

Examining new options and opportunities for providers of NHS care

The Dalton Review

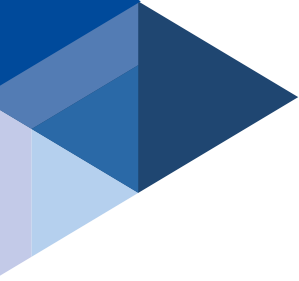


December 2014

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The variation in the quality of health and adult social care is too wide. This unacceptable variation in quality needs to be widely acknowledged and addressed.

That care can be delivered in different ways does not justify poor quality for some people, settings or locations. Everyone should receive good quality care, no matter how or where it is being delivered. This means improving the care that is inadequate or requires improvement, while leaving others to flourish to develop their good and outstanding care.

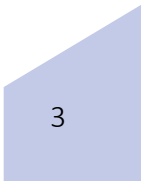
The state of healthcare and adult social care in England 2013/14

Care Quality Commission, October 2014



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Letter to the Secretary of State

Dear Secretary of State for Health

It was a privilege to be asked by you to lead this review into exploring ways to address the challenges faced by providers of NHS care. I believe that our NHS is the best healthcare system in the world, yet I know that not all of our patients are experiencing the standards they deserve. The recently published *NHS Five Year Forward View* describes the enormous challenges that the NHS faces. It emphasises that new care models are needed to support and care for people. This is the right approach. Yet, describing new care models is different from delivering them. This Report complements the *Forward View* and provides the organisational ‘delivery vehicles’ that can help translate its ideas into reality. I have confidence that NHS leaders and staff have the will and the capability to deliver what is needed.

We have significant variation in the standards of service provided by our healthcare organisations, and that troubles me. There are some excellent providers and some poor providers – and a lot in the middle. Why should any family have to accept that a relative living in one area can be confident in accessing excellent care whilst another, with the same needs living elsewhere, cannot? We might understand some of the reasons for this variation, but we shouldn’t tolerate the extent of it. All of our staff want to provide the best – and we must do our best to ensure that they can.

Whilst some providers have a track record of high performance, it is increasingly clear that, for a significant number of others, their existing organisational model will not deliver financial and clinical sustainability. The tests for Foundation Trust status, which were introduced 10 years ago, enable proper judgement to be made on good organisational governance and viability – and must be retained. Yet, a decade on, 93 NHS Trusts still have not achieved this standard. This must not continue.

The District General Hospital, established by the 1962 Hospital Plan now, in isolation, can struggle to meet the needs of the population. This is well known to those of us who provide and commission healthcare, and we are now at a point where patients and their families are beginning to understand that too. The time is right to change the way we think about the organisation of service provision. Institutions should not be preserved just because they exist. Boards should not pursue self-protectionist strategies, using the ‘interests of patients’ as camouflage. If an organisation is not able to provide high standards, reliably, to the population it serves, then its continuation in its current form should be called into question. Safeguarding reliable, high quality care to patients is more important than preserving organisations.

There are no ‘right’ or ‘wrong’ organisational forms – what matters is what works. This Report does not champion one organisational model over any other but recognises that it is for our system leaders to pursue the models that will deliver the greatest benefits to the populations they serve.

Some models will enable **collaborative** solutions: where shared services, working across organisational boundaries, meet standards, seven days a week; or where new integrated governance arrangements for primary and secondary care bring greater coherence to a locality. Other **contractual** or **consolidated** models will allow opportunities for successful organisations to bring their proven leadership, processes and expertise into organisations which are unable to demonstrate clinical and financial viability.

Leaders of successful organisations should be ‘system architects’: using their social entrepreneurial spirit to develop innovative solutions to their challenges and to codify and spread their success, so that the best standards of care can be available, reliably, to every locality in the country. I strongly believe that our leaders should be encouraged to be aspirational and to strive for improvement – and that organisational achievement

should be recognised. The Report recommends a system of ‘*credentialing*’ for our best organisations, building on the existing assessment systems of Monitor and CQC and drawing on the evidence of the characteristics of high reliability organisations. This new ‘kitemark’, beyond FT status, would enable commissioners to identify those organisations with the capability and greatest likelihood of successfully spreading their systems into organisations that are in persistent difficulty.

