatsoever. 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 acquiring foundation trust is likely to want to change its name and NHS England has published [guidance](#) on what is appropriate for a foundation trust name.

Licence and enforcement actions

The licence of the acquiring foundation trust continues in force. No changes will be made except to reflect any name change.

The licence of a target foundation trust falls away in consequence of its dissolution. NHS Improvement's licence register will be updated accordingly.

In consequence of the licence falling away, any enforcement actions associated with those licences such as undertakings or discretionary requirements will also fall away. Regulatory actions such as special measures will not automatically attach to the acquiring trust as a result of acquiring a target trust which is in special measures.

NHS trusts must comply with the equivalent of certain licence conditions but they do not have licences as such.

CQC registration and other regulatory requirements

The enlarged foundation trust must be registered with CQC from Day 1 so that any regulated activity is performed lawfully.

The acquiring foundation trust 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.²¹

The trusts will need to ensure that there is a smooth transition of insurance cover, including CNST, LTPS and PES cover with NHS Resolution.²²

The acquiring foundation trust will be required to prepare the outstanding part-year accounts of the dissolving trust and to perform all statutory duties relating to those accounts.

Commissioner requested services

The acquiring foundation trust's commissioners will be encouraged to revisit CRS designations in light of the acquisition.

TUPE

The established practice is that the target trust's staff will transfer by TUPE to the acquiring foundation trust on the effective date. Trusts are responsible for seeking their own legal and HR advice on compliance with TUPE.

NHS Improvement has the power to make a staff transfer order if, for instance, there is any doubt as to whether TUPE applies. We 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 the default position is that their employment contracts transfer to the acquiring foundation trust. NEDs are

²¹ By virtue of section 67A of the Finance Act 2003 (as amended by section 216 of the Finance Act 2012).

²² NHS Resolution is the operating name for the NHS Litigation Authority.

office holders rather than employees. However, their terms of appointment – their contract with the trust – will transfer to the acquiring foundation trust along with all other contracts held by the target trust as a result of section 56AA. For further discussion on this see the section on boards above.

Consultation

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, the new foundation trust 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 Improvement 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 obligations thereunder in relation to engaging the local authority on merger plans.

Three-way merger or acquisition – Section 56 and 56A

At the time of writing there have been no examples of three-way transactions under section 56 or 56A.

The legislation for mergers (section 56) and acquisitions (section 56A) is written in the singular – that is, ‘an NHS foundation trust’ merges with or acquires ‘another NHS foundation trust 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 foundation trust’ or ‘another NHS foundation trust 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 foundation trust can be an acquiring trust under section 56A. It is not possible to have two or more acquiring foundation trusts because section 56AA states that the target is dissolved and all of its property and liabilities transfer to an acquirer by operation of law. It is not possible to have two surviving foundation trusts 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 foundation trust with two or more targets.

It is possible for a merger to take place under section 56 between more than two parties so long as one party is a foundation trust. Only one foundation trust can be created following a merger.

As for bilateral mergers and acquisitions, the parties may wish to enter into a commercial business transfer 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, taking necessary steps, amendment of constitution, governor approval,

application to NHS Improvement, Secretary of State approval, etc. Please refer to the sections on mergers and acquisitions for more detail.

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

- in a merger, all trusts will be dissolved and a new foundation trust created. The resulting entity cannot be an NHS trust even if, for example, three NHS trusts and one foundation trust merge
- only a foundation trust can acquire trusts under section 56A. NHS trusts cannot acquire foundation trusts 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 cannot exercise his/her powers under schedule 4 to dissolve NHS trusts and transfer their property and liabilities.²³ A three-way acquisition or merger cannot therefore take place in conjunction with a schedule 4 transaction.

If the parties involved are all NHS trusts, the ability to effect a three-way transaction lies with the Department of Health in section 25 (power to create new NHS trusts) and schedule 4 (power to dissolve NHS trusts and transfer their property and liability). NHS Improvement does not have the power to grant a three-way transaction where the parties are only NHS trusts.

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 foundation trusts. 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 of its assets and liabilities. A foundation trust can also ‘acquire’ an NHS trust under schedule 4 but in this scenario it would be simpler for the foundation trust to acquire the NHS trust using the section 56A route.

²³ Section 57(5) of the NHS Act 2006.

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

Application

The dissolving trust needs to apply to the Secretary of State for its dissolution. NHS Improvement can recommend dissolution to the NHS trust but the legal power to dissolve it rests with the Secretary of State by way of statutory order.

The Secretary of State also has the power to dissolve an NHS trust if he/she considers this to be in the interests of the health service, without the NHS trust applying for dissolution.

Statutory orders

Two statutory orders are required: a dissolution order and a transfer order (the Orders). The Orders are prepared by the DH's lawyers and signed by the Secretary of State or his/her nominee. 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.

The dissolution order dissolves the NHS trust and the transfer order transfers the dissolving trust's property, liability (including criminal liabilities) and staff to one or more receiving trusts or to the Secretary of State. The Orders are timed to come into effect at the same time so that there is no time gap between the transfer and the dissolution. This means that the dissolving trust does not exist as a 'shell' entity for any period of time.

The Secretary of State does not have a freestanding ability to transfer property and liabilities out of an NHS trust unless the trust is also being dissolved.

Consultation

Except in urgent situations, the dissolving trust must consult relevant local Healthwatch organisations and staff²⁴ before the Orders can be made. In practice this is a limited consultation exercise about the form of the Orders to be prepared, not whether the dissolution should or should not proceed or about any proposed changes to staff. The dissolution consultation and the transfer consultation are

²⁴ Under the National Health Service Trusts (Consultation on Establishment and Dissolution) Regulations 2010.

separate legal requirements but they can be combined in one consultation exercise. The outcome of the consultation is reported to the Secretary of State alongside the request that he/she signs the Orders. The consultation exercise can be timed to occur alongside other transaction assurance processes so as not to lengthen the overall timetable.

Employment

The transfer order will typically 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 we will expect full and proper consultation with all trade unions and staff-side organisations in the context of TUPE. Trusts will need to seek advice on the application of TUPE from legal and HR advisers.

Board

The board of the dissolving trust falls away in consequence of the dissolution of the trust. The boards of the receiving trust(s) continue.

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. The general expectation is that individuals on the board of the receivers will stay on post transaction.

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

Executive directors from the dissolving trust who are not continuing their roles with a receiving trust will need to resign, accept severance 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. Alternatively they could be found a new role in a receiving trust. 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. Otherwise by default their appointments will transfer to a receiving trust(s) along with all other contractual rights and liabilities and they will take up vacant NED posts on the receiving trust board. If no posts are vacant, the NEDs will have no role in the receiving trusts. The trusts should therefore make appropriate plans before the transaction.

Dissolution of an NHS foundation trust – Section 57A

Section 57A provides for foundation trusts to be dissolved.

It is not legally possible for an NHS trust to be dissolved under section 57A. For the dissolution of NHS trusts, please see the section on schedule 4.

A foundation trust may apply to NHS Improvement to be dissolved provided it has the approval of more than half of the members of its council of governors. We must grant the dissolution if we are satisfied that the foundation trust has ‘no liabilities’ and has taken the necessary steps to prepare for the dissolution. Where an application is granted, we must make a statutory instrument, an Order, which:

- dissolves the foundation trust
- transfers property (if any) to the Secretary of State.

NHS Improvement does not have the power under section 57A to transfer liabilities and it does not have a general power to transfer liabilities out of a foundation trust. Before applying for dissolution a foundation trust appears to have to divest itself of liabilities. Please see the section on commercial transfer – ordinary legal powers and note in particular the difficulties with civil liabilities. A foundation trust cannot divest itself of criminal liabilities. The existence of criminal liabilities is usually identified through the due diligence process. The most likely bodies to prosecute foundation trusts for criminal offences are CQC, the Health and Safety Executive and the Crown Prosecution Service. A foundation trust with identified criminal liabilities will be unable to apply for dissolution.

The foundation trust should also divest itself of its property before applying for dissolution. Property can be passed to foundation trusts, NHS trusts or other parties. Any remaining property (or all the property if none has been transferred) will be passed to the Secretary of State. We do not have the power to distribute property. It is likely that the Secretary of State would subsequently transfer that

property to another NHS body in accordance with his/her powers under the NHS Act 2006, so there would need to be clarity as to the receiving bodies.

There have been no section 57A dissolutions to date. This provision is untested and its practical application is likely to be highly problematic. No workarounds such as the use of indemnities to deal with liabilities have yet been found. Without legislative amendment to section 57A, we cannot be confident about its effectiveness because of the difficulty in practice of securing that the foundation trust has 'no liabilities'.

Commercial transfer – ordinary legal powers

NHS trusts and foundation trusts 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; for example, one service or one site. They are however time-consuming and 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 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 subsequently acquired by the same or another trust. Alternatively, two trusts could merge and the resulting foundation trust could 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. The parties will need to be very careful to ensure that the property and liabilities end up in the right hands.

