

NHS Group Models

Working together for a more sustainable NHS



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Executive Summary

The challenge

The NHS is facing unprecedented challenges in the form of rising demand, severe workforce challenges and an increasingly constrained funding environment. By 2020/21, the funding “gap” is expected to reach £30bn* [1] across the NHS. Providers will need to deliver more than incremental cost improvements to address this; it will require bold and transformational change.

Over the last decade, the NHS provider landscape has evolved into c.250 separate organisations, each working independently and, in many cases, in direct competition with each other for capital, people and patients. This system has created unintended consequences for how providers work together.

- First, different organisations have taken markedly different approaches in response to similar challenges. This has resulted in wide-scale variation between providers, reflected in their ‘ways of working’, culture and patient outcomes. This variation acts to exacerbate existing inequalities in population health seen across England.
- Secondly, it has created entrenched organisational silos, where providers feel compelled to focus on the benefit and cost to their own institution, over and above the benefit to patients and to the wider system. This dynamic creates a mindset of ‘winners and losers’, which acts to prohibit clinical transformation.

If providers are to be successful in meeting the challenges of a modern-day NHS, they need to overcome these barriers and work together to create system-wide solutions.

Benefits of a Group model

This paper looks at how one organisational model – the “group” or “chain” – could help providers resolve the issues described above by working together in more formalised ways. Several leading NHS Trusts are already piloting and exploring the benefits of this model.

The Group model allows organisations to:

- **Learn** from one another by accessing a broader pool of knowledge and experiences;

- **Share** assets, resources and talent at scale, thereby reducing duplication and waste; and
- **Align** strategically, such that all organisations are working together toward a common goal.

These three factors mean that Groups have a number of advantages over individual, smaller organisations. We outline six key benefits of Group models (Figure 1).

The Group model, in and of itself, is not a panacea for improving performance. Rather, it allows providers to use scale as a *platform* and an *enabler* for driving improvements in the clinical, operational and financial performance of its members. Organisations must focus on the task of reconfiguring services, developing patient pathways, driving quality improvement and developing the workforce. The Group model can both enable these efforts and amplify their benefit.

This is particularly true when considering how providers can tackle the issue of unwarranted variation. It is widely acknowledged that the level of variation seen across the NHS is unacceptable, exacerbates inequality of access and care, and creates unnecessary waste in the system. By providing the necessary expertise, evidence base and analytics, Group models can address both inter-organisational variation and intra-organisational variation, by developing and reliably implementing standard approaches.

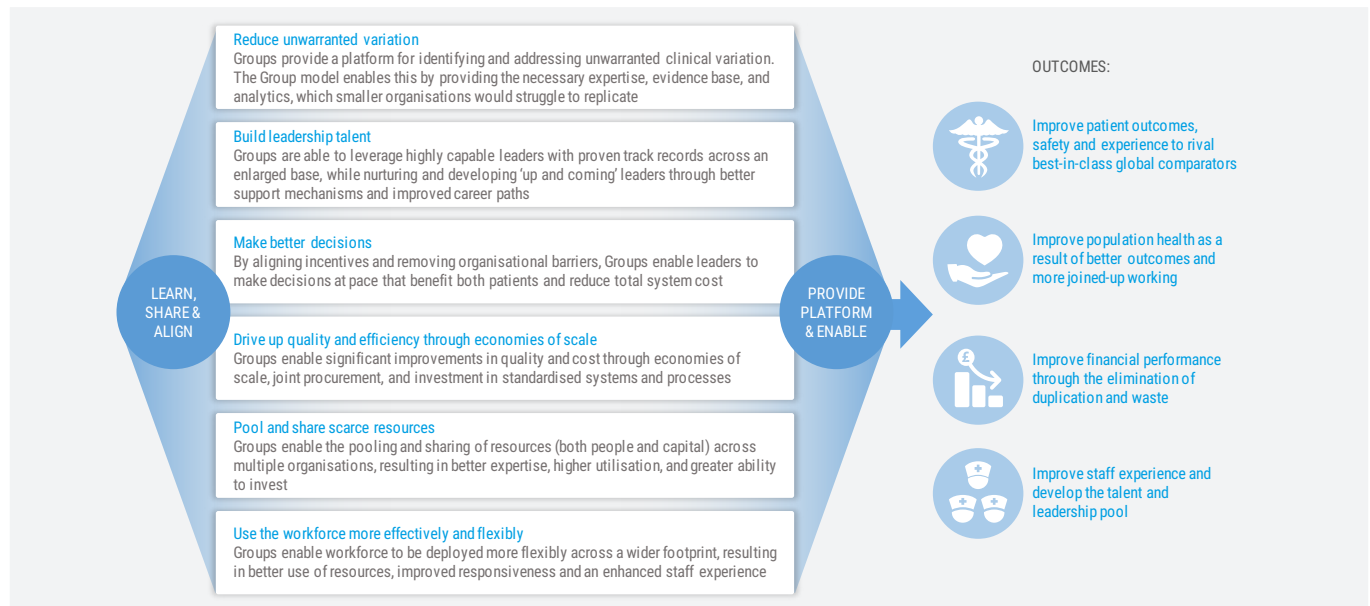
Advice to providers considering Groups

Groups can take a number of different organisational forms, from a HQ with a number of wholly-owned subsidiaries – where multiple providers merge to form a single legal entity – to federations of providers, agreeing to work together under the terms of a contract or a Memorandum of Understanding. Each model has its own merits and the ‘best’ model for one region or organisation will not necessarily be right for another. Providers need to design their approach based on a strong understanding of their own challenges, opportunities and local environment.

Providers who are considering the move to a Group should consider the following questions:

- What are the opportunities and challenges facing their organisation, and the broader region, both in the near- and long-term?

Figure 1: Key benefits of a Group model



- Is there a route to long-term clinical and financial sustainability as a stand-alone organisation, and what are the risks associated with this route?
- What is the strategic direction of the region, considering Sustainability and Transformation Plans and ambitions for Accountable Care Systems or Organisations?
- Are there like-minded organisations in the region who represent potential partners?
- What quality and cost benefits could be delivered through formalised collaboration between providers in the region?
- Which organisational model would best enable the delivery of these benefits?
- What are the regulatory implications of a new model? In particular, how would the model be viewed under the competition regime?

This paper draws on the experience of horizontal collaborations between acute (or integrated) care providers. However, Group Models have wider relevance to:

- Non-acute providers: the principles outlined in this paper can be applied to Groups of non-acute providers, including: primary care, community care, mental health, and social care providers; and
- Models of vertical integration: we believe that the hospital Group model and models of vertical integration (ACO, PACS, MCP*) can, and should, exist harmoniously. Indeed, such an approach could amplify the population health benefits and financial savings.

Conclusion

The advantages of collaborating with like-minded partners and of working at greater scale are evident from the work of the Vanguard sites to-date and from an analysis of other, international hospital chains. We would therefore expect every provider to be considering how they can work more closely with their neighbours to address their current challenges.

The myriad of organisational forms within the definition of a Group means there should be 'something for everyone', regardless of organisational type or local circumstance. This flexibility is vital to ensure that we cater for local nuances and don't force a national blueprint.

Pursuing a Group, or indeed any form of wide-scale organisational change, is by no means easy. This is particularly true in the current climate, where leaders are torn between the imperative to deliver against short-term priorities (such as A&E targets) and delivering the transformation that is necessary to ensure the long-term viability of the sector. To overcome this, those leaders and organisations who are trialling new models need to receive the full support and backing of the macro-system, as well as the local micro-systems in which they operate.

The purpose of this paper is to increase the awareness of Group models across the NHS and to offer some guidance to providers who may be considering whether a Group model could be right for them. We hope readers find it both thought-provoking and practical.

Introduction

Purpose of this paper

The 2014 *Five Year Forward View* [1], and the subsequent 2017 update, set out a shared vision for the future of the NHS, based on new models of care. These new models are becoming ever more relevant, as providers across the NHS seek to deliver improved care to a growing and ageing population, all within an increasingly pressurised budget environment.

Building on the *Five Year Forward View*, and *The Dalton Review* [2] of the same year, NHS Improvement and the New Care Models team announced 13 Acute Care Collaboration (ACC) Vanguard to investigate how organisations can come together to generate patient, staff and financial benefits. Four of these vanguards are focused on developing Hospital Groups: Royal Free London NHS Foundation Trust, Salford Royal NHS Foundation Trust, Guy's & St. Thomas' NHS Foundation Trust, and Northumbria Healthcare Foundation Trust.

The purpose of this paper is to increase awareness of Group models across the NHS and to offer some practical guidance to providers who may be considering such models. The term "group" (sometimes referred to as a "chain") can cover a myriad of different organisational relationships; as such, this guidance is just as relevant for those considering loose collaborations to those who are assessing the benefits of a merger or acquisition (M&A). Some of the learnings may be applicable to other organisational collaborations (e.g. local STP developments), despite these models not meeting the strict definition of a Group. They could also be used to help multi-site Trusts drive improvements across their numerous locations.

This guidance has been developed by Credo Business Consulting, a strategy consultancy which has supported three of the four ACC Vanguards in the development of their organisational models. This support has helped each Trust to answer the following questions:

- What are the ultimate objectives for exploring a Group model within the local context of each organisation?
- What functionality is required from the model in order to achieve these objectives? And what does this mean for the choice of organisational model?
- How will the Group function with regards to accountabilities, decisions rights, roles, and responsibilities?
- What is the most appropriate transition plan, and how can they balance delivering change at pace with the safety and robustness of a long-term change programme?

Should any providers wish to explore any of the guidance provided in this paper, they can contact Credo for further information.