It is notable that all of the European countries we visited have developed new organisational forms as a response to the challenges they faced. Many have seen the development of hospital groups and the use of management contracts. These new forms have enabled the standardisation of best practice – and the delivery of this at a lower management cost overhead. It is perplexing that these forms have not been pursued in England. This may be due just as much to leadership mindset, as to some of the system impediments and weak incentives. This must be addressed.

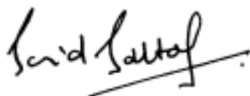
Competition law must not be seen as a barrier to developing innovative organisational solutions. There must be no doubt that patient benefit is and will be the key judgement in progressing new organisational forms. Some have said that it takes too long and costs too much to make changes. I agree – and so this Review makes recommendations to streamline processes, making it easier, quicker and less costly to transact organisational change.

I know that NHS change can be slow, due in part to an institutionally low tolerance to risk. It is important that this time we don’t miss the opportunity to act with urgency. I very much hope that boards will now develop an *Enterprise Strategy* – utilising innovative approaches for growth to deliver better care for patients – and develop the internal capacity and capability required to deliver improvement. Significant support for transactions must be made available to help organisations to gear up to deliver change. I am also recommending that national bodies accelerate change by supporting the costs of initial transactions so that we have **demonstrators**, capable of prototyping the new models and transferring their experience and learning to others.

I am indebted to the people who have supported this Review: to my Expert Panel and to the Chairs’ Group; to colleagues across Europe and the world who have allowed us to have insight into their systems; to the many people who have taken their time to participate in the numerous engagement events and to provide their views. I have been superbly supported by the Department of Health Review Team.

The Expert Panel has looked at the evidence of what works and presented this as a menu of organisational forms. We have listened and found a widespread appetite for change. We believe successful organisations should be encouraged to develop further and support organisations in persistent difficulty. There will be risks in taking this agenda forward, but I am confident that the NHS is capable of managing these. The prize will be a sustainable NHS, for the long term. We must support our NHS leaders and staff to reduce variation currently experienced and to deliver reliable, high quality care to all.

Yours sincerely



Sir David Dalton
Chief Executive
Salford Royal NHS Foundation Trust

December 2014



Executive summary

The NHS is rightly recognised as a world leading health system, highly valued by the public and those who work in it. There have been a number of remarkable successes over the last decade, but not all NHS providers have improved at the same rate, resulting in an unacceptable extent of variation in quality of care across the country. All patients and carers should expect and receive reliable standards of care, no matter where they live.

It is not only currently challenged providers who should strategically consider their future alongside that of their wider health economy partners. The NHS Five Year Forward View signposts the need for new models of care to respond to the challenges faced by the NHS. Even the best providers will struggle to meet the challenges of the future without looking outside traditional organisational boundaries and considering how their form could better support new clinical models and ways of working. Assuring the clinical and financial sustainability of the provider sector requires a wider range of options for both providers and regulators, and these must be embraced by leaders across the sector.

The evidence of the Review identified a number of organisational forms which could help providers to make these changes, which should be considered by all boards as part of their strategic planning processes. The Review also identified barriers and improvements to the system architecture surrounding these models, and makes recommendations to provider boards and to national bodies accordingly.

The organisational forms considered in this Review have different characteristics, benefits and barriers. Many are already being used in the NHS. It is clear that there should be no national blueprint or one size fits all. Accordingly, this Report does not impose wholesale change. It identifies five themes:

- i. One size does not fit all
- ii. Quicker transformational and transactional change is required
- iii. Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact
- iv. Overall sustainability for the provider sector is a priority
- v. A dedicated implementation programme is needed to make change happen

i. One size does not fit all

Organisational forms should develop to deliver the models of care which best suit local circumstances. They must not be centrally dictated. System leaders understand their own population need and geographies, and therefore need to be enabled and supported to identify and implement the best clinical models for their patients. In doing so, they need to examine their current organisational form to determine whether or not an alternative form would deliver better outcomes for their populations.

Too often, organisations seek to retain the status quo at the expense of operating outside of traditional organisational boundaries and fail to adopt best practice or pursue wider system leadership which could deliver improvements for patients. Shifting the mindset of board members towards one of joint ownership and governance with other organisations should change the unhelpful perception of service change by boards of 'winning or losing' for their organisation to one of 'winning' for their patients and wider community.

The Review considered a number of organisational forms which have the potential for wider adoption across NHS providers: federations, joint ventures, service level chains, management contracts, integrated care

organisations and multi-service chains or Foundation Groups. The Report and its supporting evidence packs explore the potential of each form to offer solutions to local challenges. In the future, it suggests, organisations are likely to operate more than one organisational form for their service portfolio.