If 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.²⁵

Foundation trusts 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 foundation trusts may, in particular, acquire and dispose of property and enter into contracts. The functions of the foundation trust are set out in the NHS Act 2006 including 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 foundation trusts or between NHS trusts and foundation trusts.

Neither NHS Improvement nor DH has a freestanding power to transfer the property or liabilities of foundation trusts or trusts²⁶ except where the trust is being dissolved under one of the statutory routes.

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.

²⁵ The statutory instrument which sets up the NHS trust describes its functions and the composition of its board.

²⁶ Under section 70 of the NHS Act 2006 (transfer of residual liabilities) the Secretary of State has a duty to secure that all non-criminal liabilities of an NHS trust are dealt with (transferred) in circumstances where the NHS trust ceases to exist. This section is used to sweep up residual liabilities in the context of dissolved NHS trusts.

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 and personal injury, there is a general rule of law that liabilities cannot be transferred (novated) without the consent of the party to whom the liability is owed; that is, the claimant. Obtaining the consent of third parties is likely to be a very time-consuming, expensive and cumbersome exercise given the large number of parties – potentially thousands – who may have claims. Even with more time and resources, obtaining consent will not be possible in the case of liabilities which have not yet materialised; that is, where the potential claimant is unknown.

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 the receiver. This can be a more efficient way of dealing with the liabilities, provided the receiver is content to give the indemnity. If the divesting trust is subsequently acquired or merged under a statutory route, the liability and the indemnity pass to the acquirer.

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 will want to check this carefully with NHS Resolution before giving any indemnity for clinical negligence claims.

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

Employment

NHS trusts and foundation trusts have the ability to employ and to transfer staff.²⁷ Staff transfers that follow a transfer of services take place pursuant to TUPE. NHS

²⁷ Schedule 4 paragraph 25 and section 47(2)(d) of the NHS Act 2006.

Improvement does not have the ability to transfer staff in the context of commercial transfers.

Procurement

Trusts and CCGs will want to assure themselves that any novation of service contracts is compliant with procurement regulations.

Significant transaction

Entering into commercial agreements may require approval from a foundation trust's council of governors. If an agreement amounts to a 'significant transaction' as described in the foundation trust's(s') constitution(s), more than half of 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 consider 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 which have been acquired or divested. For foundation trusts, this may involve changes to the constitution; for example, to create new public constituencies.

Roles and responsibilities

The decision to transact is one of the most important decisions that a trust faces. Executive directors, NEDs and governors (for foundation trusts) 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.

Governors have a role in approving applications for statutory transaction – that is, mergers, acquisitions, dissolutions and separations involving a foundation trust. 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 foundation trust's members and the public. 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
- obtained and considered the interests of foundation trust members and the public as part of the decision-making process.

Trust boards must help governors with their decision by providing appropriate information and 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 foundation trust's constitution to exercise all the powers of the foundation trust. 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 foundation trust.

Governor approval

There are no legal requirements about when governor approval needs to be sought. However, NHS Improvement 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. By this time the governors will have sufficient information about NHS Improvement'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 way of a vote. Voting procedures (including any rules on the chair's vote, casting votes or abstentions) should be determined locally and are normally set out in the trust's constitution. For a transaction application to proceed, more than half of all members of the council in post need to approve it.

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.

Appendix 2: Transaction reporting thresholds – basis for calculations

A trust should use the following rules when reviewing whether a transaction should be reported to NHS Improvement.

Long-term expenditure contracts

Trusts may propose entering into a long-term contract (five years or more) for the provision of services; for example, IT support or facilities management which may, along with other long-term transactions, add additional financial risk to the trust. For the purposes of calculating long-term contracts, trusts should calculate the whole-life cost of the contract versus turnover when considering whether transactions are reportable.

This approach is consistent with the guidance for managed service contracts and the capital regime requirements.²⁸

Transactions involving trusts in Single Oversight Framework (SOF) segment 3 or 4

Where a trust is in SOF segment 3 or 4, we may consider any material transaction as a significant transaction and consequently undertake a detailed review.

Aggregation of transactions in a 12-month period

Transactions completed with the same counterparty during the 12 months before the date of the latest transaction may be aggregated with that transaction for the purposes of NHS Improvement's (Monitor) reporting thresholds. We should be informed at an early stage of the latest transaction in such cases.

²⁸ <https://improvement.nhs.uk/resources/capital-regime-investment-and-property-business-case-approval-guidance-nhs-trusts-and-foundation-trusts/>

Joint ventures

NHS foundation trusts entering into major joint ventures, including Academic Health Science Centres (AHSCs), that meet any of the triggers set out below are required:

- as part of the annual plan each year, to certify anticipated continued compliance with the requirements set out in Appendix 14
- by exception, to notify NHS Improvement (Monitor) where an NHS foundation trust ceases to comply with the requirements set out in Appendix 14.

The relevant triggers are:

- **Control** – that is, where a separate decision-making body has influence over the development and/or delivery of an NHS foundation trust's strategy. Where the separate decision-making body is a legal entity, influence would normally be defined as at least 20% ownership.
- **Financial conditions** – where an NHS foundation trust's:
 - assets within the vehicle are >10% of its total assets (per the most recent quarterly monitoring submission) or
 - share of income or expenditure from the partnership exceeds 10% of the foundation trust's total income or expenditure respectively in any full financial year.
- **Legal arrangement** – that is, for 'accredited' AHSCs only – where an NHS foundation trust enters into a legal arrangement establishing the legal arrangement of the partnership.

Appendix 3: Investment policy good practice

A good practice policy for investments by trusts should contain the elements set out below.

Investment committee functions and structure

A clear policy and process for investment decision-making should be in place. Decision-makers may be a committee of the trust board, or the board itself in the case of smaller trusts. The investment committee should:

- comprise executive and non-executive directors (NEDs)
- have a majority of NEDs
- be chaired by a NED with relevant investment decision-making experience.

The investment committee's functions typically include:

- approving investment and borrowing strategy and policies
- approving performance benchmarks
- reviewing performance against the benchmarks
- ensuring proper safeguards are in place for security of the trust's funds
- monitoring compliance with treasury policies and procedures
- approving proposals for acquisition and disposal of assets above a certain amount
- approving external funding arrangements within their delegated authority (for NHS foundation trusts).

Investment strategy and objectives

A good practice statement of investment strategy and objectives should provide the criteria for selecting the trust's investments, and address:

- the principal purpose of the trust – the provision of goods and services for the health service in England

- the trust's corporate strategy (including geographical and service focus)
- target rates of return for investments and explanation of how rates of return will be calculated (eg return net of any cross-subsidies)
- a timeframe for realising the desired return on investments.

Attitude to risk and process for managing risk

Risk refers to the probability of an adverse outcome that is different from the expected outcome and the potential impact of such an outcome. Some major categories of investment risk include:

- **Strategic:** risks associated with a particular strategy; for instance, overcapacity, product or service-line obsolescence, competitor reactions.
- **Financial:** risks associated with the financial structure of a business, the financial transactions made by the business, and the financial systems which are in place; for instance, interest rate risk, foreign exchange risk and credit risk.
- **Operational:** risks associated with the operational and administrative procedures of a business, such as clinical operations, supply-chain management, IT systems, recruitment, HR management and post-merger integration process.
- **Execution risk:** the risk that the financial and operational activities forecasts are not achieved as expected.
- **Regulatory and political:** risks posed by potential changes in the regulatory and political environment, such as changes in tariff policy or healthcare targets.
- **Reputational:** risks to the perceived quality or brand of an institution; for instance, through bad press resulting from association with a failed joint venture.
- **Contingent:** risks that arise only if a certain contingent event takes place; for instance, guarantees of a joint venture that are only payable if it defaults.

Risk management refers to the collective processes, working practices and tools used to minimise the probability and impact of adverse outcomes. It entails:

- identifying potential sources of risk

- assessing the value at risk, estimated as probability of loss multiplied by severity of loss
- implementing controls to minimise probability and severity of loss.

It is good practice to define in the investment policy the trust's principles for managing risk aligned with its corporate strategy. Examples of risk management principles include:

- guidelines on identification of different types of risk
- methodology for calculating value at risk
- expected returns of individual investments for a given risk level – higher risk investments require higher expected returns
- aggregate targeted rate of return across the portfolio of investments
- limitations on the locations and types of investments that can be pursued; for instance, the policy may specify that overseas investments should only be within the 'core competence' of the organisation and within stated risk concentrations for each area
- guidelines for asset diversification outside core operations; for instance, specifying that either the organisation will not diversify outside the health sector in England, or specifying limits on concentration of risk in a particular technology or sector.