The Challenge

Since the NHS was founded in 1948, its spending has increased on average by 4% a year in real terms. Yet, over the foreseeable future, the NHS budget is likely to remain flat once inflation is taken into account. Over the same period, demand for health care is expected to rise as people live longer, have more complex health problems, and more advanced treatments become available. By 2020/21, patient needs are estimated to require an additional £30bn* [1] across the NHS.

Alongside this ever-increasing financial challenge, NHS organisations must address the issue of variation. It is widely acknowledged that the level of variation seen across the NHS is unacceptable, exacerbates inequality of access and care, and creates unnecessary waste in the system.

Figure 2: Examples of variation in care

"The best-performing organisations on the Standardised Hospital Mortality Indicator (SHMI) showed 18% fewer deaths in hospital at 30 days after discharge than would be expected. At the other end of the scale, the worst performing organisations showed 16% more deaths than would be expected. This range of 34 percentage points between the best- and worst-performing organisations is concerning."
The Dalton Review [2]

"In the 12 months up to August 2014, the proportion of patients being treated for pressure ulcers ranged from 2.9% in the highest performing trusts to 6.5% in the lowest performing trusts. If the standards of care were universally brought up to those of the upper decile, each month 2,000 fewer patients would have the pain and distress of a pressure ulcer."
The Dalton Review [2]

"Deep wound infection rates for primary hip and knee replacements range from 0.5% to 4%. If all hospitals achieved 1%, this would transform the lives of 6,000 patients and save the NHS £300m per year."
Carter Review [3]

"The difference in admission rates for hip operations between the highest (Shropshire) and lowest (Kensington and Chelsea) PCTs in 2008/9 was nearly four-fold."

Variations in Health Care, The King's Fund [4]

"[The proportion of patients] returned to theatre within 30 days following fractured neck of femur surgery ranges from 0% [at the best performing Trusts] to 7% [at the worst performing Trusts]."
Getting It Right First Time (GIRFT) [27]

It is widely acknowledged that the level of variation seen across the NHS is unacceptable, exacerbates inequality of access and care, and creates unnecessary waste in the system.

The examples shown in Figure 2 focus on inter-organisational variation (i.e. variation between organisations). Yet these variations are just the tip of the iceberg – intra-organisational variation (variation within a single organisation) is believed to be just as significant. This is driven by variation between sites, wards, teams and even individual practitioners. For example, studies conducted by US Hospital Group, Intermountain Healthcare, have shown up to five-fold variation in clinician preferences for certain treatments, and two-fold variation in total cost per case [5]. This variation is often difficult to define and measure, and consequently is largely untracked by the vast majority of provider organisations in the UK.

When it comes to addressing variation between individuals, it is important to bear in mind the

difference between good variation and bad variation. In 2010, Mulley [6] noted that:

"The difficulty is in reducing the bad variation, which reflects the limits of professional knowledge and failures in its application, while preserving the good variation that makes care patient centred." [6]

The NHS therefore needs to design systems that reduce unwarranted variation while nurturing and encouraging the customisation of care based on patient need or preference (warranted variation).

* Dependent on funding commitments, which could be impacted by the general election in June 2017

Group Models

To address these challenges, NHS providers need to consider new and transformational forms of care, underpinned by innovative organisational models. One such model is the creation of “groups” or “chains”.

The Vanguard programme is supporting leading provider organisations who are testing and trialling these new models of care. Through this programme, four Foundation Trusts have been formally accredited to lead Groups. These are:

- Royal Free London NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Guy's & St. Thomas' NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust

In addition, other NHS providers are pursuing models of acute care collaboration, which could be considered as falling within the definition of a Group model. Some examples include:

- As part of the Essex Success Regime, three acute Trusts (Basildon and Thurrock University Hospitals NHS FT, Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS FT) are pursuing joint leadership arrangements that will enable the region to address the issues of unsustainable services and significant financial deficit. Joint governance arrangements are already in place across the three Trusts, with Clare Panniker as CEO for all three organisations.
- As part of the 'Working Together' Vanguard, seven acute providers in the South Yorkshire region intend to adopt a 'Committees in Common' model to support faster paced decision-making, without infringing on the role of the individual Trust Boards [7].

The definition of a Group model

The word “group” or “chain” means different things to different people. In its widest interpretation, a Group could refer to any organisational form that brings multiple provider organisations together to break down institutional silos.

To define a Group with greater specificity, it is important to distinguish between two different but interrelated concepts – an organisation's

management (or organisational) model and its legal form.

- An organisation's **management or organisational model** is defined as how it sets objectives, makes decisions, coordinates activities, and allocates resources; in other words, how the organisation defines the work of management.
- An organisation's **legal form** refers to the legal entity (for example an NHS Trust, an NHS Foundation Trust or a Private Limited Company (PLC)) or other legal structure (for example a contract or a Joint Venture (JV)) through which the organisation structures its legal rights and obligations.

For the purposes of this paper, we define a Group as having an organisational model with the following characteristics:

- A 'central HQ' function, responsible for providing unified strategic leadership across the whole Group;
- Discrete and locally managed 'operating units', which have a greater or lesser amount of devolved autonomy. Each operating unit is likely to have its own management team, responsible for operational leadership of that unit;
- Standardised systems, practices, and protocols, set by the central HQ function and reliably implemented at each operating unit; and
- A culture and value-set that is shared across the Group and transcends individual relationships (although 'operating units' are likely to retain individual brands and identities relevant to their local population).

A range of different models and legal entities are able to meet this definition of a Group. These are outlined in Table 1 below*. As the Dalton Review highlighted, when it comes to choosing the most appropriate option, there is no “one-size-fits-all” approach, and we urge providers to think carefully about the specific problem they are trying to solve.

It is important to note that the models outlined below are not meant to be mutually exclusive, and many providers are contemplating how to bring multiple organisational forms together. For example, the Royal Free London NHS FT is

designing a wholly-owned Group model for the three acute sites that are part of the Trust today. Other Trusts who join the RF Group may join under the same model, or they may decide to join as an 'Associate Member'. This allows flexibility, such that joining organisations can enjoy some of the

benefits of being part of a Group, without the need to lose organisational sovereignty. Such models, with different levels of Group "membership", are common in US healthcare chains, as well as in other sectors globally.

Table 1: Organisational models and legal form options for Hospital Groups in the UK

	Model	Description	Example legal form*	Example(s)
INCREASINGLY CONSOLIDATED FORMS	Federation	<p>Several organisations come together to collaborate on areas of mutual interest/benefit.</p> <p>A federation can be structured as a 'partnership of equals' or with one organisation (either a Trust or a separate entity) acting as the lead organisation. Many federations require their member organisations to agree to a set of common standards.</p> <p>Each organisation retains its sovereignty and is therefore able to opt in or out of the federation.</p>	The agreement between organisations can be set out in a legal contract , or in a Memorandum of Understanding .	The Foundation Healthcare Group Vanguard: Guy's & St. Thomas' NHS FT and Dartford & Gravesham NHS Trust are exploring the option of creating a Group, through which the two Trusts (and others who may wish to join) will be able to work together more closely in a planned way to improve care, but with both Trusts retaining their sovereignty (see Case Study below).
	Delegated authority	<p>Several organisations agree to formally delegate some or all decision making rights to a single organisation (either a Trust or a separate entity). This single entity is then able to make strategic decisions on behalf of all members of the Group.</p> <p>Each organisation retains its sovereignty and the decision making body will remain accountable to the Boards of each organisation.</p>	<p>Neither NHS Foundation Trusts nor NHS Trusts currently have the power to set up legally binding 'joint committees'. But it is possible for Trusts to delegate to Committees in Common.</p> <p>NHS Foundation Trusts and NHS Trusts can establish their own committees, which should meet at the same time and with the same remit. Wherever possible, membership should be identical.</p> <p>The committees can be supported by a legally binding contractual joint venture between the participating providers.</p>	<p>Essex Success Regime: Three hospital Trusts in Essex have come together under a joint executive team, led by joint-CEO, Clare Panniker. The Trusts will remain as individual legal entities, with their own statutory Boards. The single executive team, along with three non-executives, will act as a Committee in Common of the three Trust Boards.</p> <p>A joint venture has also been established to support closer alignment of financial incentives between the Trusts.</p>
	Management responsibility	<p>One organisation takes management responsibility for another organisation. This could cover some or all management functions.</p> <p>Each organisation retains its Board. The host organisation is accountable for its own performance, and for the performance of those organisations under its management.</p>	The host organisation enters into a Management Contract to provide some or all management services for another organisation for an agreed duration of time.	<p>Salford Foundation Chain Vanguard: In early 2016, senior leaders from Salford Royal NHS FT were appointed to lead Pennine Acute Trust. The two Trusts have now agreed the terms of a formal Management Contract.</p> <p>Under the new Group model, the hospital sites will be arranged into four 'Care Organisations', each with a Chief Officer.</p>
	Wholly-owned subsidiaries	<p>The Group is a single sovereign entity with discrete 'operating units'. The Group will have a single Board, accountable for the performance of all parts of the Group.</p> <p>The Group could be formed through the reorganisation of an existing organisation, or through a series of transactions.</p>	Legal form is a single NHS Foundation Trust .	The Royal Free Group Vanguard: The Royal Free NHS FT is in the process of implementing a Group model across its current three acute sites. Other organisations will be able to join under the same terms as the existing sites (i.e. as a wholly-owned members). Different forms of "Group membership" will also be available for organisations who wish to gain some of the benefits of a Group, without losing organisational sovereignty.

