



The Global CEO Advisory Firm

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# NHS Collaborations: Part 1

A practical guide to collective decision making by providers



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# Foreword By Sir David Dalton



Five years ago, I was asked by the then Secretary of State to advise him on the future development of providers of NHS healthcare. The Dalton Review 2014 highlighted the significant unwarranted variation in clinical

outcomes, service quality and productivity, and recommended that Chief Executives should become system architects using organisational archetypes and governance arrangements to support strategic and operational objectives.

Five years on, some things have changed and others have not. Variation continues – even though it is now easier to identify best practice and to support its implementation due to the greater interest in improvement methodology and staff engagement. NICE, CQC and GIRFT all contribute to the signposting of good practice and yet the arrangements in local systems remain inadequate to assure best practices are replicated and reliably implemented.

I am still of the view that the English health system, compared with European countries, may have too many sovereign organisations. This creates a problem of its own making, as it requires 230+ top-drawer strategic leaders to be sourced and developed. It also means that good operational leaders seek career progression to a CEO role for which they may not be best suited. The task of operational leaders is immense and often undervalued and we are yet to create the right talent management and succession planning arrangements to support and reward our very best operational leaders.

Large-scale service change is still taking too long to reach conclusions, often because provider CEOs view proposed change through the lens of whether their organisation will ‘win’ or ‘lose’ from the change. Today, only a minority of systems provide adequate incentives or pooling arrangements for everyone to share in the fruits of the tree – especially if those fruits fall in your neighbour’s garden.

Thankfully the 2019 Long Term Plan (LTP) emphasises the need for collaborative behaviour amongst providers particularly within their Integrated Care System to enable future developments of integrated health and care, focused on local neighbourhoods. While the LTP is strong on **what** the NHS should do, it is comparatively weak on **how** the changes should be delivered.

This report by Teneo and Hill Dickinson seeks to address that deficit and comes at an important time for provider and system leaders: it emphasises why collaboration is more important than ever – both horizontally, between organisations needing to offer services collectively to a wider geography, and vertically, between organisations in the same locality. The report does not shy away from identifying obstacles to collaborative behaviour and it helps the reader to see that there are multiple organisational models that can help leaders to overcome these. These organisational ‘vehicles’, with the right driver and an agreed map of where to get to, now offer real hope for change. It is expected that the funding settlement for the next strategic period will provide the fuel in the tank, which thwarted the much-needed change of the previous period.

My view remains that there are no right or wrong places on the spectrum of collaborative organisational forms and there most certainly should not be a ‘one-size-fits-all’ design from above. My discussions around the country are clearly indicating that conditions are changing and that there is an appetite, and in some cases an enthusiasm, to find new and better ways of delivering best care and to achieve sustainable productivity improvements. Legislative change will catch up – but until then, Boards are finding their own workarounds: for example, through innovative joint committee and committees-in-common structures to create scale benefits while preserving local autonomy. More organisations are pursuing different forms of group models and are developing standard operating models to enable best practice to be implemented reliably across wider geographies by multiple points of delivery. They are the pioneers – creating the operating models to deliver the aspirations of the LTP.

This report illustrates and describes the new models which are being explored and implemented by these organisations. I support and welcome the desire of Board leaders to find new ways to drive change and improvement. Let us all hope that in five years we can look back and see that Boards heralded the new collaborative era by connecting with others to develop better organisational models, enabling best practices to be delivered reliably to the populations they serve.

Sir David Dalton  
January 2020

# 1. Why collaboration is more important than ever...

NHS Trusts and FTs were designed to be the 'delivery units' of the NHS provider sector and, in particular, FTs were designed to be autonomous and competing organisations. Yet this approach has created inefficiencies, unwarranted variation and forced organisations to make decisions out of organisational self-interest. In many ways the current system creates obstacles to addressing issues of quality, inequality and value.

To address these issues, commissioners and providers are being asked to work across their boundaries as the 'organising units' become systems and networks. This requires collaboration: put simply, an exchange between organisations in which all participants feel they benefit. Collaboration can allow organisations to accomplish what they cannot do alone. Our aim is to help show how.

## Collaboration in the contemporary NHS

The 2014 Five Year Forward View and its update in 2017 set out the ambition to "make the biggest national move to integrated care of any major western country"<sup>1,2</sup>. To enable organisations to come together for the benefit of patients, the plans outlined a number of new care models, with 50 vanguards testing these since 2015. They also introduced Sustainability and Transformation Partnerships (STPs) covering every area of England to encourage local authorities and the NHS to plan local priorities and health and social care services together.

Most recently, the NHS Long Term Plan<sup>3</sup>, published in January 2019, has reaffirmed NHS England and NHS Improvement's commitment to increased collaboration, and announced plans to introduce integrated care systems (ICSs) in every region of the country by April 2021.

Despite this commitment, there remain a number of obstacles to collaboration, including ingrained competitive behaviours, current legal frameworks and difficulties in sharing risk and benefit. These obstacles make it difficult for NHS organisations to design and implement collaborative models. Proposed legislative reform may ease these difficulties, but the timescale within which such changes may happen is uncertain.