A good practice investment policy will provide the criteria for categorising investments by level of risk (eg high, medium and low). Criteria for assessing investment risk include:

- financial magnitude of deal
- probability of loss
- complexity of the deal structure
- distance from a trust's core capabilities and operations
- financing arrangements; for instance, type of debt finance
- geographical location; for instance, investment in a highly competitive, uncertain or unfamiliar territory will increase risk
- degree of operating risk assumed; for example, construction risk or cost overrun risk

- level of post-investment management required; for example, post-acquisition integration
- cultural and behavioural differences.

Trusts might find our approach to their risk assessment (as set out in Section 2.2 of our guidance) a useful reference point when determining thresholds for each level of risk and associated scrutiny.

It is good practice for trusts to seek advice from independent external advisers (eg risk management consultants) when developing their approach to managing risk.

Decision rights

A good practice investment policy will define clearly the roles, responsibilities and approval limits of the various committees and individuals with investment oversight. These are likely to include the board, investment committee, finance director and business development group, if one exists. For example, the board might be required to approve the written investment policy and all 'high risk' investments, while the investment committee might approve all other investments and ensure that investment decisions follow the guidelines laid out in the written investment policy.

Good practice is to scrutinise investments in proportion to risk. For example, a trust board may accept 'routine scrutiny' for low-risk investments (for example, decisions delegated to the investment committee, with a short-form business case), but require 'special scrutiny' for high-risk investments (for example, engagement of external independent advisers for in-depth business case, and main board approval).

Process for evaluating and managing investments

A robust investment policy will explain the internal processes for evaluating, executing and performance-managing investments. The extent of review/due diligence needs to be appropriate for the investment proposed. For example, all material and significant investments would be expected to undergo detailed business case evaluation and challenge.

Section 3 of our guidance sets out a robust framework for evaluating and managing significant mergers and acquisitions. This framework describes the key stages in

making a major transaction decision: strategic case review, full business case and detailed review, and approval of transaction.

For each of these phases it lists the main considerations and activities that board members need to attend to, as well as the nature and scope of our involvement in each stage (if appropriate). Section 4 sets out a similar framework for managing other types of significant transaction, such as capital investments and property transactions.

These risk evaluation frameworks are an indication of the type of analysis required at each of the stages of investment appraisal. If any trust is unclear about how to apply the framework to a particular investment appraisal they should seek professional advice.

Appendix 4: Indicative due diligence 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.

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.

Pre-merger information sharing and competition considerations

Discussions between providers planning to merge are an important part of merger planning and due diligence. However, planned mergers do not always proceed, so it is sensible to have appropriate safeguards on the sharing of confidential and commercially sensitive information. Exchanging confidential and commercially sensitive information between competitors could breach competition rules if it prevents, restricts or distorts competition.²⁹ In general, exchanging information which is already in the public domain or is not confidential is unlikely to raise concerns.

Commercially sensitive information' includes strategically useful information that would allow providers to co-ordinate their plans in terms of investment or service provision. This could include information about:

- bids or tenders to provide services, procurement of goods or services
- contracts with commissioners
- applications for university hospital status
- recruitment
- terms and conditions of employment

²⁹ Section 2 of the Competition Act 1998 and Article 101(1) of the Treaty on the Functioning of the European Union.

- staff sharing arrangements
- the costs or inputs of providing a service
- future strategy or plans for service provision.

Information obtained through due diligence is likely to be commercially sensitive if it is not in the public domain. Typically there is likely to be a greater competition risk in exchanging information that is detailed (as opposed to aggregated) and current or forward looking (as opposed to historical).

As a general principle, commercially sensitive information should only be shared when it is necessary for the purposes of the merger and then only with individuals who need to know the information for that purpose, such as advisers, the programme board, proposed board and merger finance group. In addition:

- information should not be used for purposes other than the merger
- providers should have a genuine intention to proceed with the merger
- if the merger is abandoned, commercially sensitive information that has been shared should be returned or destroyed
- individuals with access to commercially sensitive information should sign a non-disclosure agreement reflecting the conditions above.

Further information about the application of competition rules to information sharing can be found in Monitor's [Consultation on the application of the Competition Act 1998 in the health sector](#), and the [Office of Fair Trading's guidance on agreements](#) (which has been adopted by the Competition and Markets Authority).

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

- sub-committees (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 events³⁰)
 - 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

³⁰ Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

- 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 (clinical commissioning groups (CCGs)/commissioning support units) 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 Single Oversight Framework (SOF) 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; for example, 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; for example, 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; roles and responsibilities; 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; 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.

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:

- listing 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
- analysis of organisation's culture and values
- 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 TUPE³¹ arrangements
- mapping of HR policies and procedures between organisations.

Pensions:

- summary of the main pension and other post-retirement benefit arrangements, early retirement allowances, retirement indemnities,

³¹ Transfer of undertakings (protection of employment) Regulations 2006 (SI 2006/246).

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 and two years of financial projections.

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

- summary of results
- analysis of revenue and profitability by hospital/unit
- 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, and 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, and comparison with historical results and current year outturn
- key assumptions
- analysis of year-to-date trading (including comparison with 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).

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
- mitigations plans.

Other matters:

- key accounting policies (eg revenue recognition) and any significant changes in 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 CCGs and the geographical reach of particular services
- assessment of the benefits of the acquisition of the target NHS organisation:
 - How does the geographical, service and CCG 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?
 - Does the acquisition give access to CCGs that previously were unserved?

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; for example, 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

- Review corporation tax computations for all years still open to audit, and related working papers and correspondence in the files of the transacting NHS organisation and those provided by the transacting NHS organisation's tax advisers.
- Analyse the transacting NHS organisation's corporation tax position on the basis of discussions with the transacting NHS organisation's management and tax advisers. The analysis will cover:
 - procedures for administering corporation tax affairs
 - historical and prospective tax charges
 - the extent to which the transacting NHS organisation has complied with relevant statutory, regulatory or other legal requirements.
- Discuss with the transacting NHS organisation's management and tax advisers:

- the key issues in the transacting NHS organisation's corporation tax position and the key judgements it has made in determining the tax charge included in the transacting NHS organisation's accounts and in preparing its tax returns
- any potential material exposures of which they are aware in the transacting NHS organisation's corporation tax position
- any other matters arising which require further explanation.

Other taxes:

- 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 which have been made in preparing tax returns
 - any material potential exposures of which it is 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

- 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 coordinate development of all transitional plans to deal completion.

Appendix 5: NHS Improvement scope and submissions

Indicative NHS Improvement detailed review full scope by transaction stage

Domain	Stage 1: Strategic case – scope	Stage 2: Business case – scope
<p>Strategy</p> <p>Is there a clear strategic rationale for the transaction and does the board have the capability, capacity and experience to deliver the strategy?</p> <p>Does the transaction raise any competition issues?</p>	<p>Is the trust’s overall strategy well reasoned and can the board articulate how the transaction supports its delivery?</p> <p>What challenges faced by the trust is the strategy seeking to address?</p> <p>What other options were considered for addressing those challenges?</p> <p>What was the basis for selecting the proposed transaction approach?</p> <p>Has there been a detailed options appraisal and is there a clear rationale for the option that the trust has selected?</p> <p>Does this rationale set out why it is the best option for patients, the trust and local health economy?</p> <p>Does the board have capability, capacity and experience to deliver the trust’s strategy?</p> <p>Has the trust appropriately determined the potential nature and extent of any competition issues which may be raised by this transaction?</p> <p>If relevant, review of trust's completed assessment of any competition issues; comparison to NHS Improvement’s assessment</p> <p>If relevant, preliminary review of trust's approach to assessing relevant patient benefits, robustness of plans for their realisation, and the fit with local commissioning intentions</p>	<p>Update as necessary if any changes since stage 1</p>

<p>Transaction execution</p> <p>Does the trust have the ability to execute the transaction successfully?</p>	<p>Is the trust sufficiently prepared and equipped for this transaction?</p> <p>Are there any governance concerns or early indicators of concern in the acquiring trust?</p> <p>Does the board understand the transaction's key risks and is a sufficient, robust due diligence programme planned?</p> <p>Has the board identified mitigations to the key risks?</p> <p>Is there a vision for the post-transaction organisation's structures and governance; a strategy for benefits realisation; and an outline implementation plan (including high-level timeline, dedicated resource for implementation management/ programme management office (PMO) and identified integration workstreams)?</p> <p>Has the trust sought legal advice on the transaction, with no indicators of risk that transaction could not legally proceed?</p>	<p>Does the board have the appropriate capability and capacity to minimise execution risks?</p> <p>Is the board able to identify and quantify transaction risks appropriately (including any risks associated with competition rules)? Is its approach to due diligence robust and is there evidence that key risks have been recorded?</p> <p>Has the board effectively mitigated key risks and established effective processes for the continued management of these risks post transaction?</p> <p>Is there a robust and comprehensive plan for delivery of the transaction, including integration and realisation of other benefits?</p> <p>Is the integration plan sufficiently supported by clear lines of accountability, governance processes, delivery milestones and dedicated resource?</p> <p>Has the trust met all regulatory and legal requirements (including NHS Improvement (Monitor) certification), and is it planning the transaction with reference to good practice guidance?</p>
<p>Quality</p> <p>Is quality maintained or improved as a result of the transaction?</p>	<p>What is CQC's view of both trusts and the impact of the planned transaction?</p> <p>Would the enlarged organisation trigger any governance concerns under Appendix 1 of NHS Improvement's Single Oversight Framework?</p>	<p>Has the trust received a clean quality governance opinion in relation to the transaction (where relevant)?</p> <p>Has the medical director provided a certification to NHS Improvement?</p>
<p>Financial</p> <p>Does the transaction result in an entity that is financially viable?</p>	<p>What are the trust's key assumptions (synergies, transaction costs and funding sources)?</p>	<p>Does the trust's plan demonstrate financial viability post-transaction?</p> <p>Has the trust received an unqualified Financial Reporting Procedures (FRP) opinion? (where relevant)</p> <p>Has the trust received an unqualified working capital opinion? (where relevant)</p>

Indicative NHS Improvement detailed review full scope submissions by stage

This appendix gives a comprehensive list of expected submissions against each of the scope domains for each stage. All submissions are relevant for a stage 2 review.