* This draws upon guidance issued by NHS Improvement in October 2016 on the legal form options for Hospital Groups https://improvement.nhs.uk/uploads/documents/Foundation_groups_guidance.pdf

This definition of a Group naturally excludes a number of common organisational models, most notably large, multi-site Trusts. Such organisations could be considered Groups in the widest sense. The majority of multi-site Trusts operate with the same organisational model as single-site Trusts, with integrated clinical services and a single leadership team encompassing both strategic and operational leadership. This model has been successful and is considered by many to be the best organisational model for managing a small number of geographically contiguous sites. However, it has material scalability challenges (as outlined on Page 13) and does not meet the definition used above.

We also exclude single-service chains – these models on their own are not considered to be Group models. However, we note that such arrangements could be part of a wider Group offering.

The need for M&A

A common misconception is that Groups can only be developed through merger and/or acquisition. Whilst that is certainly one way to develop a Group, it is not a necessity; for example, Groups can also be formed through contractual arrangements between members, such as the model being developed by Guy's & St. Thomas' NHS FT and Dartford & Gravesham NHS Trust.

Case Study: Creating sustainable local providers – the Foundation Healthcare Group

District General Hospitals (DGHs) are often severely challenged by the financial and clinical sustainability pressures facing the NHS; they must provide local services, that are regularly used and viewed as important by their local population (such as maternity and A&E) on a smaller scale than large hospitals and without the workforce or financial benefits that tertiary activity brings.

Guy's & St. Thomas' NHS FT and Dartford & Gravesham NHS Trust are developing "The Foundation Healthcare Group" (FHG) as a blueprint to support local providers in becoming clinically and financially sustainable. Under this model, local providers will be able to access the support of a larger and more stable Trust within the same geographic footprint.

It is anticipated that DGHs will realise significant benefits in partnering with other hospitals to achieve greater scale, and to share key assets, skills and expertise. As one of the largest Trusts within the NHS and a globally recognised leader in delivering specialist care, Guy's & St. Thomas' is well placed to lead the development of this type of model, whilst also benefitting itself from increased scale, driving a reduction in unwarranted variation and removing duplication across both its own and other member sites.

To deliver these objectives, Guy's & St. Thomas' and Dartford & Gravesham have agreed to explore a collaborative relationship, underpinned by a contract or a Memorandum of Understanding between both Trusts, rather than explore a formal merger or model of delegated authority. Both Trusts anticipate a number of immediate benefits to this approach:

- The model preserves local knowledge and accountability;
- The Boards of both Trusts are able to retain full decision rights over any matters pertinent to the Trust;
- It avoids the expense and management distraction of a full transaction process; and
- The benefits can be scaled to include other Trusts who may wish to enter into a similar bilateral arrangement, although the exact terms of membership can be varied to reflect the specific opportunities and challenges of the joining Trust.

"If you are a district general hospital within the sphere of influence of a big neighbour, it makes sense to form a structured relationships with that trust... [the FHG model provides] the advantages of scale that come with merger and acquisition without the downside."

Susan Acott, Chief Executive, DGT

"At Guy's and St Thomas' we have 1,300 consultants working for us. We want to share our consultants across a wider geographical area. We could pull up the drawbridge. But that is not our values. Nor would it work. We couldn't cope as a trust if our neighbouring trust fell over and all their patients came our way. It is about making sure the system as a whole works."

Sarah Morgan, Director of Organisational Design & Vanguard Programme Director, Guy's & St. Thomas' NHS FT

Design and implementation of the FHG is currently underway. A number of benefits have already been realised, including:

- The accelerated development of a new clinical model to optimise patients for surgery (POPs);
- The introduction of new clinical roles such as the Epilepsy Specialist Nurse and streamlining of the epilepsy pathway for children; and
- Significant financial efficiencies from strategic procurement support.



In many cases, creating a Group without organisations ceding their sovereignty (and without the need for a transaction), represents 'the best of both worlds'. However, there are also challenges inherent to this model:

- First, the model relies on having a number of interested and willing partners close-by – local politics as well as differences in working styles and organisational culture mean that this is by no means a given for many organisations.
- Second, institutional sovereignty and individual accountability makes it difficult for leaders to put the interests of the wider population above the interests of their individual institution. This is particularly true where decisions may have an uneven impact on the financial position of one or more Trusts.

As set out above, it is important to develop a model that is specific to the challenges and opportunities faced by the individual organisations and their local geography. Should this process result in the consideration of a consolidated model, providers must be challenged to think beyond sovereignty for sovereignty's sake.

The benefits of Group Models

“Is bigger really better?”

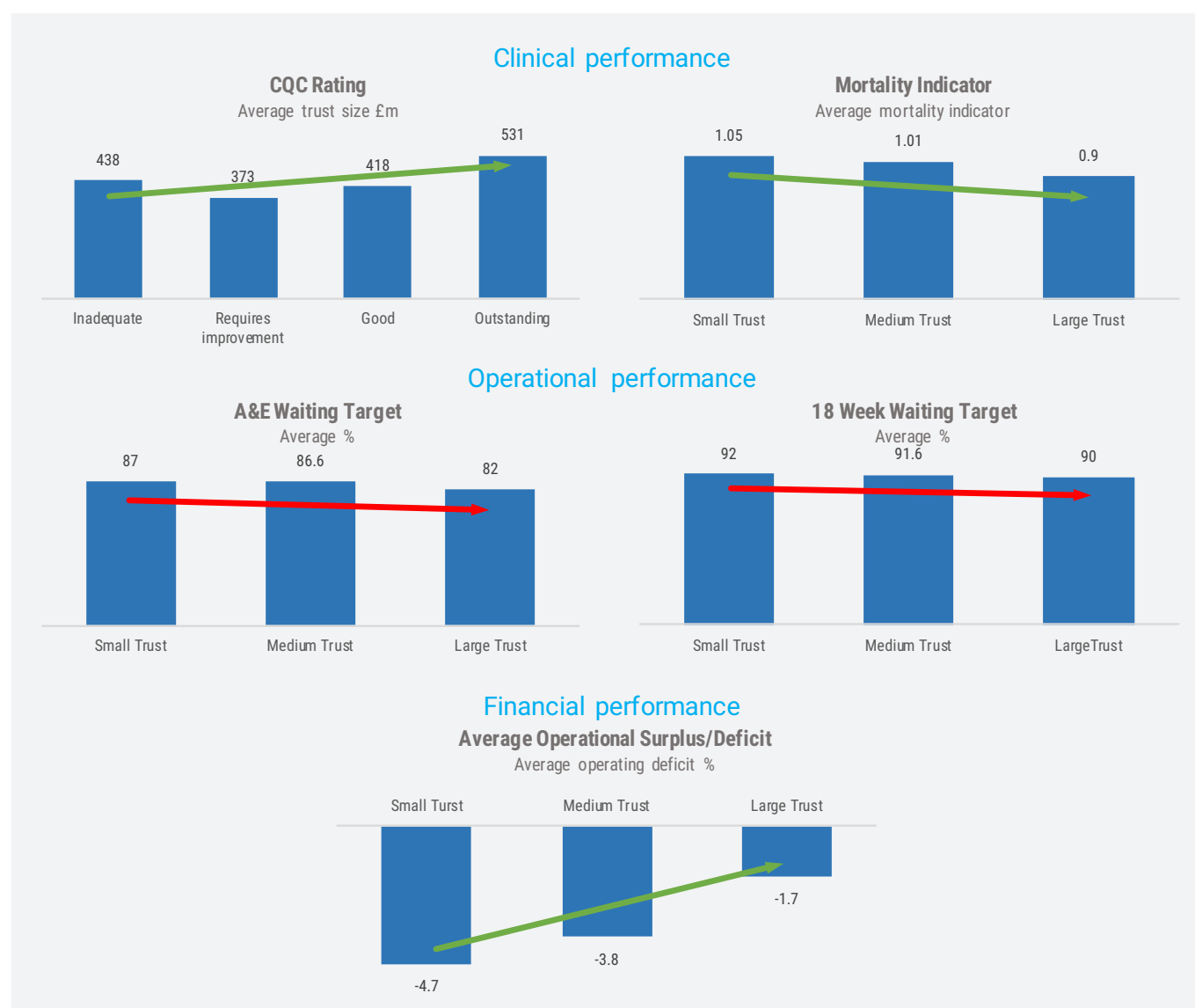
One of the characterising features of a Group is its scale. Hospital Groups in the US and Europe consist of multiple hospitals ranging from two to 150+ individual facilities within a single entity. In its current form, the NHS appears fragmented by comparison.

The introduction of multiple Groups in the NHS would lead to fewer institutions, each responsible for portfolios that would be significantly larger than the average NHS Trust or NHS Foundation Trust today. This begs the immediate question: ***Is bigger really better?***

The short answer to this is: ***In theory, yes; but in our experience, not always.***

A review of hospital performance (Figure 3) shows a weak positive correlation between size and clinical and financial performance, and a weak negative relationship between size and operational performance. In addition, the plethora of reviews undertaken to assess the benefits of provider M&A [9, 10, 11, 12, 13 & 14] suggest that the results are, at best, inconclusive.

Figure 3: The impacts of scale on clinical, operational and financial performance



This suggests that, in their current forms, provider organisations are not set-up to leverage the full benefits of scale. As previously noted, one reason for this is that most large, multi-site Trusts employ the same organisational model used by small, single-site ones. This, along with underinvestment in standardised processes and in business intelligence, has created a range of scalability challenges:

- Increasing the span of control of operational managers often results in a lack of site “grip”;
- Significant variation in ‘ways of working’ results in management challenges, duplication of effort and opaque management information – many large NHS organisations have not invested in standardising practices within their organisation (due to time, cost, or a combination of both);
- Where small organisations can often rely on management’s intuition and proximity to the front line to identify and rectify issues, larger organisations must rely on a performance management framework that is typically underinvested; and

- To manage an enlarged organisation, leaders need to delegate effectively to high-calibre individuals beneath them. However, the Accountable Officer framework does not always create an environment conducive to effective delegation.