A plethora of models for collaboration and multi-organisation service delivery have developed organically in recent years, including: clinical networks such as MCNs, SCNs and ODNs<sup>\*</sup>; corporate JVs; single service chains; alliances; group models; shared service models; and ICSs. Many of these organisational archetypes were explored as part of The Dalton Review<sup>4</sup> in 2014 and subsequently in publications by the regulators on organisational form.

Very few of these models have a legal or otherwise well-defined meaning or a codified operating model, but at their heart they are all attempting to do the same thing: to allow multiple separately managed and individually motivated organisations to act together for common purpose. Each model is trying to allow organisations to make collective decisions, on a 'best for patient' basis, within the confines of existing statutory frameworks. This concept of collective decision-making is the cornerstone of system working.

These different operating models represent both an opportunity and a risk to NHS organisations. Organisations need a way to collaborate, while continuing to meet their statutory and regulatory obligations and maintaining clarity and simplicity in their operating model.

This paper seeks to provide answers to the following questions:

- In what scenarios should NHS organisations be looking to collaborate?
- What models exist and when might they be more or less suitable?
- What are the challenges to collaboration and how might we overcome them?

<sup>\*</sup> Managed Clinical Networks (MCNs), Strategic Clinical Networks (SCNs), Operational Delivery Networks (ODNs)



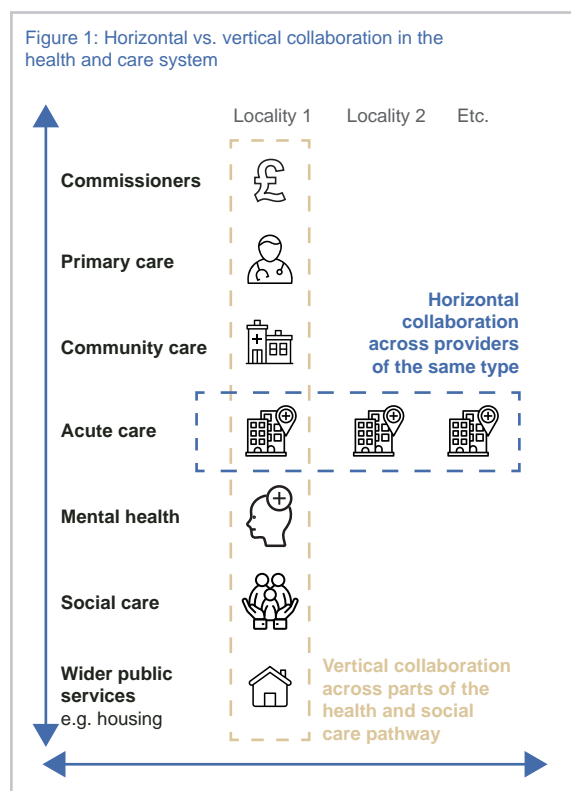
## 2. Horizontal vs vertical collaboration

Whole system collaboration requires the participation of a range of organisational types – including NHS Trusts and FTs, GPs, commissioners, public health bodies and Local Authorities (LAs) – each working within their own separate statutory frameworks. Collaboration may also be required between health and social care organisations on the one hand and, on the other, different types of organisations such as wider public service providers (housing, prisons etc) and, in the context of education, research and innovation, universities.

Within whole system collaboration for health and social care, there are two primary axes:

- **Horizontal collaboration** between organisations of the same type, operating in the same or neighbouring geographies, for example between two acute Trusts; and
- **Vertical collaboration** between organisations who occupy different parts of the health and social care pathway but within the same geography, for example, between primary and secondary care.

Often, horizontal and vertical collaborations are trying to achieve different overlapping objectives. However, they must both coexist in a single system if we are to address the issues of quality, inequality, sustainability and value.



Horizontal collaboration focuses on improving the quality and efficiency of care for patients through:

- reducing variation, improving quality and reducing inequality e.g. through the development of standard operating models;
- disseminating clinical learning and best practice between organisations;
- making best use of capital by investing at scale;
- making best use of shared assets and resources, including workforce and estate; and
- leveraging economies of scale and scope to drive value.

Vertical collaboration focuses on creating place-based models of care that address the holistic needs of a population through:

- creating more joined-up care for patients;
- coordinating efforts to improve the health and wellbeing of a population; and
- taking collective responsibility for managing resources and meeting targets across a region.

Models for vertical and horizontal collaboration are not inconsistent. Indeed, they are complementary and must co-exist within each health economy. For example, an acute provider may be working locally with GPs, community services and mental health services as part of a place-based Integrated Care Partnership (ICP), while at the same time it may be working with its neighbouring acute provider on issues such as clinical variation, workforce and service sustainability.

Integrated Care Systems (ICSs) are whole-system collaborations that incorporate both horizontal and vertical integration within a place. According to the NHS Long Term Plan, an ICS “brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care”<sup>3</sup>. The NHS has set itself a goal of all regions in the country being an ICS by April 2021. However, there is no national ‘blueprint’ for the organisational form of an ICS, and its interpretation is therefore somewhat fluid. Each area must develop its own models for shared decision-making, leadership and governance.

**The remainder of this paper focuses on horizontal collaborations between NHS Trusts and FTs. The models described could be applied to acute, community or mental health trusts.**

A subsequent publication will focus on vertical collaborations.