Strategic rationale

Is there a clear strategic rationale for the transaction and does the board have the capability, capacity and experience to deliver the strategy?

Stage 1 submissions

Minimum requirement:

- summary paper on the rationale for the transaction, including details of:
 - challenges being addressed by the transaction
 - opportunities for patient, trust and local health economy benefits
 - competition analysis (including analysis of patients benefits, where appropriate)
 - evidence of alignment, support and engagement from STP plan/commissioners
 - consideration of how the transaction supports the trust's strategy
 - strategic options analysis: to include 'do nothing' and management contract option between parties as a consideration
- trust board paper evidencing discussion and review of options proposed
- corporate risk register.

Best practice supporting documents

- trust plan for ongoing stakeholder engagement.

Stage 2 submissions

- Analysis/work performed on identification of the synergies and benefits associated with the transaction (both financially and clinically, including the impact on workforce).

- Analysis of opportunities the transaction represents.
- Details of any issues raised during board and stakeholder engagement and how these have been resolved.
- Analysis of relevant patient benefits.
- Evidence of the decision process undertaken to conclude on option selected, including evidence (eg board minutes and board papers) of board challenge and consideration of potential barriers to success and how these have been reflected in final plans.
- Evidence of engagement with key stakeholders in the local health economy, patients and key staff, and of views/issues raised in this engagement having been considered and incorporated into final plans.
- Assessment of the level of support for the transaction in the local health community, in particular the level of support received from CCGs and confirmation of their commissioning intentions.
- Evidence of continuing stakeholder engagement.
- Analysis of local health economy and market.

Transaction execution

Does the trust have the ability to execute the transaction successfully?

Stage 1 submissions

Minimum requirement:

- proposed execution plan to deliver the transaction including:
 - plan to develop business case
 - outline transaction governance and programme management plan
 - transaction delivery plan including key milestones
 - high-level benefits realisation strategy
 - capacity and capability assessment of trust's ability to deliver the transaction
 - timetable and resources for delivery
 - proposed legal/transaction structure
- access and outcomes performance analysis against operational targets including recovery plans for failing targets

- details of any existing governance issues in the acquiring organisation and action plans in place to address these within the plan
- board structure and composition for enlarged trust, including appointment process
- preliminary due diligence and plan for completion of further due diligence
- high-level consideration of downside risks to the transaction (both financial and non-financial)
- details of any legal advice sought regarding the transaction
- plans to develop heads of terms, covering key commercial terms and process to complete.

Stage 2 submissions

- All due diligence reports and summaries considered by acquiring board as part of the transaction.
- Evidence of review and challenge of the due diligence carried out and agreed action plans addressing issues identified within the due diligence.
- Draft transaction agreement with evidence of agreement by all parties, including details of assets liabilities and staff to transfer.
- Benefits realisation plan describing benefits (cost, revenue, patients, clinical, etc) arising from the transaction, including specific benefits by service line, timing and supporting evidence (persons responsible for capturing specific synergies should be clearly indicated), draft then final.
- Organisation chart of the proposed enlarged trust.
- CVs and biographies of proposed board members or interim directors (highlighting any relevant experience in mergers and acquisitions).
- Skills-gap analysis of board performed for enlarged proposed board and if relevant, a plan to fill any necessary positions in the proposed board members which are vacant or will be vacant post transaction.
- Details of any external advice sought in respect of capability or change management.
- Details of engagement with target organisation's board and senior clinicians, including evidence of discussion/consideration of barriers to integration and attempts to resolve these.
- Change management strategy, eg plan to manage cultural/behavioural harmonisation.

- Proposed governance structure for the combined organisation including the board and its sub-committees, and rationale for changes from current structure (showing, where relevant, due consideration of continuity of relations with clinicians, local authorities, voluntary bodies, etc).
- Details of major action and contingency plans to mitigate risks, including details of key mitigation enablers.
- Details of additional integration arrangements, eg time-limited committees.
- Post-transaction integration risk management plan.
- Current corporate risk register for both target and for transaction.
- All board minutes and papers relevant to the proposed transaction, including minutes evidencing board approval of mitigations.
- Copy of the latest integration plan monthly monitoring progress/status report to acquiring trust's board.
- Summary of reporting arrangements for patient experience and complaints at the acquiring trust including: (1) the author and distribution of the patient experience report, (2) the names and membership of any groups that review patient experience and complaints, (3) the frequency with which patient experience data is reported to the board and any other applicable groups.
- Serious incident policy and reporting arrangements at the acquiring trusts including: (1) the names and membership of any groups that review serious incidents, (2) the frequency with which serious incident data is reported to the board and any other applicable groups (both internal and external to the trust).
- Plans to integrate quality governance systems (including patient experience, complaints and serious incident reporting arrangements), risk management systems, financial reporting procedures, performance management systems, IT systems, services and culture.
- Detailed post-transaction integration timeline, with milestones and deadlines.
- Post-transaction management team structure/summary.
- Communication plan for staff and key stakeholders.
- Decision and rationale on physical service configuration/location.

- Specifications of changes to clinical services appropriately cross-referenced with the business plan, with evidence of appropriate consultation on the changes.
- Planned format for performance reporting for the enlarged trust.
- Reports (including action plans where available) from third-party inspectorates.
- Self-certification and supporting board minutes and papers.
- Draft constitution for the post-transaction foundation trust and explanation of major changes from the previous constitution membership strategy, including steps taken to ensure representative membership for the post-transaction foundation trust.
- Proposals and timetable for the proposed membership and council of governors and elections for the post-transaction foundation trust.
- Register of proposed directors' interests.
- Schedule of commissioner requested services (CRS) – with any changes to CRS currently provided by the trust(s) clearly indicated; changes to the provision of CRS resulting from the transaction must be undertaken in accordance with Continuity of Service Licence Condition 1.
- Board statement confirming its review and approval of the PTIP (pro forma provided in Appendix 10).
- Independent accountant's report and signed opinion on PTIP, draft then final.
- Signed board statements and memorandum on financial reporting procedures.
- Independent accountant's report and signed opinion on financial reporting procedures, draft then final.
- Details of interim/shadow directors (see Appendix 1), mutually agreed by both boards and reflecting the expected future composition of the new trust's board.
- Details of the selection process for NEDs.
- Details of the proposed external and internal auditor of the new trust should be provided.

Finance

Does the transaction result in an entity that is financially viable?

Stage 1 submissions

Minimum requirement:

- preliminary financial analysis with financial assumptions to include:
 - underlying financial position and performance of acquiring organisation (both parties if a merger)
 - forecast transaction costs to complete
 - synergies and other benefits identified
 - funding requirement and proposed sources of funding
 - realistic counterfactual analysis
 - current trading.

Best practice supporting documents:

- benchmarking opportunities identified for the enlarged trust
- turnaround plan for target, where concerns have been identified with performance (operational or financial)
- preliminary downside analysis of financial risk.

Stage 2 submissions

- LTFM – completed comprehensively with supporting working papers.
- Summary of CIP plans.
- Activity analysis – if not already detailed in the LTFM.
- Details of major initiatives, such as new investments, or synergies from the transaction, including timeframe in which they will be achieved, key assumptions used and scenario analysis to demonstrate risks to achievement of plan.
- Where the other merger/acquisition party has a significant financial deficit, a summary of the key initiatives and components of the plan to eliminate the deficit.