These challenges are evident in large providers, such as Bart’s Health NHS Trust, who have struggled to maintain or improve performance following merger or acquisition.

In their current forms, provider organisations are not set-up to leverage the full benefits of scale.

We therefore conclude that increased scale, on its own, is not a panacea for clinical or financial improvements. So how and where do Groups add value?

Benefits of a Group model

Group models boast significant successes in international health economies and in non-health sectors. The benefits of Groups are many and varied, with different organisations focusing on leveraging different benefits. The benefits of Groups, and a summary of how they compare to the NHS’s current model, are outlined below.

Table 2: Benefits of a Group model

Model	From...	To...
Leadership	<ul style="list-style-type: none"> • Calibre of leadership is variable • Difficult for high-calibre leaders to play a role in supporting the development of others, particularly ‘up-and-coming’ leaders 	<ul style="list-style-type: none"> • Leveraging highly capable leaders with proven track records across an enlarged base • Separation of strategic and operational leadership creates “dual-track” career paths for leaders
Decision making for the benefit of patients and taxpayers	<ul style="list-style-type: none"> • The changes necessary to deliver the best outcomes for patients and taxpayers are difficult to achieve with multiple separately managed and differently motivated organisations • A culture in which service reconfiguration always result in a ‘winning’ and ‘losing’ organisation • Slow, bureaucratic decision making across organisational boundaries, with some initiatives that would improve patient outcomes never implemented 	<ul style="list-style-type: none"> • Organisations each working towards a common strategy and vision • Ability to make changes to services for the benefit of patients and taxpayers • Ability to make decisions at pace
Economies of scale	<ul style="list-style-type: none"> • Several hundred individual corporate and back-office services, each covering a relatively small organisation • Inability to deliver economies of scale 	<ul style="list-style-type: none"> • A consolidated number of back-office and clinical support services, supported by investment in systems and standardised processes • Significant improvements in cost and quality through economies of scale, joint procurement, and automation
Pooling of scarce resources (people and capital)	<ul style="list-style-type: none"> • Individual organisations each competing for a limited pool of scarce resources • Expertise is expensive due to low utilisation and a lack of shared learning • Individual organisations cannot afford the necessary investment to innovate and digitise 	<ul style="list-style-type: none"> • Resources and expertise shared across multiple organisations, resulting in better expertise, higher utilisation, and greater ability to invest • Cost and risk of investment spread across multiple organisations
Workforce	<ul style="list-style-type: none"> • Limited flexibility, resulting in high agency and locum spend, and an inability to respond to demand changes in real time • Demotivated workforce 	<ul style="list-style-type: none"> • Workforce used flexibly between organisations, resulting in: <ul style="list-style-type: none"> - Reduced agency spend and improved patient experience - Greater ability to respond to demand changes in real time - Higher utilisation of the workforce • Improved staff engagement through better career paths and investment in training and development

Case study: leadership and talent management at the Royal Free

An inquiry by HSJ [15] in June 2015 revealed the extent of the leadership crisis faced by the NHS. The report noted that *"a third of trusts either have vacancies at board level for key leaders, or they have interims in post and [...] more than one in six trusts have no substantive chief executive."* The inquiry discovered that:

- There has been an increase in the degree of political exposure experienced by senior NHS leaders – which, while always to be expected in a tax funded healthcare system, has now reached unsustainable levels;
- There is a cadre of people who operate well in second-tier leadership positions but who are reluctant to step into chief executive and other board level posts, in part because of the sheer exposure that comes with the job;
- There has been a dilution of the informal "mentoring" networks that supported younger leaders, both clinical and non-clinical, as they progressed; and
- There is a widely-held belief that the NHS has too many organisations and, as a result, too many chief executive and other board level positions. This means the NHS's available talent is spread too thinly.

The development of Groups will allow the NHS to address some of these leadership issues through

leveraging experienced and highly-capable leaders to support and nurture up-and-coming talent. Consolidated Group forms, with a 'central HQ' and 'operating units' will provide a degree of shelter for capable leaders to 'get on with the day job', without the growing distraction of political exposure and regulatory burden, thus making such roles significantly more attractive.

The Royal Free's recent experience of recruiting Hospital Unit CEOs is testament to the potential success of this approach. These roles will be responsible for running the Royal Free's three acute hospitals on a day-to-day basis and will report into the Group CEO. Three leaders have been appointed, each with a clinical background and with substantial leadership experience. These individuals are excellent examples of highly capable individuals who, without the Group model, may have been unwilling to pursue a traditional CEO role.

The Royal Free has also supported the leadership of other organisations outside of its immediate Group. In 2016, the Royal Free supported the introduction of Elizabeth (Libby) McManus to the North Middlesex University Hospital. Since Libby's introduction she has worked closely with, and been supported by, Sir David Sloman (RFL CEO) and other members of the RF's Executive Team.

Case study: consolidation of pathology services

The opportunities and challenges of developing multi-organisation solutions have been demonstrated by the development of cross-Trust pathology solutions over the previous decade.

Lord Carter's 2008 review of NHS Pathology Services in England [16] recommended the development of 'pathology networks'; designed to improve service quality and patient safety, while also generating savings through efficiencies of scale. The review demonstrated that collaboration and consolidation allows for: greater specialisation; increased purchasing power; investment in new, scalable and innovative solutions; and a platform to reduce unwarranted variation.

Carter reiterated the pathology opportunity in his broader 2016 review of Operational Productivity and Performance in English NHS Acute Hospitals [3], where he stated that those Trusts who were failing to hit operational benchmarks *"should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017"*. The opportunity was further reinforced by Jim Mackey (Chief Executive, NHS Improvement) in his 2016 letter to NHS providers: *"We will therefore be asking all STP leads to develop proposals to consolidate back office and pathology service with outline plans initially on an STP footprint basis."* [17]

Despite strong central guidance and a clear evidence base in the clinical and financial benefits, progress in developing multi-Trust solutions has remained frustratingly slow. Some exemplar partnerships have been developed, such as the Pathology at Wigan and Salford (PAWS) service, yet a significant proportion of the NHS does not have an advanced plan in place. One reason for this is that Trusts have struggled to reach consensus on:

- How to equitably share investment, risk, ongoing costs and returns across participating Trusts;
- How to develop a combined workforce plan, recognising that staff may change location or role under a consolidation plan; and
- How to govern the activities of the consolidated entity, in-line with Trusts' own governance and assurance requirements.

The development of Groups has the potential to break-down some of these organisational barriers and accelerate a consolidation that could, and perhaps should, have happened several years ago.



How will Groups help the NHS address the issue of variation?

When it comes to addressing unwarranted clinical variation, Groups have a number of advantages over smaller organisations. Namely, operating at-scale within a Group will allow providers to:

- Create a strong evidence base and pool of expertise on which to determine best practice standards;
- Address both inter- and intra-organisational variation;
- Spread the benefit to a larger number of patients and increase total financial returns; and
- Spread investment cost and risk across an enlarged base, thereby improving affordability.

However, the Group model itself is not a silver bullet for the problem of unwarranted clinical variation. Indeed, while many Hospital Groups internationally have successfully implemented standardised back-office processes, they have struggled to address clinical variation. In other words, Groups need much more than scale; to be successful they need an unwavering commitment to identifying and addressing unwarranted variation in all of its forms. Potential approaches to this issue are explored on Page 19.

Group structures

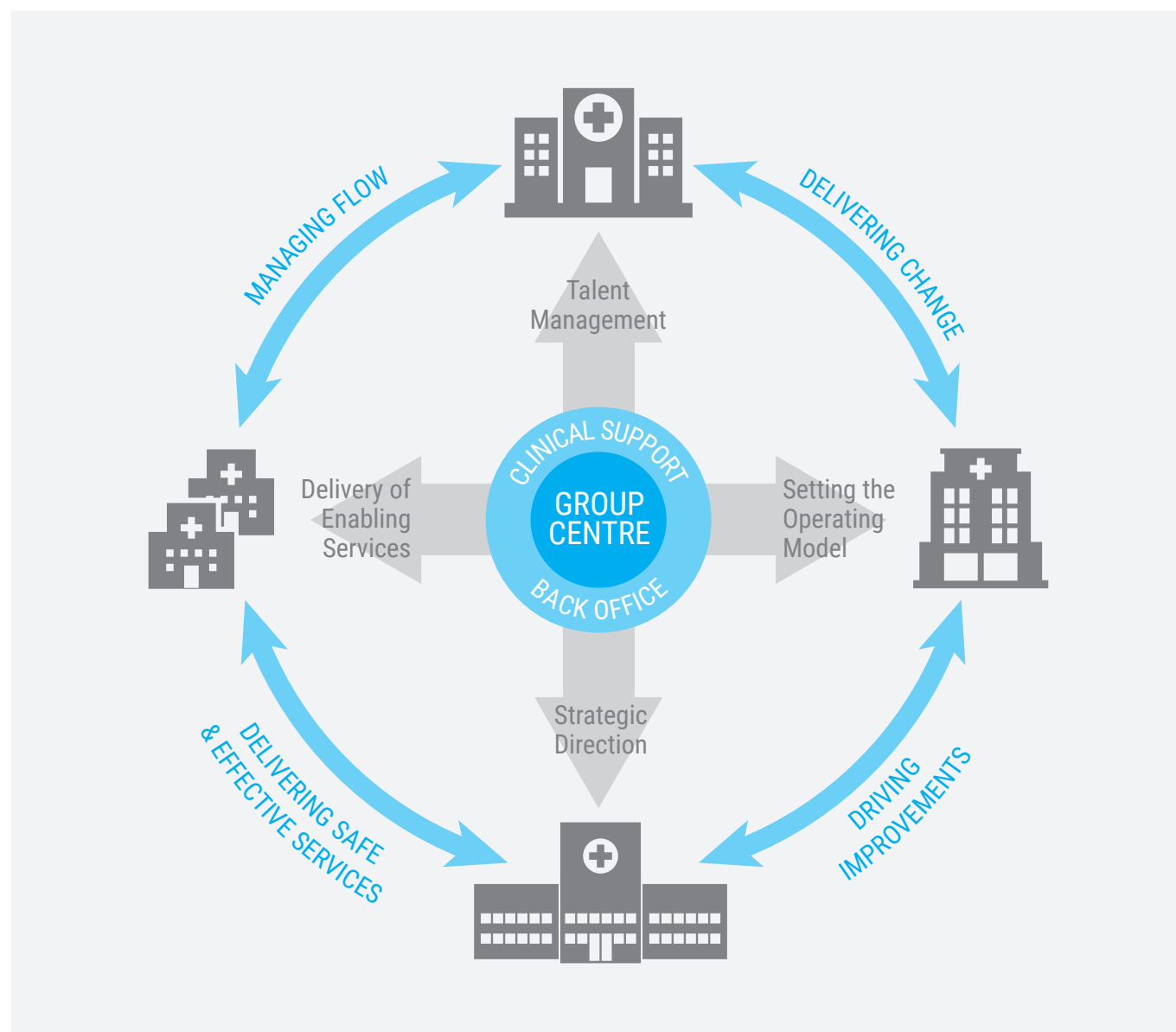
On Page 9, we outlined the range of organisational models and legal forms that Groups can take. In this section, we explore typical Group structures, focusing on consolidated forms (see Table 1). The principles discussed below should still apply to federated forms, although they may need to be adapted to account for increased organisational sovereignty.