### 3. Why do organisations find it difficult to collaborate?

Most organisations in the NHS intuitively understand the case for, and the benefits of, collaboration. Yet the reality of implementing collaborative models in the current environment is not easy. The majority of obstacles stem from the concept of organisational sovereignty and while some are real obstacles, others are driven by an ingrained competitive mindset. Common obstacles are illustrated in the example below.

Many of the obstacles described below stem from the mindset of leaders and can be considered through the lens of behavioural economics or game theory. For example, the prisoner's dilemma is a paradox in decision analysis in which two individuals acting in their own self-interests do not produce the optimal outcome. The typical prisoner's dilemma is set up in such a way that both parties choose to protect themselves at the expense of the other participant. As a result, both participants find themselves in a worse state than if they had cooperated with each other in the decision-making process. Prisoner's

dilemmas occur in many aspects of decision-making in the NHS and in the wider economy. Over time, other industries have worked out a variety of solutions to prisoner's dilemmas in order to overcome individual incentives in favour of the common good. For example, people have altered the incentives that individual decision-makers face and attempted to enforce cooperative behaviour through regulation and collective decision-making. Many of the models being tested in the NHS (for example, the introduction of single control totals for ICSs) are attempting to do the same thing.

There is no quick fix to some of the obstacles described above. The organisational forms described in the following chapters can provide some, but not all, of the answers to these challenges. It will take time and a change in incentives to fully crack these issues. However, a lot can, and should, be done now to begin this journey.

#### Legal barriers

The current statutory framework does not provide any specific mechanisms for NHS provider collaboration. The FT model in particular is largely based on autonomy. Those providers that do wish to formalise their collaboration, while meeting requirements as to competition and patient choice, must therefore put quite intricate bespoke arrangements in place.

#### Organisational interest

Trusts and FTs are judged on the basis of their own performance. This has created an environment where organisations routinely compete for patients and poach each other's staff. It has also created a 'winners and losers' mentality, whereby organisations routinely feel unable to make decisions that are in the best interests of patients and the system if it does not benefit their own organisation and often their own bottom line.

#### Financial disincentives

It is currently difficult for organisations to share financial risks and benefits. Yet the types of decisions that need to be made collaboratively have significant financial implications for individual organisations. Implications include the loss of income, stranded fixed costs and the introduction of double running costs. This inevitably results in organisations resisting change in an attempt to maintain financial sustainability.



#### Relationships and a lack of trust

Many neighbouring organisations have grown up competing with each other – for patients, income and workforce. This has created a culture of mistrust that often runs deep within the organisations. This mistrust is often exacerbated by past events where organisations have attempted to collaborate and been thwarted by decisions made out of organisational self-interest. In some areas, years of NHS reconfigurations and incentives to drive top-line activity growth have created an environment where these relationships are very strained indeed.

#### Local sovereignty

The concept of local sovereignty and local accountability is deeply ingrained. This often plays out in the governance of FTs where Members, Governors and local stakeholders fear that collaboration will ultimately mean that decisions which affect their local population are no longer made by local people.

#### Variation in size and performance

Where there is a significant difference in size or organisational performance (either clinical or financial) between two neighbouring organisations this can lead to protectionist behaviour on one side and defensive behaviour on the other, with neither organisation being willing to collaborate. This is often the case where there is one large and dominant teaching hospital attempting to collaborate with one or more smaller district general hospitals.

## 4. Operating models for horizontal collaboration

The NHS is facing unprecedented challenges in the form of unwarranted variation, rising demand, workforce shortages and capital investment scarcity, many of which require system-level solutions. The days of “fortress mentality” are on their way out and provider organisations must think and behave differently to succeed.

The current legislation has, in many cases, incentivised organisations to prioritise competition over collaboration. However, organisations all around the country are pursuing innovative solutions to circumvent or change the incentives created by the current legislation.

Within horizontal collaboration, there are operating models that provide vehicles for **organisational level collaboration** and vehicles for **service level collaboration**. These models are not mutually exclusive or sequential; they can be combined at the same time and they may also represent an evolution over time.

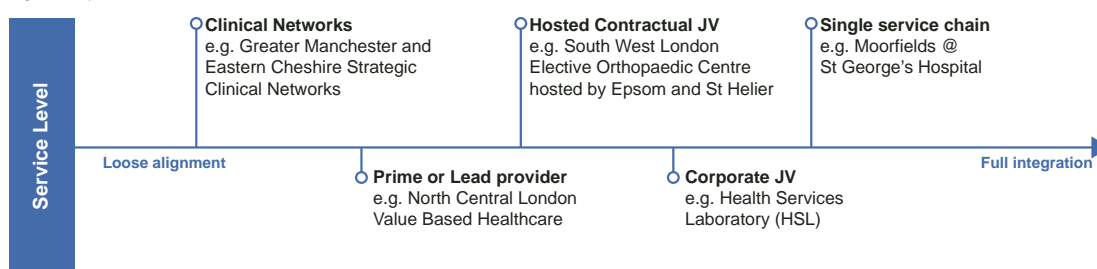
Figures 2 and 3 below outline the spectrum of models for each, ranging from “loose alignment” to “full integration”.