- Summary of the costs expected to be incurred to complete and implement the transaction, including assumptions used to calculate them and timings of when they are to be incurred.
- Details and quantification of downside risks and mitigation actions.
- Signed heads of terms.
- Draft transaction agreement.
- Financial due diligence reports.
- Reconciliation of acquiring trust's base case to regulatory operating/annual plan submitted to NHS Improvement.
- Analysis of transaction funding, internal (operating cash flow) and external.
- Details of ongoing discussions of funding sources and confirmation from all funding parties.
- Completed contract templates for both acquiring trust and target trust (as provided by NHS Improvement) as reconciled to the LTFM.
- Details of CQUIN targets and year-to-date achievement for target including any risks to achievement for the full year.
- Finance committee reports (covering a six-month period).
- Latest audited accounts for both trusts.
- Details of any outstanding contract disputes and potential financial impact (if applicable).
- Detailed CIP plans for outturn year and the subsequent two years, and as much as is available beyond that for both trusts (including projected WTE data), as reconciled to the full business case (FBC).
- Where the other merger/acquisition party has a significant financial deficit, details and analysis of the plans to address and, over time, eliminate the deficit.
- Reconciliation of FBC CIP to actual CIP.
- Latest board report on CIP achievement.
- Minutes of the forum where CIPs are monitored (both trusts).
- Any quality reviews performed on the CIP schemes to verify they do not impact on clinical quality.
- Summary of accounting-related choices or issues presented by the transaction, and of their resolution.
- Integrated estates plan for the combined organisation.

- Analysis of asset disposal plans for the coming year.
- Analysis of supporting activity assumptions.
- Completion of current trading templates (as provided by NHS Improvement) for both acquiring trust and target trust.
- Completion of historical accuracy of budgeting template (as provided by NHS Improvement) for both acquiring and target trust.
- Board statement and memorandum on working capital (see Appendix 10).
- Independent accountant's report and signed opinion on working capital, draft then final (see Appendix 11).

Long-term financial model

We will provide a transaction LTFM which should be completed to support the business plan. This model can be obtained by emailing nhsi.modelqueries@nhs.net. The transaction LTFM has similar functionality to the standard LTFM. The model includes three years of historical data, the current year outturn and five years of forecast data. The first two to three years of projections are on a monthly basis and checks are incorporated into the model to ensure consistency between monthly projections and the annual projections. Trusts with major PFIs or other major investments opening in future years need to incorporate their projections and assumptions over a 10-year period and the model has been constructed to allow for this where necessary.

Quality

Is quality maintained or improved as a result of the transaction?

Stage 1 submissions

Minimum requirement:

- latest CQC comprehensive inspection reports for all transacting parties (including draft reports)
- list of areas of CQC non-compliance including action plans for the acquirer (both trusts in the case of a merger) and for the target, where available
- latest well-led report (including draft) for acquirer (both trusts in the case of a merger).

Best practice supporting documents:

- details of operational performance targets at individual trusts with additional analysis showing the rating for the combined organisation over the proposed review period
- initial mitigations to identified potential breaches of targets.

Stage 2 submissions

- Clinical due diligence report.
- Completion of workforce analysis and bridging template (as provided by NHS Improvement) to bridge movements in workforce in the forecast period.
- Latest available signed annual governance statement for each trust.
- Any public interest reports issues for either trust in the last 12 months.
- Latest available quality account.
- Up-to-date summary of complaints and serious incidents at acquiring and target trust with comparative information from previous year, including the number of complaints received monthly or quarterly (however reported internally) and the categories these complaints relate to (to be provided in summary form – that is, whatever gets reported to management/the board).
- Analysis of the complaints at both acquiring and target trusts for two historical years.
- Latest available patient experience survey summary results for acquiring and target trust; details of how frequently surveys are performed and to whom they are reported.
- Quality committee reports for the six-month period.
- Staff survey and most recent analysis thereof for both trusts with comparison with previous year and key trends.
- Self-certification on the service reconfiguration by medical director, with supporting board memorandum.
- Signed board statement and memorandum on quality governance arrangements.
- Independent accountant's report and signed opinions on quality governance, draft then final.

Specific submission requirements for statutory transactions

The submissions detailed above relate to all transactions where a detailed review is carried out by NHS Improvement. For all statutory transactions as defined in Section 1.3 of our guidance, statutory submissions will also be required as set out in Section 9.

Guidance on the contents of a post-transaction integration plan

The plan should span from the current state of the trust(s) as they exist today, to the post-transaction entity after it has completed all activities necessary for consolidation. Plans should include the following.

Organisation chart of the proposed enlarged trust:

- composition of proposed council of governors
- composition of board of directors of proposed enlarged trust including decisions on all key named posts
- relevant experience of directors in conducting successful transactions, if any
- clear plan to fill any necessary positions in the above which are vacant or will be vacant post transaction
- contact information for all persons specified in the organisation chart
- composition and relevant experience of the proposed integration team.

Implementation timeline:

- activities for transitional period leading up to completion date – to meet objectives for ‘Day 1’ (such as addressing any critical clinical issues raised in due diligence, ensuring safe Day 1 staffing across the enlarged organisation, staff engagement/induction)
- timing of all key post-completion workstreams and objectives (milestones); specific milestones are left to the applicant’s discretion but should include events such as management changes, closures or movements of sites,

significant changes to service provision, and significant costs, cost savings or revenues incurred as a result of the transaction

- projected dates of all management changes (or changing lines of authority), service reconfigurations, site closures, or any other post-transaction events material to the financial plan or provision of clinical services
- timetable for service-line consolidation, laid out by the individual service line. In general the timetable should provide:
 - a clear path from the current state of affairs to the future structure of the post-transaction NHS foundation trust's clinical services
 - guidance as to the timing of costs, cost savings and revenues specifically deriving from the post-transaction programme
 - a clear layout so that we (or anyone reviewing the plan) can verify, after the merger, whether the post-transaction integration is proceeding according to plan and on schedule.

Specifications of changes to clinical services appropriately cross-referenced with the business plan, with evidence of appropriate consultation on the changes:

- plan for how clinical services will be distributed post transaction, including a complete list of planned changes to clinical services from those currently offered by trust(s)
- timing and location of sites to be shut, moved or where time of service provision will be affected.

Post-transaction management team summary

This is a team dedicated to overseeing the PTIP and solving problems that arise, and is directly accountable for the results of the integration:

- composition of post-transaction management team with roles/responsibilities for delivery of the PTIP
- contact information for all members of the post-transaction management team.

Post-transaction integration risk management plan

- summary of key risks inherent in the plan including magnitude of risks, nature of risks and their likelihood
- risk management strategy to mitigate risks identified in the post-transaction integration, including fall-back plan for accomplishing significant elements of the plan if, for example, the schedule slips, or in the case of unforeseen events that prevent achievement of key milestones.

Summary of accounting-related choices or issues presented by the transaction and of their resolution:

- advice obtained from external accounting firms (where applicable).

Guidance on the contents of a full business case

We will review the applicants' business plan to understand the assumptions driving the plan, to identify key risks and to determine whether there are adequate processes in place for the proposed merged entity to achieve its goals and manage its risks. We will also seek to ensure that CRS are being provided and will verify compliance with relevant statutory requirements. We will also closely compare the assumptions post transaction with current values for the applicant trusts to check that their derivation makes sense.

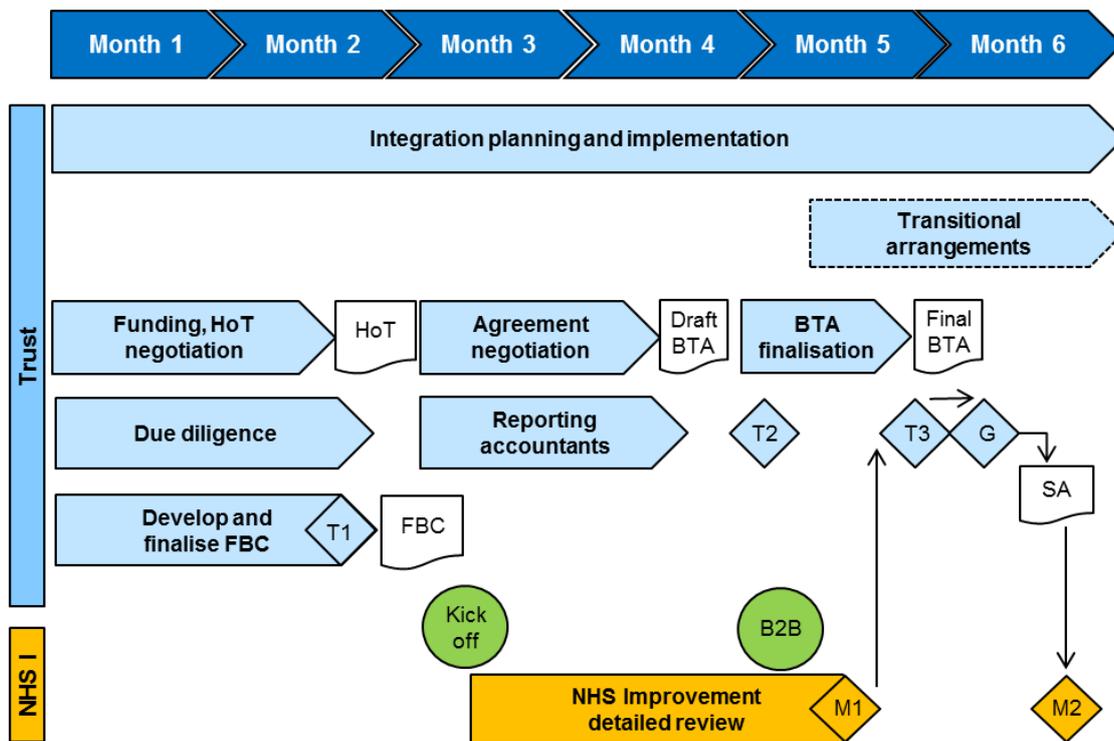
The business plan is a key document that should:

- detail the rationale for the transaction, including details of how the transaction supports the acquiring trust's strategy
- detail the synergies and benefits associated with the transaction (both financially and clinically, including the impact on workforce)
- detail the current challenges the trusts face that the transaction seeks to address
- detail the opportunities the transaction represents
- include options appraisal, including analysis of relevant patient benefits
- identify key risks to execution of the post-transaction strategy
- clarify major action and contingency plans to mitigate key risks

- detail the level of consultation and engagement with key stakeholders, including details of feedback and how this has been incorporated into proposals
- detail continuing stakeholder engagement
- explain the level of support for the transaction in the local health community, in particular the level of CCG support
- detail the financial plan, identifying key assumptions, underlying projections and their relationship to the local health economy; include details of funding sources
- set out clearly how any restructuring costs (including treatment of accumulated deficits or debts) will be handled, and how it is proposed that they will be funded
- identify the impact of patient choice and competition for services on the activity assumptions
- the submitted plan should demonstrate continued provision of CRS for all patients currently serviced by the transaction parties, or detail and explain the rationale for significant changes to be made post transaction
- highlight major changes to the property portfolio post transaction, with particular emphasis on property material to provision of CRS
- summarise key themes of any due diligence carried out for the transaction
- summarise planned delivery of the proposed transaction, including proposed timeline.

Appendix 6: Indicative timeline

The indicative timeline below illustrates the main concurrent workstreams of the trust alongside our detailed review during the business case and approvals stages of a significant transaction (stages 2 and 3). The actual timelines for these stages of significant transactions will vary significantly, depending on many factors including the size and complexity of the transaction and the interactions with other stakeholders.



Decisions and approvals

- T1 – Board approves final FBC documents for submission to NHS Improvement
 - T2 – Board approves certification, board statements, memoranda and final reports from reporting accountants/experts
 - T3 – Board decision to approve transaction
 - G – Governors’ formal vote on the transaction
 - M1 – NHS Improvement approves and issues transaction risk rating
 - M2 – NHS Improvement grants formal application for statutory transaction, makes Statutory Order (if applicable)
- HoT, heads of terms; BTA, business transfer agreement; SA, statutory application (if applicable); FBC, full business case; B2B, board-to-board meeting

Appendix 7: Investment adjustments

Introduction

So as not to discourage trusts from undertaking transactions that have short-term negative implications for the Single Operating Framework (SOF) segment and operational performance metrics, trusts may apply for investment adjustments before we assign the transaction a risk rating. This appendix provides guidance for trusts considering applying for an investment adjustment by describing:

- the application process and documents that need to be submitted
- our review for risk rating.

Purpose of the adjustment

Trusts may be discouraged from undertaking major transactions or investments if potentially these will have a short-term negative impact on their SOF segment. We recognise trusts may need some short-term concessions if they are to deliver longer-term improvement; for example, where a failing organisation is being acquired by a high performing organisation to address underperformance and improve patient care.

The investment adjustment will ensure that the acquiring trust's SOF segment is not impacted by a failing trust's operational performance on acquisition, provided it has adequate plans to recover the target trust's performance (and therefore the enlarged trust's) to the relevant standard within a reasonable timeframe. In applying for an investment adjustment, we recognise that the trust understands its forecast position and may require some additional support from us; however, a revision to its segmentation is not required.

We will consider investment adjustments on a case-by-case basis and only in the following circumstances:

- the relevant investment is a material or significant investment

- the trust has applied to us in writing for an investment adjustment and provided supporting information, as explained in more detail below.

Application for adjustments and supporting documents required

A trust will need to write to us to request maintenance of its SOF segment before committing to a legally binding agreement in respect of the transaction.

To allow us to assess a potential investment adjustment, trusts will need to provide:

- a proposed threshold trajectory for the relevant national indicator for the acquired organisation by quarter, with management plans showing how it will recover performance to the target threshold within an appropriate timeframe to be agreed with us
- a proposed threshold trajectory for each indicator against which the enlarged, post-transaction trust should be scored
- a rationale for the above thresholds.

In the case of a material transaction we may ask to review the documents on which the trust's self-certification is based (eg due diligence work or advice the trust received from external advisers).

NHS Improvement's process

Our regional team and transaction review team need to agree investment adjustments before these can be approved by the appropriate NHS Improvement committee that approves the transaction risk rating.

Qualifying criteria

We will consider a revised trajectory for SOF segmentation purposes only. Where trusts receive payments for delivery of performance-related targets from commissioners, these are not covered by NHS Improvement's investment adjustment and need to be discussed separately with commissioners.

We will approve an investment adjustment if it delivers an improvement in patient care as a result of the transaction. We may only approve an application if the adjustment:

- is limited to the impact of the transaction
- is short-term and time-limited
- a credible planned trajectory is in place.

Appendix 8: Board certification

All trusts undertaking material and significant transactions should complete this certification as part of the transaction review process.

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

Where a potential transaction is deemed to be material, as defined in Section 2.2 of our guidance, NHS Improvement will, as part of our overall assessment of financial risk and governance, request evidence that the trust board is satisfied that it has:

- considered a detailed options appraisal before deciding that the transaction delivers benefits for patients and the trust in delivering its strategy
- assured itself that a proposed transaction will meet the requirements of the choice and competition licence conditions
- conducted an appropriate level of financial, clinical and market due diligence relating to the proposed investment or divestment
- considered the implications of the proposed investment or divestment on the resulting entity's Single Oversight Framework (SOF) segment, focusing in particular on the use of resources metric and having taken full account of reasonable downside sensitivities
- conducted appropriate enquiry about the probity of any partners involved in the proposed investment or divestment, taking into account the nature of the services provided and the likely reputational risk
- conducted an appropriate assessment of the nature of services being provided as a result of the investment or divestment and any implications for reputational risk arising from these
- received appropriate external advice from independent professional advisers with relevant experience and qualifications
- taken into account the good practice advice in NHS Improvement's transaction guidance or commented by exception where this is not the case
- resolved any accounting issues relating to the proposed investment or divestment and its proposed treatment

- addressed any legal issues, including those associated with the transfer of staff (either via an acquisition, divestment or fixed-term contract)
- complied with any consultation requirements
- established the organisational and management capacity and skills to deliver the planned benefits of the proposed investment or divestment
- involved senior clinicians at the appropriate level in the decision-making process and received confirmation from them that there are no material clinical concerns in proceeding with the proposed investment or divestment, including consideration of the subsequent configuration of clinical services
- in the case of a contract for a specified period, ensured appropriate legal protection in relation to staff, including on termination of the contract
- ensured relevant commercial risks are understood
- made provision for the transfer of all relevant assets and liabilities
- at the time of the acquisition, provided a corporate governance statement (see Appendix 13) for the acquiring trust
- at the time of the acquisition, provided a board statement that plans are in place to make the corporate governance statement (see Appendix 13) within six months of formation of the new organisation, with the exception of the following statement concerning quality governance:

“The board is satisfied:

(f) that there is clear accountability for quality of care throughout [insert name] trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the board where appropriate.”

This requires an appropriate timescale for compliance, which should be determined by the trust board and agreed with NHS Improvement.

Appendix 9: Pro forma medical director's certification

NHS Improvement
Wellington House
133-155 Waterloo Road
London SE1 8UG

[Date]

Dear Sirs

[Applicant trust(s)] ('the trust[s]')

In connection with the trust['s/s'] proposed transaction [detail transaction], I have reviewed the business plan. The results of this review are set out in the attached memorandum dated [date] which has been prepared after due and careful enquiry.

In my opinion, taking into account the business plan and all changes to the clinical service configurations that are proposed to be made following the transaction, there is no reason based in clinical practice to object to the service configuration set out in the business plan.

Yours faithfully

[Proposed medical director of the enlarged trust]

Appendix 10: Board statements

In addition to the board certification (Appendix 8), the medical director's certification (Appendix 9) and the board's corporate governance statement (Appendix 13), for significant transactions, NHS Improvement (Monitor) will often seek, on a discretionary basis, additional evidence for the level of assurance the trust board has obtained in respect of the sufficiency and adequacy of the following aspects of the transaction plans:

- working capital
- financial reporting procedures
- post-transaction integration plan
- quality governance.

The board will need to produce statements (in the case of a merger of two trusts, joint statements approved by both boards). This appendix gives the standard form for these.