The organisational structures employed by Groups vary from one organisation to the next, but there are some components that are common to the

majority of Group organisations. These are:

- A '**central HQ**' function tasked with strategic leadership of the Group;
- Discrete '**operating units**' with high degrees of autonomy;
- **Services** (typically back-office) that are **shared** across the 'operating units'; and
- Mechanisms for **standardising practices and processes**.

Figure 4: The role of Group vs. the operating unit



Central HQ

The responsibilities and accountabilities of a typical 'central HQ' function are many and varied. Through a review of existing literature and conversations with leaders of existing and emergent Groups, we have identified five characteristics that are critical to the success of any central HQ function:

- 1. The ability to make population and system-based decisions:** Groups need to make strategic decisions that are in the best interests of the whole Group. In the context of the NHS, this means making decisions that benefit the local population and the broader system, rather than just individual institutions. This will involve making difficult decisions on service reconfiguration, capital allocation, and the consolidation and rationalisation of back- and middle-office functions.
- 2. An approach to systematising and embedding learning and improvement:** An important role of the central HQ function is to identify and spread best practice and innovation between operating units. To do this successfully, organisations must systematise this process such that it becomes part of 'business as usual'.
- 3. Strong compliance and governance:** The central HQ function is responsible for ensuring effective governance is in place across the Group, and for ensuring each operating unit is compliant with external regulation and internal standards. To achieve this, many Groups have invested in central compliance teams responsible for monitoring, policing, and supporting the operating units.
- 4. A focus on talent management:** Groups, and indeed all large organisations, emphasise the importance of strong talent management. Following a review of Group models [18], the Nuffield Trust noted that, "[Within Groups] there is a clear emphasis on organisational development, driving people management, training, and performance development. Many of the unit managers have worked their way up through the company, supported by extensive systems designed to identify and nurture in-house talent".
- 5. Driving reliable implementation of standardised practices within each of the operating units:** The following section is dedicated to the ways in which Groups can organise themselves to do this.

Shared services

Where economies of scale exist, Groups in any sector typically look to consolidate back- and middle-office functions, either within the central HQ or within a separate delivery vehicle. In a hospital environment, Groups should consider opportunities to consolidate non-clinical support functions such as procurement, payroll, and IT, as well as opportunities to drive scale benefits in clinical support services such as pathology, pharmacy, and radiology. In today's environment, providers will need to carefully consider how such arrangements impact the objectives of local Sustainability and Transformation Plans (STP), especially where Trusts within a Group span more than one STP.

It is crucial that the managers responsible for delivering these shared services see the operating units as their customers. Where this is not the case, we often observe the interface between operating unit and shared service becoming a cause of tension and inefficiency.

Autonomous operating units

The skill set of the central HQ function is very different from the skill set of those whose job it is to run and deliver high-quality services on a day-to-day basis. The clinical and operational leaders within each operating unit are critical to the success of the Group. As the Dalton Review [2] noted in 2014: *"The development of the Foundation Group structure offers the opportunity for a 'dual track' career path for leaders ... [Groups] will require the development of a new Operational Managing Director role to be accountable for all operational management on each site. This role could enable those with excellent operational skills to focus on the single site or subsidiary management of the chain. These should be highly valued roles and remunerated accordingly."*

To be successful, leaders in the central HQ must allow their operating units a significant degree of autonomy and resist becoming involved in the day-to-day operational running of the sites. This approach is critical to ensure that:

- Clinical and operational managers are able to make real-time decisions to ensure high-quality patient care and the smooth operation of the hospital;
- Operating units are able to respond dynamically to local opportunities and challenges; and
- Groups are able to attract and retain high-calibre individuals within their operating units.

Leaders in the central HQ must allow their operating units a significant degree of autonomy and resist becoming involved in the day-to-day operational running of the sites.

In some instances, this philosophy of devolved autonomy appears to be at odds with the principle of highly standardised processes. To address this conflict, Groups must set clear expectations with regard to decision rights at each level of their organisations and across all functional areas. Table 3 shows the types of decisions we would expect at different levels within a Group structure.

Table 3: Example decision rights at Group and operating unit level

Area	Example decisions	Role of central HQ	Role of operating unit
Day-to-day operations	<p>Cancel planned activity due to lack of ITU beds.</p> <p>Open beds temporarily to cope with rise in emergency admissions.</p> <p>Decision to act following the identification of quality issue.</p>	<p>Supports operational delivery but does not interfere on a day-to-day basis.</p> <p>May interfere at the request of the operating unit or if performance is consistently below expected level.</p>	<p>Autonomy for day-to-day operational decisions, drawing on the support of the central HQ where required.</p>
Strategic	<p>Develop a new service.</p> <p>Reconfigure clinical services.</p> <p>Develop a new private patient unit.</p>	<p>Determines the strategic direction, ensuring that wider population interests are placed above individual organisational interests.</p>	<p>Responsible for developing and delivering against their own local strategic agenda (within the high-level strategic direction set by the Group).</p>
Financial	<p>Virement of budget between pay and non-pay.</p> <p>Implement redundancies to drive cost efficiency.</p> <p>Replace equipment reaching end of life (with a replacement value of ~c.£2m).</p>	<p>Determines investment priorities in line with strategy.</p> <p>Ensures best value from capital through preventing duplication.</p> <p>Sets budgets and holds units to account for delivery against budget.</p>	<p>Determines local priorities for investment (typically through a devolved capital "pot").</p> <p>Autonomy to manage expenditure to meet budget.</p>
Workforce	<p>Appoint individual to unit leadership position.</p> <p>Appoint medical consultant.</p> <p>Approve temporary staff expenditure to address short-term increase in demand (e.g. winter pressures).</p>	<p>Key role in attracting, nurturing and developing top leaders.</p>	<p>Leaders within units have the autonomy to respond to local workforce opportunities and challenges.</p>

Standardising practices and processes

All Groups emphasise the importance of creating standard practices and processes that are reliably implemented in each operating unit. Groups in other sectors have successfully achieved this, allowing them to deliver consistent and cost-efficient services to customers across a geographically disparate portfolio of locations. However, where others have succeeded, healthcare organisations have often struggled. The specific reasons for this are many and varied but can be summarised into two key themes.

Evidence-based care

Unlike other sectors, healthcare professionals have, for many years, operated in an environment where individual variation is not only tolerated, but

in many cases encouraged. The traditional model of medicine involves clinicians using their expert knowledge and individual experiences to make a judgement on the most appropriate treatment. As a result, different clinicians routinely arrive at different answers to the same question. A model of evidence-based care, where clinicians are able to rely on statistically relevant evidence and then vary the treatment according to individual patient needs and preferences would reduce this variation. However, moving to this model will require cultural change and investment in organisational development, communication, and education.