### Service level collaboration

Service level collaboration allows organisations to improve care quality by:

- coordinating service delivery;
- sharing assets and resources such as workforce;
- integrating care across sites and organisations;
- reducing unwarranted variation and inequality; and
- addressing issues related to clinical or financial sustainability.

Figure 3: Spectrum of service level collaboration



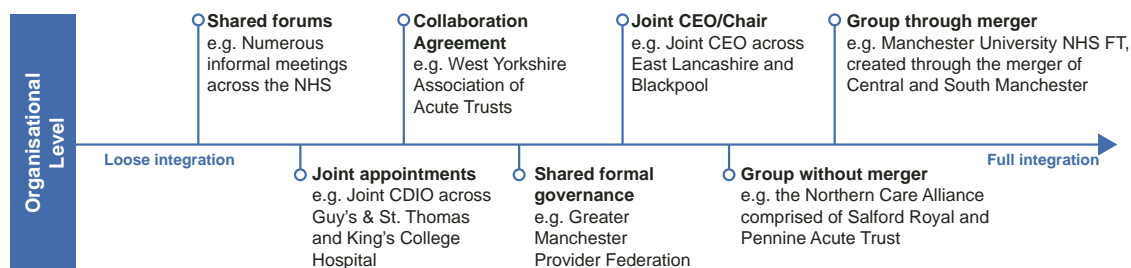
Description		Why do it...
<b>Clinical networks</b>	Coordinating strategy, transformation and/or delivery of a service across multiple organisations within a single geography <i>E.g. Operational Delivery Networks for specialist services</i>	<ul style="list-style-type: none"> <li>• To standardise and coordinate services</li> <li>• To establish/ improve referral pathways and protocols</li> <li>• To share resources</li> </ul>
<b>Prime or Lead provider</b>	One organisation is commissioned to provide all elements of a service or pathway. This organisation becomes the prime provider and sub-contracts aspects of the service or pathway. The prime provider acts as an integrator	<ul style="list-style-type: none"> <li>• To integrate services across a pathway</li> <li>• To address financial sustainability of services that are currently fragmented</li> </ul>
<b>Hosted contractual JV</b> <i>(see page 9)</i>	Services are combined across multiple organisations to create a 'single service'. The service is hosted by one organisation, but all partners collaborate to deliver the service and share risk	<ul style="list-style-type: none"> <li>• To integrate services across multiple organisations</li> <li>• To share assets and resources</li> <li>• To leverage the benefits of scale</li> </ul>
<b>Corporate JV</b>	Services and assets are transferred from multiple organisations to a new legal entity. The organisations are the shareholders of the new entity.	<ul style="list-style-type: none"> <li>• To share assets and resources</li> <li>• To leverage the benefits of scale or share investment</li> </ul>
<b>Single service chain</b> <i>(see page 11)</i>	One organisation takes over the delivery of a service at the site of another organisation. <i>E.g. Trust A delivers ophthalmology services at the site of Trust B</i>	<ul style="list-style-type: none"> <li>• To address the clinical or financial sustainability of services that are sub-scale at one site</li> <li>• To provide specialist services closer to home</li> </ul>

## Organisational level collaboration

Organisational level collaboration allows organisations to make collective decisions on a 'best for patient' basis, putting aside organisational interests. For example, through these arrangements organisations may:

- make decisions about how services should be configured to best meet patient needs and to improve taxpayer value;
- decide to consolidate or standardise non-clinical services to deliver cost efficiencies;
- create joint strategic and operational plans; and
- share investment, resources, workforce or risk.

Figure 2: Spectrum of organisational level collaboration



Description		Why do it...
<b>Shared forums</b>	Regular meeting forums across organisations, providing an environment for sharing and aligning decisions. Likely to be given effect by a partnership or collaboration agreement <i>E.g. two organisations establish a quarterly Board to Board meeting</i>	<ul style="list-style-type: none"> <li>• To create an environment for greater alignment, coordination and knowledge sharing across organisations</li> <li>• To build relationships</li> </ul>
<b>Joint appointments</b>	Senior appointments covering two or more organisations <i>E.g. two organisations share a single Finance Director, who is an Executive Director of both Boards</i>	<ul style="list-style-type: none"> <li>• To facilitate greater alignment and coordination across organisations</li> <li>• To consolidate or standardise functions</li> <li>• To save cost on senior appointments</li> </ul>
<b>Collaboration agreement</b>	A contracting arrangement where a number of organisations agree to work together for a specific purpose and, in some cases, to share risks and rewards Sometimes also established by a document described as an MoU or partnership agreement	<ul style="list-style-type: none"> <li>• To facilitate greater alignment and coordination of decision-making between organisations</li> <li>• To provide a structure that has some formality but is relatively easy to put in place</li> <li>• To provide a supporting framework for other models such as shared formal governance</li> </ul>
<b>Shared formal governance</b> <i>(see page 10)</i>	Aligned and/or shared formal governance structures across two or more organisations <i>E.g. two organisations create committees-in-common</i>	<ul style="list-style-type: none"> <li>• To create an environment that supports collective decisions</li> <li>• To ensure greater alignment and coordination</li> </ul>
<b>Joint CEO/Chair</b>	CEO appointment covering two or more organisations <i>E.g. two organisations share a single CEO who is an Executive Director of both Boards and the Accountable Officer of both orgs.</i>	<ul style="list-style-type: none"> <li>• To ensure alignment across organisations and facilitate collective decision-making</li> <li>• To save cost on senior appointments</li> </ul>
<b>Group without merger</b> <i>(see page 12)</i>	Two or more organisations operating as a 'group', with a central HQ function and discrete, semi-autonomous operating units The organisations remain separate legal entities. The group operating model is created through shared appointments, governance and contractual arrangements	<ul style="list-style-type: none"> <li>• To make collective decisions</li> <li>• To reduce variation, both clinically and non-clinically</li> <li>• To leverage the benefits of scale</li> <li>• Quicker and less expensive compared with merger</li> </ul>
<b>Group through merger</b>	Two or more organisations merge to create a single legal entity The new organisation operates as a 'group', with a central HQ function and discrete, semi-autonomous operating units	<ul style="list-style-type: none"> <li>• To make collective decisions</li> <li>• To reduce variation, both clinically and non-clinically</li> <li>• To leverage the benefits of scale</li> <li>• To remove financial obstacles to change</li> </ul>