Board memoranda

Each of these statements must be supported by a board memorandum or plan that sets out in some detail the basis of the board's(s') statement, which must be reviewed and approved by the board(s). Table 1 below summarises the regular contents of these supporting memoranda.

Table 1: Contents of supporting memoranda

Working capital board memorandum	Financial projections for the first two years post transaction, key assumptions, downsides and sensitivity analysis.
Financial reporting procedures board memorandum	The post-transaction organisation's proposed corporate governance arrangements, high-level controls, risk management processes, management reporting framework.

Post-transaction integration plan	Post-transaction management and governance; integration management, governance, workstreams, timeline; integration risk management, benefits realisation (see Appendix 5).
Quality governance board memorandum/ plan	The post-transaction organisation's proposed quality governance arrangements, covering NHS Improvement's well-led framework's requirements for effective governance that safeguards quality.

Pro forma board statements

The board statements should be addressed to NHS Improvement and signed for and on behalf of the board of directors (for a merger, both boards).

Pro forma wording for the following board statements are set out below:

- working capital
- financial reporting procedures
- post-transaction integration plan
- quality governance framework.

Working capital

NHS Improvement
Wellington House
133-155 Waterloo Road
London SE1 8UG

[Date]

Dear Sirs

[Post-transaction NHS foundation trust/NHS trust] ('the enlarged trust')

In connection with the trust['s/s'] proposed transaction [describe brief summary of transaction] (post transaction, 'the enlarged trust'), the board[s] of directors [of both applicant trusts] [has/have] reviewed the enlarged trust's future working capital requirements following the proposed transaction from [date] to [one year from date]. The results of this review are set out in the attached board memorandum dated [date] which has been prepared after due and careful enquiry.

In the opinion of the board[s] of directors [of both applicant trusts], taking into account the enlarged trust's [existing and proposed new] working capital facilities, the working capital available to the enlarged trust is sufficient to meet the requirements of the enlarged trust, that is at least the 12 months from [date].

Yours faithfully

For and on behalf of [board of directors]

Financial reporting procedures

NHS Improvement
Wellington House
133-155 Waterloo Road
London SE1 8UG

[Date]

Dear Sirs

[Post-transaction NHS foundation trust/NHS trust] ('the enlarged trust')

The board[s] of directors of [name(s) of applicant trust(s)] confirm that [it has/they have] established procedures for the enlarged trust that provide a reasonable basis for [it/them] to reach proper judgement as to the financial position and prospects of the enlarged trust.

The basis of the board[s] of directors' confirmation is set out in the attached board memorandum dated [date]. This describes a range of financial reporting procedures for the enlarged trust for which plans have been drawn up by the board[s] of directors, but which the board[s] of directors [have/has] not brought into operation as of the current date. The board[s] of directors confirm[s] that [it is/they are] committed to ensuring that these financial reporting procedures are brought into operation and subsequently operated in accordance with the plans.

Yours faithfully

For and on behalf of [board of directors]

Post-transaction integration plan

NHS Improvement
Wellington House
133-155 Waterloo Road
London SE1 8UG

[Date]

Dear Sirs

[Post-transaction NHS foundation trust/NHS trust] ('the enlarged trust')

In connection with the trust['s/s'] proposed transaction [detail transaction] the trust['s/s'] board[s] of directors [have/has] reviewed the post-transaction integration plan.

This plan has been prepared in accordance with applicable NHS Improvement (Monitor) guidance and good practice, including the principles set out in NHS Improvement's *Transactions guidance*, and after due care and consideration and is supported by appropriate evidence.

In particular, the trust['s/s'] board[s] of directors believes that the post-transaction integration plan (where applicable) addresses and outlines:

- benefits to be derived from the transaction including synergies, cost reductions and increases in revenue
- feasibility of the proposed organisational structure and changes from the current state
- feasibility of the timeline
- risk management strategy for all risks considered material by the current board of directors and the qualified professional advisor to the integration
- plans to resolve any service development problems
- detailed plans to address any current non-achievement of national targets or core standards as well as plans to ensure ongoing compliance with national targets and core standards.

Yours faithfully

For and on behalf of [board of directors]

Quality governance framework

NHS Improvement
Wellington House
133-155 Waterloo Road
London SE1 8UG

[Date]

Dear Sirs

[Post-transaction NHS foundation trust/NHS trust] ('the enlarged trust')

In connection with the trust['s/s'] proposed transaction [detail transaction], (post transaction, 'the enlarged trust'), the trust['s/s'] board[s] of directors confirm that:

The board[s] [is/are] satisfied that, to the best of [its/their] knowledge and using [its/their]own processes (supported by CQC information, [its/their] own information on serious incidents, patterns of complaints, and including any further metrics [it/they] choose to adopt), the [trust has/trusts have], and will keep in place, 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 substandard performance
- planning and managing continuous improvement
- identifying, sharing and ensuring delivery of best practice
- identifying and managing risks to quality of care.

This encompasses an assurance that due consideration has been given to the quality implications of future plans (including the integration of the two organisations, service redesigns, service developments and cost improvement plans), and that processes are in place to monitor their ongoing impact on quality and take subsequent action as necessary to ensure quality is maintained.

The basis of the board[s] of directors' confirmation is set out in the attached board memorandum dated [date] and the quality governance plan, both of which have been prepared after due and careful enquiry.

The memorandum and quality governance plan describe the quality governance arrangements for the enlarged trust which have been planned by the board[s] of directors. The board[s] of directors [confirm/confirms] that [it/they] will ensure these plans are brought into operation, and subsequently operated in accordance with the plans.

Yours faithfully

For and on behalf of [board of directors]

Appendix 11: Independent reviews and opinions

Each of the statements and supporting board memoranda or plans may be the subject of a review by an independent accountant or expert, to be selected and appointed by the trust. On conclusion of its reviews, the reporting accountant or expert will issue a report and a formal opinion on each of the four board statements. Each opinion should conclude that the respective board statement has been made ‘after due and careful enquiry/consideration’.

The independent accountant’s or expert’s reports and opinions must be made available to us but should be addressed only to the trust (or, in the case of a merger of two trusts, addressed jointly to both trusts).

Use of accounting firms

To avoid potential conflicts of interest over the use of independent accountants, trusts should note the following:

- We consider that it is possible for an accounting firm to act as both an adviser to the trust and the independent reporting accountant on a significant transaction, assuming appropriate safeguards are in place to manage conflicts.
- Where an accounting firm is also the trust’s external auditor, we draw the trust’s attention to the [National Audit Office – Guidance and information for auditors](#), particularly AGN/01 which discusses the restrictions on non-audit services. This section outlines the fee restrictions for non-audit work (currently a maximum of 70% of the annual audit fee) as well as a list of services that the auditor is prohibited from undertaking as the trust’s external auditor.
- Where an accounting firm has an internal audit role at a trust, we consider it should not act as the independent reporting accountant on a significant transaction.

Potential conflicts of interest are ultimately an issue for contracting trusts to manage jointly with appointed independent accountants. We should be consulted where trusts and their independent accountants consider that it would be appropriate for the independent accountant to perform the services contrary to the relevant guidelines set out above.

Pro forma opinions

These are given below for:

- working capital
- financial reporting procedures
- post-transaction integration plan
- quality governance framework.

Working capital

Dear Sirs

[Post-transaction NHS foundation trust/NHS trust] ('the enlarged trust')

We refer to the board memorandum dated [date] which has been prepared by the board[s] of directors of [the/both] trust[s] in connection with [its/their] statement relating to the sufficiency of working capital ('the board statement') contained in the letter dated [date] to NHS Improvement. Copies of the board memorandum and the letter, for which the directors of [the/both] trust[s] are solely responsible, are attached to this report and have been initialled by us for the purpose of identification.

We also refer to our commentary report dated [date] (the 'working capital report') which was prepared in accordance with our engagement letter dated [date]. This letter should be read in conjunction therewith.

In accordance with the terms of our engagement letter dated [date], we have reviewed the board statement. We attach copies of letters from [bank] regarding borrowing facilities that we have relied upon in arriving at our opinion.

On the basis of our work we report that, in our opinion, the directors of [the/both] trust[s] have made the board statement in the form and context in which it is made, after due and careful enquiry.

Yours faithfully

For and on behalf of [independent external qualified professional adviser]

Financial reporting procedures

Dear Sirs

[Post-transaction NHS foundation trust/NHS trust] ('the enlarged trust')

We are writing in connection with the [brief description of the transaction], (together, 'the enlarged trust').

We refer to the attached letter dated [date] from the board[s] of directors of [the/both] trust[s] addressed to NHS Improvement and the attached board memorandum dated [date] confirming that the board[s] of directors [has/have] established procedures which provide a reasonable basis for [it/them] to make proper judgements as to the financial position and future prospects of the proposed trust.

We also refer to our report dated [date] which was prepared in accordance with our engagement letter dated [date]. This report contains a description of and commentary on the proposed trust's financial reporting procedures. This letter should be read in conjunction with that report.