Data and analytics

The popular maxim "*what gets measured, gets managed*" highlights the problem; the majority

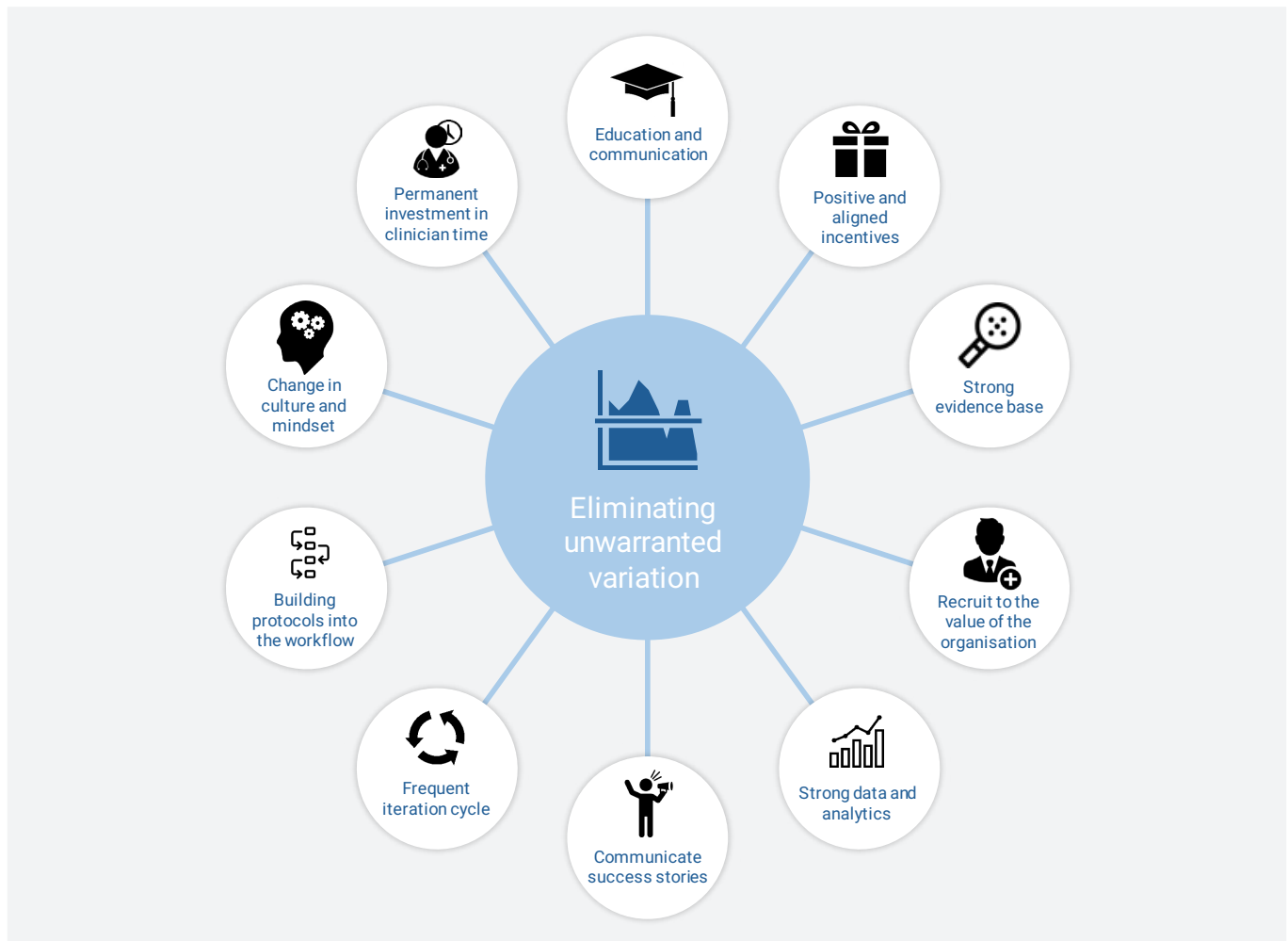
of provider organisations have focused on the measurement of outputs. Providers can only identify, understand, and address variation, if they measure input-based KPIs as well as output-based ones. Only then can the causal relationship between actions and the impact they have on patients be properly understood. This will require significant investment in data capture and analytics.

One organisation that has been leading the way in both areas is Intermountain Healthcare in Utah. Intermountain's success is evidence of the potential of this approach (see Case Study).

Groups in other sectors often achieve standardisation through the central HQ function prescribing a series of systems and protocols that each operational unit is expected to adhere to. Individuals in the operating units are rarely invited to take part in the design process. We believe that healthcare requires a different approach. To be successful, providers need to create a system that is able to tap into the deep clinical and operational expertise within the operating units, build consensus across a large and varied group of clinicians, and drive reliable implementation. Figure 5 highlights the key success factors for any organisation considering how to address unwarranted variation. These are relevant for both Groups, and other organisations looking to systematically reduce variation.

Providers need to create a system that is able to tap into the deep clinical and operational expertise within the operating units, build consensus across a large and varied group of clinicians, and drive reliable implementation.

Figure 5: Success factors for reducing unwarranted variation



Case study: Intermountain healthcare

Intermountain Healthcare is a non-profit provider of integrated healthcare based in Utah and Idaho. Its network includes 22 hospitals and over 150 clinics, which range from critical-access facilities in rural areas to large, urban teaching hospitals. It is recognised internationally for its approach to quality improvement, where its programmes have resulted in significant improvements to safety, clinical outcomes, patient experience and the affordability of healthcare.

Intermountain began its quality improvement journey following a study launched in 1986 to measure clinical practice variation. They found that most hospital admissions for a specific treatment had very similar characteristics and that there was no instance in which any one physician's patients demonstrated higher levels of severity or complexity than the patients of another physician [5]. Despite this, massive variation existed in physicians' practices. Following this study, Intermountain developed an approach to measuring and addressing variation, by focusing on the clinical processes that underpin care delivery. This approach resulted in some significant successes:

- During the initial study, Intermountain developed clinical protocols for total hip replacement. As a result, the cost of performing a total hip replacement fell from more than \$12,000 per case in 1987 to about \$8,000 per case in 1989 [5].
- In 1991, clinicians at Intermountain's flagship LDS Hospital created an evidence-based clinical practice protocol for managing the settings on mechanical ventilators used to treat acute respiratory distress syndrome. Within four months, protocol variances went from 59% to 6%, patient survival increased from 9.5% to 44%; physicians' time commitments fell by about half; and the total cost of care decreased by 25% [5].
- Intermountain clinicians created a shared baseline that identified when elective induction is medically appropriate and deployed it across the entire Intermountain system, which, at the time, performed more than 32,000 deliveries each year. The new protocol reduced the rates of unplanned surgical delivery and reduced admission rates to new-born intensive care units. It is estimated that the elective induction protocol reduced healthcare costs in Utah by about \$50 million per year [5].

Since these early results, the same methodology has been systematically applied to over 100 care pathways over the last 20 years, resulting in significant improvements in safety, clinical outcomes and patient experience. The methodology has also resulted in significant cost reductions through the elimination of inappropriate treatment, duplication and inefficiency.

Intermountain's Chief Quality Officer (Dr Brent James), attributes the success of Intermountain's approach to two key factors [5]:

'First, Intermountain developed an ability to measure, understand, and feedback to clinicians and clinical leadership detailed clinical variation and outcome data.'

'Second, the system created an administrative structure that uses its robust clinical information to oversee the performance of care delivery and to drive positive change.'

When considering the practicalities of these factors it is evident that the Intermountain approach is unlikely to be successful (or indeed, affordable) without sufficient scale. Without scale, organisations are unlikely to have sufficient knowledge or an established evidence base on which to develop robust clinical practices. Moreover, the investment in systems for data capture, analytics and administrative structures would be prohibitively expensive for individual hospitals.

Several NHS organisations are already working with Intermountain to translate its success factors into methodologies and ways of working suitable for their own organisations. Groups can provide these organisations with the critical mass needed to pursue quality improvement programmes akin to those of Intermountain and other global leaders.

Supporting organisational models

The solution to reducing unwarranted variation is not a structural one, but we do believe there are organisational models that can help to drive engagement, ownership, and accountability for variation.

One way is to create lateral links between the operating units, which bring together clinical and operational leaders from across the organisation to build clinical consensus on 'what good looks like' and support implementation at each of the operating units. This approach is best evidenced by the Royal Free London NHS Foundation Trust, which has designed a permanent organisational model comprised of autonomous 'Hospital Units' and lateral links called Clinical Practice Groups.

Case study: Clinical Practice Groups at Royal Free London NHS Foundation Trust

As part of the Vanguard programme the Royal Free London NHSFT (RFL) has developed an organisational model focusing on the systematic identification and reduction of unwarranted variation.

Approach to reducing unwarranted variation

RFL's proposed approach to reducing variation has been developed working alongside Intermountain Healthcare in Utah. The approach seeks to create a "shared baseline" which clinicians adopt but then vary according to individual patient needs. The approach follows six key stages:

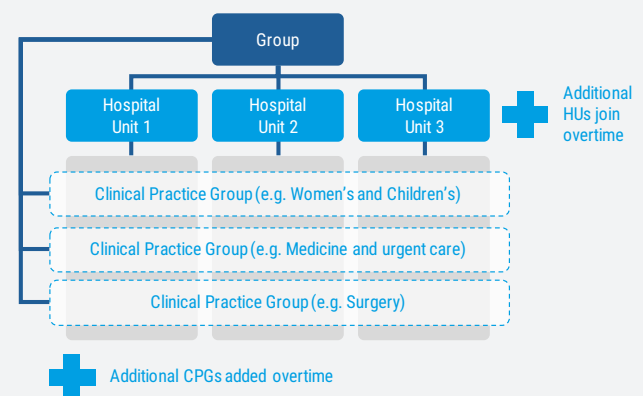
- Step 1. Identify and define high priority pathways
- Step 2. Measuring clinical outcomes, activity, performance and costs
- Step 3. Analysing pathways to select which will be developed and standardised
- Step 4. Design and test to improve pathways
- Step 5. Continuous improvement phase when pathways are built into Electronic Patient Record supported by Standard Operating Procedures

The organisational model

RFL realised that the above approach needed to be embedded within its organisational model. It therefore developed a model comprised of autonomous Hospital Units (HUs) and Clinical Practice Groups (CPGs).

- **HUs:** One or more hospital sites run together as a single operational unit.
- **CPGs:** The lateral links between HUs, typically covering a single clinical area (e.g. women's and children's).

Figure 6: Royal Free Group structure



The role of the CPGs will be to answer the question "how do we deliver the best possible outcomes for patients?" This requires more than simply developing a best practice 'guide'; CPGs must reconfigure the services, the workflow, the workforce, and the technologies across their clinical areas. The Hospital Units are primarily responsible for managing the day-to-day flow of patients through the hospital, implementing change (including the recommendations of the CPGs) in a locally sustainable way and driving improvements in performance.