Organisational and service-level collaborations often coexist. Indeed, by facilitating shared decision-making, an organisational-level collaboration can act as an enabler for organisations who are wishing to pursue multiple service-level collaborations. The current legislative and regulatory framework and the deeply ingrained concept of sovereignty may make it difficult for organisations

to opt for 'full integration' as a first step. However, the spectrums outlined in Figures 2 and 3 could represent a journey, from loose collaboration toward closer integration and alignment over time.

The final section of this paper explores four example models in more detail.





## 5. Legal basis for collaboration

The operating models for horizontal collaboration described in the previous chapter range from ‘loose alignment’ to ‘full integration’.

It is important to understand that there are different ways of describing these operating models, and there is no “right answer” as to how they should be described; these descriptions are not legally defined terms.

In legal terms, the main differentiating factor between the different options is the extent of organisational integration involved. In fact, all of the operating models at both organisational-level and service-level will fall into one of the following three categories of legal model:

### 1. Contractual arrangement

Any model which is given effect by a written agreement will fall into this category:

- Shared forums and shared formal governance which will be underpinned by some form of collaboration agreement
- Joint appointments and Single CEO / Chair which will be governed by employment contracts
- Group without merger and Single service chain which will be set up by a management agreement
- Hosted contractual JVs, clinical networks, collaboration agreements and prime provider models which will be set up by a network of contracts between the participants (and which will usually be legally binding unless the participants agree otherwise)

### 2. Corporate joint venture

This model will involve two or more Trusts setting up and jointly owning a corporate entity.

### 3. Merger or acquisition

This legal model will apply when some or all services and assets of one Trust move to another Trust, such as in the Group through merger model.

Legal considerations when deciding which model to adopt will include:

- Legal powers to enter into the arrangement – clarity as to the scope of decision-making arrangements and how these will be exercised
- Employment and pensions – whether the model may result in transfers of staff under the TUPE regulations or similar arrangements and impact on NHS Pension Scheme access
- Regulatory issues – whether the model may have any impact on CQC and other registrations and licences
- Information Governance – how patient and staff personal data will be shared between the parties
- Clinical Governance – whether clinical governance policies and procedures will be harmonised
- Indemnity – whether the model may have any impact on access to NHS Resolution schemes
- Procurement, patient choice and competition law – which may apply when contracts are awarded and services move between Trusts
- Contracts – whether any existing contracts may be impacted by the proposed model
- Tax including VAT – which may be particularly relevant in the context of Corporate JVs

## 6. Shared decision-making



How can sovereign organisations take collective decisions? That is the question at the heart of collaborations – to allow multiple separately managed and individually motivated organisations to ‘act as one’ on a ‘best for patient’ basis within the confines of existing statutory frameworks. This concept of collective decision-making is the cornerstone of system working.

There are two approaches to taking collective decisions in the NHS:

- **Joint decision-making** – where a single decision is made using a process which binds multiple organisations e.g. joint committees.
- **Aligned decision-making** – where separate decisions are made by different organisations, but the process and setting for these decisions is designed to encourage the organisations to take decisions that are the same or complement each other e.g. shared forums.

The operating models for horizontal collaboration, which are at the looser end of the spectrum are based on aligned decision-making, emphasising organisational sovereignty where decisions either cannot be made jointly or there is not yet the appetite for pooled sovereignty between partners.

Collaboration using aligned decision-making is not easy – it requires skill, including in particular an understanding of others’ motives, and an acceptance that collaboration needs to be worked on and developed. For this reason, it is helpful to create a model for collaboration which is flexible and can be built on over time.

### Options for shared decision-making

In practical terms, this might involve the use of multiple operating models which can be layered on top of each other as trust builds and partners develop their respective collaboration skills. For example:

### Shared forum

Trusts can align their decision-making by establishing a forum where nominated decision-makers of each Trust participate in a shared discussion before making their respective decisions. This arrangement can be supported by a collaboration agreement which provides that where one Trust moves out of alignment with a plan that has previously been agreed between them, it can be required to compensate the other Trust for any related stranded costs or losses.