We note and draw to your attention that the board memorandum describes a range of financial reporting procedures for the proposed trust for which plans have been drawn up by the board[s] of directors of [the/both] trust[s], but which the board[s] of directors of [the/both] trust[s] [has/have] not brought into operation as of the current date. We also draw to your attention the commitment made by the board[s] of directors of [the/both] trust[s] as recorded in the board memorandum that [it/they] will ensure that the financial reporting procedures are brought into operation, and subsequently operated, in accordance with the plans. In providing this letter we are relying on this commitment of the board[s] of directors of [the/both] trust[s].

All financial reporting procedures are dependent for their effectiveness on the diligence and propriety of those responsible for operating them and are capable of being overridden by persons holding positions of authority and trust. Although we can therefore provide no assurance as to the day-to-day operation of those procedures, we can confirm that, in our opinion, the directors have provided their written confirmation after due and careful enquiry.

Yours faithfully

For and on behalf of [independent external qualified professional adviser]

Post-transaction integration plan

Dear Sirs

[Post-transaction NHS foundation trust/NHS trust] ('the enlarged trust')

We are writing in connection with the [brief description of the transaction], (together, 'the enlarged trust'). We refer to the statement made by the board[s] of directors of [the/both applicant] trust[s] to the effect that the post-transaction integration plan has been prepared after due care and enquiry.

The statement, together with the basis of belief of the directors for making the statement, the sources of information supporting the statement and the directors' analysis and explanation of the underlying constituent elements, are set out in the post-transaction integration plan prepared, considered and approved by the board[s] of directors of [the/both] trust[s].

We have discussed the statement and post-transaction integration plan together with the underlying plans with senior management and the board[s] of directors. We have also agreed the financial and other supporting data in the report to supporting information where appropriate and where such information has been made available to us. We refer to our commentary report on the post-transaction integration plan dated [date]. This letter should be read in conjunction therewith.

We do not express any opinion as to the achievability of the benefits identified by the board[s] of directors in the post-transaction integration plan. Because of the significant changes to the enlarged trust's operations expected to flow from the integration and because the post-transaction integration plan relates to the future, the actual integration benefits achieved are likely to be different from those anticipated in the statement and the differences may be material.

We draw your attention to the assumptions set out in the post-transaction integration plan and to the comments in our report as to the extent that these assumptions are supported by evidence.

On the basis of the foregoing, we report that in our opinion the board[s] of directors of [the/both applicant] trust[s] have made the statement, in the form and context in which it is made, with due care and enquiry.

Yours faithfully

For and on behalf of [independent external qualified professional adviser]

Quality governance framework

Dear Sirs

[Post-transaction NHS foundation trust/NHS trust] ('the enlarged trust')

We are writing in connection with the [brief description of the transaction], (together, 'the enlarged trust').

We refer to the attached letter from the board[s] of directors of [the/both] trust[s] and the attached board memorandum dated [date] confirming that the trust[s] [has/have], and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare provided by the enlarged trust to its patients, and encompassing an assurance that due consideration has been given to the quality implications of future plans (including service redesign, service developments and cost improvement plans), and that processes are in place to monitor their ongoing impact on quality and take subsequent action as necessary to ensure quality is maintained.

We also refer to our commentary report dated [date], which was prepared in accordance with our engagement letter dated [date]. This report contains a description of and commentary on the enlarged trust's quality governance arrangements and future plans. This letter should be read in conjunction with that report.

We note and draw to your attention that the board memorandum describes the quality governance arrangements for the enlarged trust for which plans have been drawn up by the board[s] of directors of [the/both] trust[s], but which the board[s] of directors of [the/both] trust[s] [has/have] not brought into operation as of the current date. We also draw to your attention the commitment made by the board[s] of directors of [the/both] trust[s] as recorded in the board memorandum that [it/they] will ensure that the quality governance arrangements are brought into operation, and subsequently operated, in accordance with the plans. In providing this letter we are relying on this commitment of the board[s] of directors of [the/both] trust[s].

All quality governance arrangements are dependent for their effectiveness on the diligence and propriety of those responsible for operating them and are capable of being overridden by persons holding positions of authority and trust. Although we can therefore provide no assurance as to the day-to-day operation of those

procedures, we can confirm that, in our opinion, the board[s] of directors [has/have] provided their written confirmation after due and careful enquiry.

Yours faithfully

For and on behalf of [independent external qualified professional adviser]

Appendix 12: Management letter of representation

NHS Improvement
Wellington House
133-155 Waterloo Road
London SE1 8UG

[Date – in the month prior to 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 Improvement Single Oversight Framework (SOF) ('the transaction review') as detailed in the *Transactions guidance* (November 2017). For the purposes of this letter, NHS Improvement means Monitor.

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:

Transaction long-term financial model (LTFM) 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 LTFM provided to NHS Improvement have been disclosed and are reasonable.

2. The LTFM 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 LTFM are consistent with the board's knowledge of the business and [both trusts'/the trust's] operating environment.
4. All material events and material changes subsequent to the submission of the LTFM and [FBC title] have been disclosed to NHS Improvement.
5. 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

6. 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 NHS Improvement's *Transactions guidance* (November 2017).

Internal control

7. 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 Improvement, 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.

8. 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.
9. There have been no instances of material fraud or suspected fraud that the board is aware of, other than those already reported to NHS Improvement 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 Improvement.

Legal compliance

10. 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.
11. 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

12. The board has actively considered all information provided to NHS Improvement 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:

Definitions (for letter of representation)

Material matters

Material omissions or misstatements of items are material if they could, individually or collectively, influence NHS Improvement's view on the impact of the transaction on the trust's compliance with the NHS Improvement Single Oversight Framework (SOF). 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 13: Corporate governance statement (FT4)

	Risks and mitigating actions
<p>The board is satisfied that [insert name] NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS.</p>	
<p>The board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.</p>	
<p>The board is satisfied that [insert name] NHS Foundation Trust implements:</p> <ul style="list-style-type: none"> (a) effective board and committee structures (b) clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees (c) clear reporting lines and accountabilities throughout its organisation. 	
<p>The board is satisfied that [insert name] NHS Foundation Trust effectively implements systems and/or processes:</p> <ul style="list-style-type: none"> (a) to ensure compliance with the licence holder's duty to operate economically, efficiently and effectively (b) for timely and effective scrutiny and oversight by the board of the licence holder's operations (c) to ensure compliance with healthcare standards binding on the licence holder including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of 	

<p>healthcare professions</p> <p>(d) for effective financial decision-making, management and control including, but not restricted to, appropriate systems and/or processes to ensure the licence holder's ability to continue as a going concern</p> <p>(e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for board and committee decision-making</p> <p>(f) to identify and manage (with, but not restricted to, forward plans) material risks to compliance with the conditions of its licence</p> <p>(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery</p> <p>(h) to ensure compliance with all applicable legal requirements.</p>	
<p>The board is satisfied:</p> <p>(a) there is sufficient capability at board level to provide effective organisational leadership on the quality of care provided</p> <p>(b) the board's planning and decision-making processes take timely and appropriate account of quality of care considerations</p> <p>(c) accurate, comprehensive, timely and up-to-date information on quality of care is collected</p> <p>(d) it receives and takes into account the accurate, comprehensive, timely and up-to-date information on quality of care</p> <p>(e) [insert name] NHS Foundation Trust including its board actively engages on quality of care with patients, staff and other relevant stakeholders, and takes into account as appropriate views and information from these sources</p> <p>(f) there is clear accountability for quality of care throughout [insert name] NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues, including escalating them to the board where appropriate</p>	

<p>The board effectively implements systems to ensure it has personnel on the board, reporting to the board and within the rest of the licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of this licence.</p>	
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Appendix 14: Joint ventures and academic health science centres

This appendix is for NHS foundation trusts:

- that are part of a major joint venture or an academic health science centre (AHSC)
- whose boards are considering entering a major joint venture or becoming part of an AHSC.

	Risks and mitigating actions
<p>The board is satisfied it has or continues to:</p> <ul style="list-style-type: none"> • ensure the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence • have appropriate governance structures in place to maintain the decision-making autonomy of the trust • conduct an appropriate level of due diligence relating to the partners when required • consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities • consider implications of the partnership on the trust's governance processes • conduct appropriate enquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk • comply with any consultation requirements • have the organisational and management capacity to deliver the benefits of the partnership 	

- involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any reconfiguration of clinical, research or education services
- address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework)
- ensure appropriate commercial risks are reviewed
- maintain the register of interests and no residual material conflicts identified
- engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.

In addition, before entering into an accredited AHSC or other major joint venture, boards of NHS foundation trusts are required to certify that they have:

- received external advice from independent professional advisers with appropriate experience and qualifications
- taken into account the best practice advice in NHS Improvement's transaction guidance or comment by exception where this is not the case.

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