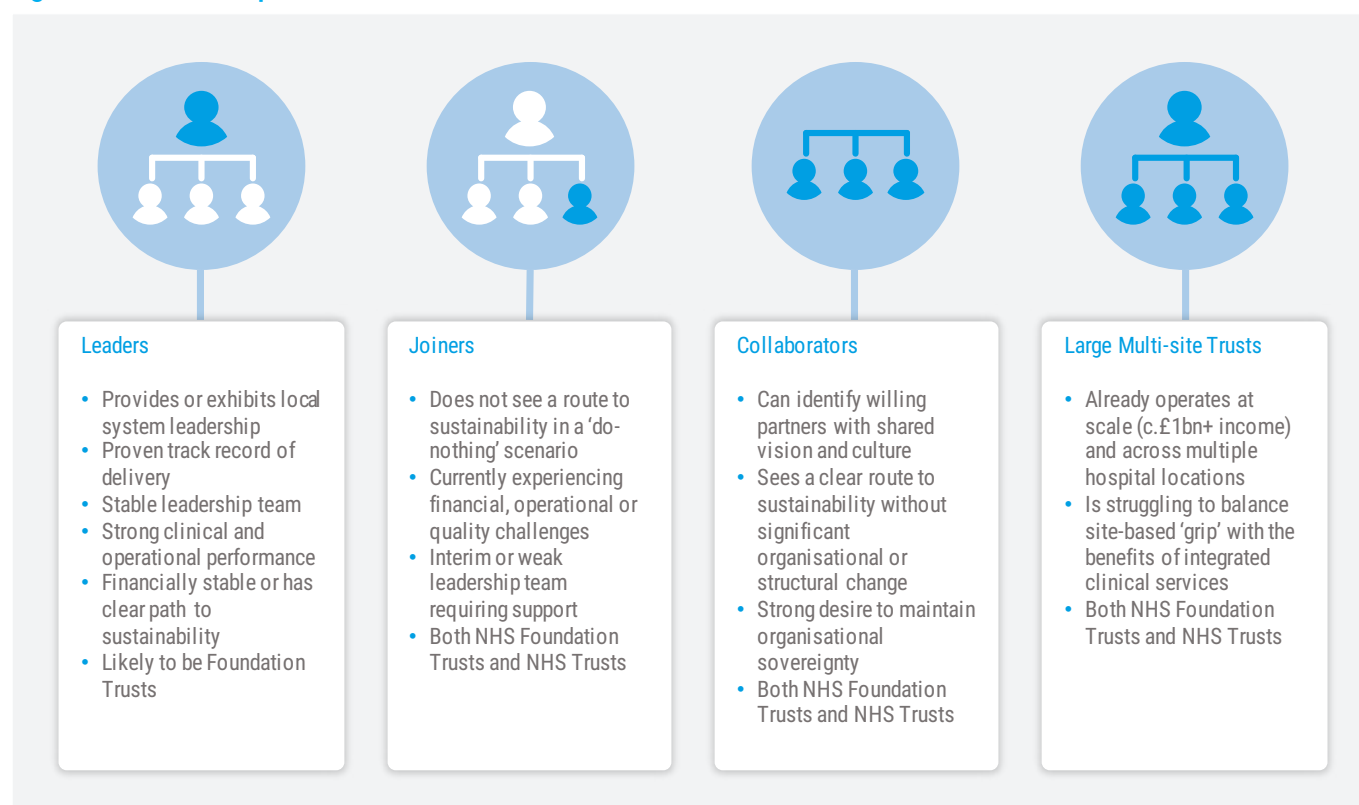
The interface between the CPG and the HU is critical to the effectiveness of this model. First, the CPGs must act in support of the HU, helping it to simultaneously deliver improvements in the quality and efficiency of care. Second, the activities of the HU and the CPG should not be considered as discrete from one another; rather, the CPG must work closely and iteratively with the HUs.

Who are Groups suitable for?

The financial, population, and variation challenges that have been discussed earlier are ubiquitous across the NHS. We therefore expect that the benefits that can be unlocked by Groups would be attractive to almost any Trust in the country. However, we recognise that the Group model will not be right for all.

The type of Group that is pursued by those who are interested in the model will naturally be dictated by local conditions, and Trust-specific objectives and ambitions. However, as a guide, we see Trusts falling into one of four categories:

Figure 7: Who are Groups suitable for?



We anticipate that Groups will include non-acute providers, including: primary care, community care, mental health, and social care providers. Salford Royal NHS FT is already leading the way, combining its proposed Acute Care Collaboration Group with its Integrated Care Organisation (ICO) model. The development of a "Group" of Accountable Care Organisations could amplify the population health benefits and financial savings discussed earlier, although the design of such a Group would require careful consideration. We believe that the acute Hospital Group model and Accountable Care Organisations / Systems (ACOs/ ACSs) can, and should, exist harmoniously, although pragmatically, it may be easier to pursue such models in series rather than in parallel.

Any provider considering whether a Group is right for them should consider the following questions:

- Have you calculated the benefits that a Group model could deliver, based on robust assumptions and a strong evidence base?
- Are you fully aware of the time and resources required to design, implement, and manage your proposed Group model, and do the benefits justify this investment?
- Have you fully understood any legal constraints and the regulatory environment that will impact your design, both now and in the future?
- Do you have willing partners and a realistic view of how the Group could evolve over time?
- Is your own organisation ready and willing to undergo this change?

Barriers to implementation

Despite the benefits of Group models, there remains a number of barriers to their development. These barriers have the potential to prevent organisations from creating Groups, disincentivise others from joining Groups, and generally restrict the pace of change. These barriers fall into one of three categories: financial barriers, regulatory barriers and organisational barriers.

To succeed, Groups also need whole-system support. They require the backing of the macro-system (NHS England, NHS Improvement, and the CQC) as well as their local micro-systems (commissioners, other providers across primary care, mental health, community and social care, local politicians and the multitude of other important local stakeholders).

Table 4: Potential barriers to the formation of Groups

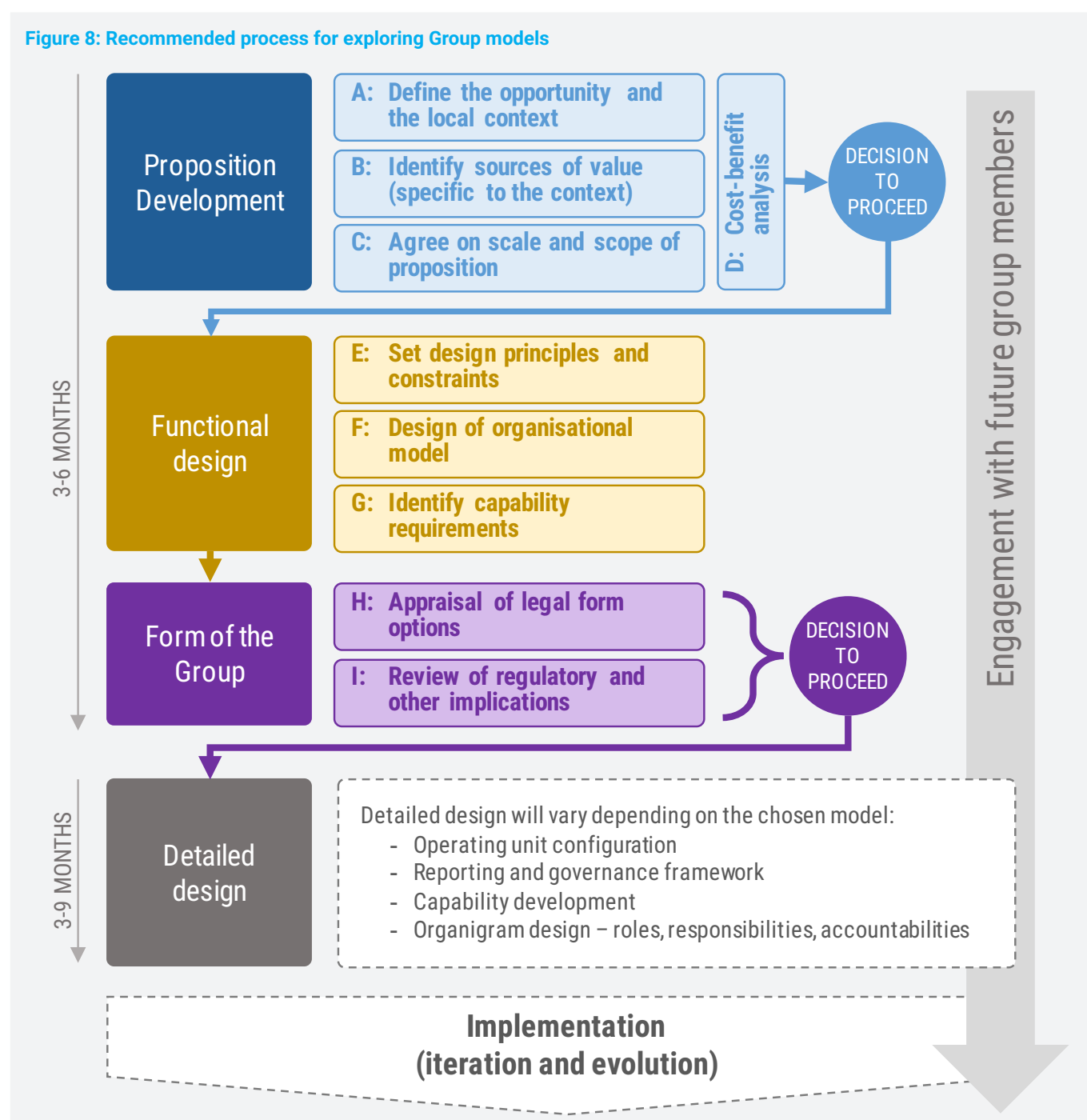
Financial barriers	Ability to invest	<p>Delivering the benefits of scale will require investment. This investment is needed to reconfigure services, develop new workforce models, develop standardised ways of working, and to invest in enablers such as digital technologies and analytics. Without this investment, any changes to organisational form are merely “rearranging deck chairs”.</p> <p>At scale, Groups have the potential to attract some or all of this investment from private sector sources. The provider sector has the potential to be much more commercially minded in this regard.</p>
	Financial disincentives	<p>For providers considering consolidated forms (i.e. the wholly-owned subsidiary model), the presence of significant debt on the balance sheet of interested parties is a significant barrier (for example, those Trusts with large PFI contracts). The system should consider ways of ring-fencing this debt to remove the financial disincentive.</p>
Regulatory barriers	Competition and Markets Authority (CMA)	<p>The CMA must recognise the patient and economic benefits available through new forms of provider consolidation and collaboration. This remains an area of concern for providers considering Group models.</p>
	Trust legislation	<p>The legislation for NHS Foundation Trusts and NHS Trusts was created to accommodate organisations with a small number of geographically proximate hospital sites. When applied more broadly to hospital Groups, it has a number of limitations:</p> <ul style="list-style-type: none"> • First, for FTs, the role of the Council of Governors (to represent a very local population and workforce), does not translate to an enlarged, and potentially geographically-disparate, set of hospitals; and • Second, the single Accountable Officer framework does not easily lend itself to a model of devolved responsibility and accountability. <p>These issues do not prohibit the formation of Groups, but could act to limit the pace and effectiveness of their execution.</p>
Organisational barriers	Internal support	<p>Groups must have the backing of their own organisation, particularly the clinical body. Without this, organisations will struggle to implement new models of care (Groups or otherwise).</p>
	Organisational sovereignty	<p>In some cases, the formation of a Group will result in the loss of some (if not all) organisational autonomy. This will require the Boards of joining organisations to think maturely about the best future for their Trust. The “human” aspects of this can be difficult to overcome.</p>