### Joint appointments or Single CEO / Chair

Trusts may decide to make joint appointments across senior positions, but they will need to recognise that they do not provide a basis for joint decision-making arrangements and 'in practice' joint appointments will only work where there is also a high degree of consensus between the Trusts in respect of the matters on which the relevant employees will be asked to decide.

### Shared formal governance

Trusts can establish their own decision-making committees, with the committees meeting to have shared discussions before making their decisions (sometimes known as 'committees-in-common').

### Gated decision-making

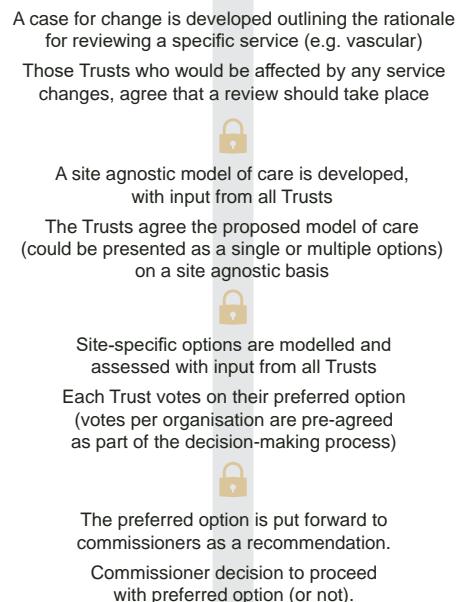
Trusts can agree to a process for making common decisions, with a number of 'gateways' throughout the process. Once a proposal has passed through a decision gateway, the parties agree to draw a line under discussions to date and focus on the next steps. This reduces the likelihood that providers will revisit, or deviate from, previous decisions if they don't like the subsequent direction of travel or the outcome. This can be combined with agreements around how Trusts will be financially compensated for decisions that have a negative impact on their financial position (see example below).

Once collaboration arrangements become more formally integrated, for example as a result of assets or resources moving from one Trust to another, decision-making becomes easier - it is only the Trust which owns or controls such assets or resources that will have ultimate decision-making rights in respect of the use of those assets, even if it may commit to have regard to the views of the Trust from which the assets have transferred.

## Illustrative example of a gated decision-making agreement and process

### Principles of gated decision-making

- The purpose of a gated decision-making process is to ensure that decisions are made on a 'best for patient' basis
- It does this by reducing the ability for Trusts to 'back out' of a decision for reasons relating to organisational self-interest
- The model seeks to 'lock down' the participation of all Trusts in a review process, before the outcome of the review is reached
- It is suitable for decisions relating to service configuration and for non-clinical services such as back-office reorganisation
- It involves the development of a decision-making process, which is agreed by all Trusts ahead of any individual service being reviewed. The decision-making process will include a number of well-defined gateways. Consequences for Trusts who pull out after a locked gateway would form part of the agreed process
- The agreement needs to include how a Trust would be financially compensated should a decision be made that is financially punitive to it





## 7. How to choose the right model



Despite the restrictions of the current legislation, the forms described in previous chapters can be combined in a number of ways to achieve almost any end. In choosing any model, we recommend that organisations follow a four-stage process, as outlined below.

In reality, very few organisations follow the exact process outlined below and the journey is often messier and more iterative. For reasons to do with local sensitivities and politics, organisations often

start at Stage 3 or 4 – by hypothesising the end design – and later realise the importance of setting out the case for change.

Organisations embarking on this process should not see this as a one-time opportunity to design the model they will work within for years to come. Rather, they should think of this as an opportunity to set out a roadmap that allows them to take the first step.

**1**

**Define the objectives**

First, organisations must be clear on what they are trying to achieve and why. This may involve creating a robust case for change, including the impact of a 'do nothing' scenario. All organisations who will be part of the future collaboration must buy in to this before design work begins.

**2**

**Describe the function of the collaboration**

Organisations must then describe the way they want to work together in the future. Describing this from a functional (rather than form) perspective, will help to ensure that the end design is fit for purpose. For example, this may require organisations to describe:

- the outcomes they would like to achieve;
- the types of decisions they want to be able to make collectively;
- the nature of the relationship they want to have; and
- challenges or opportunities they would like to address together.

**3**

**Perform an options appraisal**

Once everyone is agreed on the function of the collaboration, an appraisal can be performed to understand the options that are available. Each option should be assessed on its ability to meet the functional specification versus the consequences for the sovereign organisations. In some cases, the organisational consequences are too high, and the partners may wish to scale back their ambitions in the short-term.

**4**

**Undertake detailed design**

Once an option is chosen, organisations must then spend time working through the specifics of how the model will work and how it will be implemented. We recommend that this stage includes a period of rigorous scenario-based stress testing, to ensure that all potential issues are ironed out in plenty of time. This process may have implications for organisations and individuals and requires careful handling and a clear communications strategy.



