Aintree, Broadgreen and Royal Liverpool hospitals coming together for patients

NHS

Merger - Key Points
February 2019

1. Liverpool has a unique health care economy with multiple healthcare providers delivering a mix of acute, specialist and community services to the local population which includes some of the most deprived parts of the country with associated poor health outcomes.

2. Aintree University Hospital NHS FT (AUHFT) and the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) have a combined turnover of around £900 million, deliver care on three sites barely five miles apart; and duplicate over 20 clinical services which is inefficient, unsustainable (particularly out of hours), and in some services prevents the development of the critical mass needed to deliver truly excellent NHS care and clinical academic services.

3. The move to merger has been led by the consultant bodies of both Trusts, with the Strategic Outline Case (SOC) having been developed and approved by both Trust Boards and NHS Improvement (NHSI) in July 2016 and an Outline Business Case (OBC), based on improving patient outcomes and experience, sustainability of services and financial efficiency approved by both Trust Boards in October 2017.

4. Alternative organisational forms were examined as part of the OBC, but the decision of the clinicians and both Trust Boards was that nothing short of full merger would deliver the desired outcome.

5. The merger, planned for 1 October 2019, has widespread support from clinicians, commissioners, the University of Liverpool, Liverpool City Council and local politicians.

6. The vision for healthcare in North Mersey culminates in the eventual development of a city centre university campus which brings together health and academia to improve patient care and outcomes, and to maximise research and development capability, attracting and retaining the best staff. The proposed merger is key to delivering the benefits as neither Trust can individually deliver the benefits as standalone organisations.

7. The vision for clinical services, articulated by commissioners is one of single service, city-wide delivery in several key areas; local where practicable, central when necessary. These include urgent and emergency care, trauma & orthopaedics, cardiology, stroke and haemato-oncology.

8. The OBC described service redesign to deliver improvements in mortality and morbidity; efficiency by reducing duplication; equity of access for the combined population; integration with primary care and community services; access to research funding and clinical trials; education and development to attract and retain the best staff and maximising the benefits of digital technology and innovation in patient care.

9. The Patient Benefit Case, for submission to the Competition & Markets Authority (CMA) in January/February 2019, builds on the detail of improvements for patients in a number of services. The Post Transaction Implementation Plan (PTIP) extends over a five year period with early consolidation of services including trauma and elective orthopaedics, ENT and urology, with stroke, nephrology, general (upper GI, hepatobiliary and colorectal) and emergency surgery being planned within three years post merger.

10. These service reconfigurations have widespread support (trauma and orthopaedics has been through public consultation and Clinical Commissioning Group (CCG) and NHS England (NHSE) assurance processes) and demonstrate patient benefits including improvements in mortality and morbidity as well as financial efficiencies.

11. Furthermore, there will be two fully functioning emergency departments for the foreseeable future at Aintree and the Royal. Major trauma and emergency surgery will be delivered on the AUH site and all elective orthopaedics on the Broadgreen site.

12. Improved recruitment and retention of staff in key areas, such as urgent care, will create a higher performing sustainable service led by senior clinicians. Emergent benefits from similar healthcare systems have included an increased flexibility in addressing urgent care pressures and delivering elective activity.

13. In addition to the efficiencies described in the standalone financial models, there will be early (within 12 months) corporate and management pay savings by eliminating duplication at Trust Board and in some leadership roles; for example, only one Clinical Director will be required for specialties instead of the current two. Furthermore, the combined Trust will also deliver additional efficiencies through job planning and harmonisation of roles and increased R&D income.

14. The OBC demonstrated an improved financial position for the merged organisation, compared to the standalone positions, recognising that, in the current NHS context, the merged organisation will not achieve financial balance. A series of workshops with clinical and corporate teams have been held during 2018 to determine the level of savings that can potentially be achieved through service re-design and this has been finalised through an Executive-led confirm and challenge process to inform the final assumptions in the Full Business Case (FBC). This has resulted in potential merger savings as at January 2019 of which £15.7m having been quantified.

15. The Trusts and NHSI have agreed that merger by statutory acquisition (by AUHFT of RLBUHT) is the legal route that will be followed, although it is being managed as a merger of two equal partners, effectively forming a new organisation as a result of both boards agreeing to be replaced by a new, single board.

16. NHSI's competition team is working closely with the Trust on the drafting of the Patient Benefit Case with the aim of achieving a stage 1 review with the CMA. The Full Business Case is being drafted to gain approval from both Trust Boards in March 2019 so that a Board to Board with NHSI can be scheduled for July 2019.

17. The process to support the Interim Shadow Board appointments has begun with the support of Gatenby Sanderson and the interview date for the Chair and CEO appointments is arranged for March and April 2019.

18. The main risk of proceeding with merger is the capacity and capability to deliver the programme and maintain business as usual which is being managed through the resourcing of the Programme Management Office (PMO) and the Transaction and Integration Governance structure which is in place across both organisations. This risk has been discussed in detail with the Regional Director of NHSI and there are regular calls in place to review progress.

19. Failure to progress the programme within the proposed timescales risks engendering a reduction of support from staff groups, particularly clinicians. There are significant risks associated with not proceeding with a merger which are similar for both organisations – i.e. the inability to materially improve service quality, patient experience, research potential or clinical and financial sustainability.

20. Both Trust Boards recognise the significant risks to not proceeding with a merger and believe that, only through merger, can service quality, patient experience, research potential and clinical and financial sustainability be materially improved for the population we serve.

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