Potential approach to exploring Group models

Exploring a Group model is a significant undertaking which will require Trusts to consider carefully a range of factors. Using our experience supporting the Royal Free London NHS FT, Salford Royal NHS FT and Guy's & St. Thomas' NHS FT, we have designed an approach (described in Figure

8 and in more detail over page) covering the key questions that need to be answered in order to develop an appropriate and robust Group model for a provider's individual circumstances and strategic objectives.

Figure 8: Recommended process for exploring Group models



A: Define the opportunity and the local context

- What is the specific opportunity or problem that we are trying to solve for?
- Does the local context support consideration of a Group model?
 - Does the proposition meet the needs of other local organisations?
 - Are there other organisations for whom this would make a compelling proposition?
 - Does this fit with the strategic direction of the regions, including STPs and other local dynamics/initiatives?
 - Does the proposition support the direction of local and national stakeholders?

B: Identify sources of value

- What are the benefits of a Group?
- Are there any dis-benefits which need to be considered?
- How applicable are they to the local situation?
- Therefore, what are the specific objectives we are trying to achieve and how will the Group enable them?
- How scalable are the benefits?
- Can the benefits be delivered at geographic distance?

C: Agree on the scale and scope of the proposition

- What is the optimum size for the Group?
- What is the geographic reach of the Group?
- What type of organisations may join the Group?
 - NHS Foundation Trusts and NHS Trusts?
 - Acute providers only or other provider types (mental health, community, primary care, social care)?
- Will the Group accept organisations facing clinical, operational, and financial challenges?
- How quickly will the Group grow, and how can risks of growing too quickly be mitigated?

D: Cost benefit analysis

- What are the forecast quality improvements (clinical outcomes, patient experience, safety)?
- What are the forecast financial improvements?
- What are the expected costs (recurring revenue costs + capital investments)?
- What risks can be identified? How can they be mitigated?
- Are the costs and risks justified by the forecast quality and efficiency improvements?

E: Set design principles and constraints

- What principles should the design be based on? (based on the answers to A-C)
- What (if any) design constraints are there?
 - What are the 'non-negotiable' areas for the founding organisations and their stakeholders?
 - What are the constraints of the current regulatory and commissioning environment?

G: Identify capability requirements

- What capabilities and resources are required by each organisational unit?
- How does this compare to current capabilities and resources?
- Therefore, what are the capability and resourcing gaps and how will they be filled?

F: Design of management model

- To deliver the sources of value (B) within the design parameters (E), what is the most appropriate management model?
- What are the organisational "units" within the Group?
 - Most models will include a 'central HQ' and 'operating units'. Other components such as the Royal Free's 'Clinical Practice Groups' may also be considered
- What are the responsibilities of the central HQ vs. the operating units?
- What level of autonomy will the operating units have? Who is responsible for making which decisions? Will the Group operate a policy of 'earned autonomy' for its operating units?
- What are the operating units accountable for and to whom? What is the central HQ accountable for and to whom?
- What is the relationship between central HQ and the operating units?
- Therefore, what organisational model best supports the proposal?

H - I: Form of the group

- What legal vehicle best supports the proposed organisational model?
- Can the proposed organisational model be fully supported by the available legal forms? If not, what changes are required?
- How will the model fit within the regulatory and commissioning landscape?
- What other (if any) implications are there of the proposed model?

Key lessons learned

It quickly became apparent in Credo's work with Royal Free London NHS FT, Salford Royal NHS FT, and Guy's & St. Thomas' NHS FT that, whilst case studies were helpful, there is no "off-the-shelf" model that can be used to create a Group. The models from across the world were invaluable as examples, but applying those models directly to the complex world of the NHS would not have been possible.

Furthermore, all Trusts face a range of common challenges which are complicated by unique, local factors. As such, a model that works for one Trust may be inappropriate for another. Accordingly, we have shared information and approaches from across a range of Group models in order to provide reference material to Trusts potentially interested in developing their own Group structures.

Five lessons from our experience:

1. **Understand your baseline:** It is important for any organisation to have a strong understanding of its baseline, where it is strong and where it is not. What the Group can offer its members may be partly driven by the areas in which Trusts have strong capability (although investment in weaker areas should not be discounted).
2. **Don't underestimate the difficulty in achieving behavioural change:** Standardising pathways and removing variation is an important, achievable, but very difficult, aim. Positive intent alone is not enough, and strong supporting infrastructure (including a combination of incentives, enablers, and organisational structures) is required to achieve the necessary behavioural change.
3. **Stress test the model:** Using example scenarios is a powerful tool to help bring the model to life for stakeholders across the organisation. For example, what happens if A&E targets are missed?
4. **Develop a common language-set:** Developing a clear terminology and language-set is vital to creating a shared understanding and buy-in across the organisation.
5. **Implement, test and refine:** Careful preparation is important, but implementing a model sooner (followed by a period of testing and refining) may be a better approach than spending material amounts of time polishing a theoretical model.

Five key principles:

1. **Function before form:** There must be a clear statement of what the Group is trying to achieve for its members, rather than assuming a new structure is a means to an end.
2. **Clinically-led:** Clinical buy-in must be ensured at all stages of development. This requires working closely with clinical leaders from across the organisation(s).
3. **Local autonomy:** It is crucial to place emphasis on local autonomy and expertise – the 'operating units' are what ultimately drive the care given to patients, and must be at the heart of any Group model.
4. **Stakeholder engagement:** Intra- and inter-organisational stakeholder engagement is key, preventing internal talent flight and ensuring plans are understood and backed externally by patients, governors, commissioners, other providers, and regulators.
5. **Bespoke models but informed by others:** Trying to use an "off-the-shelf" model risks neglecting important local dynamics, conversely, it is important to not reinvent the wheel with numerous models available to learn from and adapt.

Conclusion

The NHS remains an exemplar and envied healthcare system. When compared to other healthcare systems globally it delivers high quality outcomes within a funding envelop that represents excellent value for money.

But it is also a system that faces huge and unprecedented challenges, and addressing these challenges may require fundamental changes to how care is delivered. We believe that the new models of care being developed by the numerous Vanguard sites across the country are critical to achieving this. Without major breakthroughs in how to deliver 'more for less', it is difficult to envisage how the current system will cope with the demographic, workforce and funding challenges it is likely to face in the coming years. Whether considering how to drive integration between health and social care, or how hospitals can better work together, these new models have the potential to 'future-proof' the NHS, and the outcomes it delivers, for many years to come.

However, the challenge of delivering these new models cannot be underestimated. Having evolved to increasingly compete with each other, providers are now being encouraged to work together to leverage their collective experiences and the benefits of scale. Whilst the evidence base clearly indicates the benefits this can bring, there is a multitude of pragmatic and emotional reasons why such efforts can end in partial success or indeed total failure.

Providers wishing to explore a Group model must have a shared belief in the value of working together; reluctant partners will not commit the time nor make the difficult decisions that are necessary to successfully implement this model. Even for organisations who start with a shared vision, developing a Group model that is robust and affordable, while meeting the needs of all partners, is a significant undertaking.

Leaders and policy-makers across the NHS believe that these models have the potential to be ground-breaking, but they also recognise the complexity involved with successful execution. The funding NHS England has provided for the Vanguards is being used to test and trial these models with a focus on proving replicability and facilitating learning across organisations. While every individual situation will be different, there is now a wealth of information and experience available to those considering what model might best meet the needs of their organisation.

This paper provides some of this knowledge base in relation to Group models. We hope that readers find it useful, practical and thought provoking.



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About the author

Lucy Thorp is a Senior Manager within Credo's Health and Social Care Practice. She has worked alongside the Executive Teams of several NHS Trusts to support the design and implementation of their Group models as part of NHS England's Acute Care Collaboration Vanguard.

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