## 8. Models in focus

### Hosted Contractual JV<sup>6,7</sup>

MODELS

1

2

3

4

- A joint venture (JV) is an organisational form primarily used by Trusts to achieve a specific goal that could not be reached by each party independently. In contrast to a corporate JV, a contractual JV does not require the creation of a new legal entity. A common form of JV is an arrangement where one partner organisation becomes the 'host' of the JV.
- A contractual JV allows organisations to combine or effectively merge their services to improve quality, share resources and leverage the benefits of scale.
- Where applicable, the host organisation is financially and clinically responsible for the activity within the JV. Financial risk/ reward may be shared between the partners through a legal agreement.
- Consideration must be given to governance and leadership arrangements, decision-making, clinical accountability and financial flows between partners.

### Case study: South West London Elective Orthopaedics Centre (SWLEOC)

Location	Ownership	Facilities	Services
Epsom Hospital Surrey	Contractual JV between four NHS acute Trusts	5 theatres, 71 beds (two 27-bed post-op wards and a 17-bed recovery suite with HDU and critical care facilities)	Elective orthopaedics

#### Organisational structure



- 36 visiting consultants from four Trusts provide services
- Epsom and St. Helier Trust is financially and clinically responsible for the activity at the site
- Epsom and St. Helier Trust provide all clinical, HR and back office support functions
- There is a SWLEOC Board, which includes representation from all Trusts
- SWLEOC has its own leadership team, led by a Managing Director
- There is a profit share agreement in place between all Trusts
- Centralised IT provides single view of patient pathways

## Single Service Chain<sup>8,9,10</sup>

### MODELS

1 2 3 4

- A single service chain is where one organisation (Trust A) provides services at the site of another (Trust B).
- Within this model, there are a range of options depending on the exact arrangement between the two Trusts. In some models, Trust A is fully accountable for all aspects of patient care and just leases clinical space from Trust B. This is often accompanied by the use of Trust A's brand – for example 'Moorfields @ Trust B'.
- This model is often suitable where acute hospitals are facing challenges to deliver safe and cost effective care in smaller clinical specialties due to a lack of scale in a local setting.
- Consideration must be given to clinical governance and accountability, financial flows and how access to interdependent clinical services (e.g. imaging) will be managed.

### Case study: Alder Hey @

#### Who

Alder Hey is a specialist paediatrics hospital in the Liverpool City Area, delivering a range of specialist acute services for children

#### What

It utilises a service level chain model to deliver paediatric services at c. 30 partner District General Hospitals (DGHs) across the North West and Wales. The services it provides range from single specialist services within a larger paediatrics ward to independently run full-service paediatrics

#### Why

Some DGHs struggle to deliver specialist paediatric services due to a shortage of skilled clinicians, lack of expertise and low patient volumes. Alder Hey looks to support these Trusts through a franchised service level chain model, branded as AlderHey@

#### Organisational structure

- Alder Hey typically provides fully bundled services at local DGHs, taking on accountability for all management, costs, revenue and clinical outcomes
- It makes contractual agreements with the local organisation to lease space in the hospital, with SLAs in place around outcomes
- Alder Hey retains full control of workforce contracts and deployment, although resource sharing across sites exists for highly specialised services (e.g. cardiology)
- It leverages its expertise to train all staff centrally and disseminate best practice
- Alder Hey preserves full control over revenue and costs and is generally responsible for working with local commissioners

## Shared governance and gated decision-making<sup>11</sup>

### MODELS

1 2 3 4

- Shared governance arrangements are used to allow multiple organisations to align decision-making in the pursuit of common objectives.
- Shared governance can take a number of forms along a spectrum from loose alignment to binding collective decision-making. In its loosest form, forums attended by Executives from each organisation may make non-binding decisions that are carried to individual Boards for ratification.
- More formalised shared governance allows organisations to make joint decisions; the principle mechanism for doing so is through committees-in-common.
- A committees-in-common arrangement involves each of the collaborating organisations having its own separate committee, but the different committees meet at the same time and place and have a common discussion. There can be partial or complete overlap of membership between the committees, depending on the governance arrangements of the organisations involved. Each committee will take a decision on behalf of the organisation to which it belongs, but the arrangement is intended to promote the alignment of the different organisations' decisions. Committees-in-common arrangements are particularly useful where joint committees between organisations are not permitted by legislation.
- This allows group decisions to be made at pace, with adequate representation from each organisation and retained independence and accountability of each Board.
- The current legislation places restrictions on organisations with respect to joint decision-making. For example, all the powers of an NHS Foundation Trust must be exercised by its Board, a committee of its directors or executive directors acting individually. By contrast, NHS Trusts can make arrangements for the joint exercise of their functions with third parties and have representatives of those parties on Trust committees. When FTs and NHS Trusts are collaborating, between themselves and with others, the arrangements that are made need to respect these requirements.
- Shared governance can be complemented with a gated decision-making process, whereby all providers formally agree to a specific process, which includes a number of gateways. Once a gateway has been passed the decision is effectively 'locked down', such that no individual Trust can back out of the agreement. These types of processes could be particularly helpful for Trusts looking to make difficult decisions, for example, around the reconfiguration of clinical services or the consolidation of back-office services.
- Shared governance should be considered for organisations aiming to collaborate more closely while maintaining individual accountability.

### **Case study: Greater Manchester Provider Federation Board**

- The GM HSC Provider Federation was established in January 2016 to enable increased collaboration on strategic issues and to fulfil three key objectives:
  - providing a structured provider voice for Greater Manchester Health and Social Care Devolution;
  - providing a strategic approach to transformation; and
  - addressing provider quality and efficiency.
- To ensure the dialogue with providers is as effective as possible, the Provider Federation Board was incorporated into the route map for decision-making and signing off GM proposals prior to discussions at Partnership Executive level.
- The Provider Federation Board enables GM providers to collectively influence and inform GM approaches at the developmental phase through a single conversation. In particular, the Provider Federation Board provides:
  - a system of mutual aid and support, including peer benchmarking and review;
  - a leadership environment for the development of relevant policies, plans and programmes on behalf of the Partnership Executive; and
  - a space for providers to hold each other to account for acting in accordance with the objectives of the Taking Charge Plan.
- The GM Provider Federation includes an agreed gated decision-making process. The first stage of the process is for providers to decide whether they will be part of a proposed review process. If they decide to proceed the gate closes. A review will then be undertaken which will result in a preferred decision being reached. There are pre-agreed consequences for any organisation who pulls out after a locked gate.



## Group without merger<sup>12,13</sup>

### MODELS

1 2 3 4

A 'group' model can be described as an organisational model with the following characteristics:

- A 'central HQ' function, responsible for providing unified leadership across the whole group and for making key decisions such as where capital should be invested.
- Discrete and locally managed 'operating units', which have a greater or lesser amount of devolved autonomy.
- Standardised systems, practices, and protocols, set by the central HQ function and reliably implemented at each operating unit.
- Consolidated back-office functions.
- A culture and value-set that is shared across the group and transcends individual relationships.

A 'group' model can be created without organisational merger or acquisition, through a combination of:

- A legally-binding Management Agreement
- Shared governance such as committees-in-common
- Shared senior leadership

Group models allow organisations to improve quality and value by:

- reducing unwarranted variation and addressing inequality;
- building and nurturing leadership talent;
- removing organisational interest to make decisions on a 'best for patient' basis;
- leveraging economies of scale and scope;
- pooling and sharing resources; and
- using workforce more flexibly.

Group models/ chains are common in other international healthcare systems.

### Case study: Northern Care Alliance

The Northern Care Alliance is an NHS Group formed by bringing together two NHS Trusts, Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust.

The Group provides a range of healthcare services including five hospitals and associated community services - Salford Royal, The Royal Oldham Hospital, Fairfield General Hospital in Bury, Rochdale Infirmary and North Manchester General Hospital.

#### Organisational structure

- The arrangement is underpinned by a Management Agreement between Salford Royal NHS FT and Pennine Acute Hospitals NHS Trust.
- From 1 April 2017, the Trust Boards of both Salford Royal and Pennine delegated their functions to a Group committees-in-common. The Boards continue to meet formally three times per year to perform their statutory functions (e.g. to sign off the annual accounts) and each meeting lasts for only c.10mins).
- While the two Trusts currently remain statutory bodies, the Group Committees in Common effectively manages both Trusts under the Northern Care Alliance NHS Group and is the route through which joint decisions are made.
- The Group is led by the Group CEO and a single common Non-Executive and Executive Team, who are the statutory Directors of both Trusts.

Teneo is a global CEO-advisory firm, advising the leaders of the world's most complex organisations. Within its Management Consulting division, it has a leading position within the Health and Social care sector, supporting both public and private organisations to develop strategies, transform services and realise change. We pride ourselves on working collaboratively with our clients to deliver real value.

Our experienced consultants work with CEOs, Boards and senior Executives on their most challenging questions; covering everything from formulating long-term strategies to addressing their 'here and now' pressures. We have developed clinical and organisational strategies, facilitated the development of new models of care, supported the redesign of acute services across local health economies and supported organisations to work more effectively through our approach to organisational design and development.

Within the NHS, we are experts in multi-agency organisational and system design. We work with organisations, teams and individuals to understand their challenges, design and shape solutions, and support the delivery of new organisational forms. Through this approach, we have supported the development of federations, clinical networks, provider groups and Integrated Care Systems.



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Hill Dickinson LLP is a leading and award-winning international commercial law firm with more than 850 people including 185 partners and legal directors. The firm delivers advice and strategic guidance spanning the full legal spectrum, from non-contentious advisory and transactional work, to all forms of commercial litigation. The firm acts as a trusted adviser to businesses, organisations and individuals within a wide range of specialist market sectors.

The firm has a leading Health practice providing legal advice and support to the NHS and independent healthcare organisations, both nationally and internationally. Our experienced team advises on major and complex projects for the NHS, including service transformation projects, mergers and acquisitions, joint ventures, procurements and outsourcings. We provide expert advice on collaboration models for integrating health and care services, including putting in place governance structures to facilitate decision-making, data sharing arrangements, value-based contracting mechanisms and stakeholder engagement processes.

We support organisations in documenting their collaborative arrangements including for provider collaborations, emerging Integrated Care Systems and place-based models. Depending on factors such as the nature of the organisations involved and the regulatory framework they work under, those arrangements can vary from a simple MOU to an alliance agreement with an accompanying risk share arrangement to a lead provider contracting structure. Our advice is always that the extent and complexity of the arrangements should be proportionate to what the organisations hope to achieve.



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