Who	Recommendation
Trust boards	As part of the 2015/16 business planning process, trust boards should consider their response to the NHS Five Year Forward View and determine the scale and scope of their service portfolios. They should consider whether a new organisational form may be most suited to support the delivery of safe, reliable, high quality and economically viable services for their populations.
Trust boards	Trust boards of successful and ambitious organisations should develop an enterprise strategy and should consider developing a standard operating model that could be transferred to another organisation or wider system.

ii. Quicker transformational and transactional change is required

System leaders need to collectively own the transformation required across their local health economy. Historically transformation and transaction processes have been lengthy and protracted, particularly the early stages of planning and gaining consensus across the local health economy. Simplifying these processes will both accelerate opportunities for improvements in patient care and reduce the costs of transactions. The 'rules' also need to be explained and understood further as perception of competition and legislative issues can cause organisations to become overly risk averse.

Who	Recommendation
NHS England and Clinical Commissioning Groups	NHS England should require Clinical Commissioning Groups (CCGs) to set out in their five year strategic commissioning plans: <ol style="list-style-type: none"> the future care/service models they wish to support; and, how they will use their allocated funds for service transformation to support providers to deliver the agreed transformational and organisational change. Where multiple CCGs and providers are taking forward service transformation across a shared geographical area, NHS England should help broker agreement as to how costs are met between all parties.
Department of Health	A single, unified process with standardised documentation outlining clear criteria should be developed to support future transactions. This should include guidance for all parties including Governors.
Department of Health, Monitor and NHS Trust Development Authority (TDA)	A Tender Prospectus that has the parameters of the transaction clearly laid out should be made available to all potential bidders in the interests of speed and transparency.
Secretary of State for Health	The Secretary of State should set a requirement to the national bodies that, except in exceptional circumstances, all transactions should be completed within one year or less from the time the decision is taken by the board of the NHS Trust Development Authority (TDA) or Monitor.

iii. Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact

Transformational change requires strong and capable leadership. There are many successful NHS organisations and individual leaders with a track record of delivering consistently high quality healthcare to patients, but many have not thought beyond their current organisational boundaries. Leaders of successful organisations should become ‘system architects’, encouraged to use their entrepreneurial spirit to develop innovative organisational models and to codify and spread their success to other localities. Recognising these successful organisations, supporting them to develop enterprise strategies that expand their reach and developing new incentives will encourage more successful organisations to have greater impact with less successful ones.

Who	Recommendation
Monitor and the Care Quality Commission (CQC)	A new credentialing process, to recognise successful organisations capable of spreading their systems and processes to other organisations, should be developed by July 2015. This should build on CQC and Monitor ratings, with a good or outstanding rating a prerequisite. Once agreed, Monitor should be responsible for the process and the first wave of credentialing should be completed by October 2015.
Monitor and the CQC	A list of all credentialed organisations should be published on both Monitor and the CQC websites and made available to every Clinical Commissioning Group.
Clinical Commissioning Groups and providers	CCGs and providers should use this list of credentialed organisations to identify new partner organisations most likely to deliver transformational improvement.
Monitor and the TDA	A procurement framework should be developed which allows interested credentialed organisations the ability to register for management contract and acquisition opportunities. This framework should be live from or before April 2016. Inclusion on this register would mean that an organisation automatically passes the pre-qualification questionnaire (PQQ) stage of any tendering processes. The framework should then be used by the TDA and Monitor to procure support for challenged organisations.
Trust boards	Trust boards should consider new operational and strategic leadership roles required in order to support the new organisational models, and put development plans in place accordingly.
Leadership Academy	The Leadership Academy should support the development of the requisite skills and experience for the new operational and leadership roles and build these into the career paths and leadership and development training of current and future NHS leaders.
Department of Health, Monitor and CQC	The Department of Health, Monitor and the CQC should agree a ‘grace period’ for acquiring organisation with an agreed trajectory of finance, performance and quality standards improvement for the acquired or contractually managed organisation, separate from the overall performance of the combined organisations. This ‘grace period’ should take into account historical quality issues and the impact of any agreed financial investment adjustments.
Monitor and the TDA	Monitor and the TDA should ensure that – where appropriate – an acquiring or contractually managed organisation can start to create integrated operational structures, once the Heads of Terms have been agreed, so that these may be run in shadow form prior to the final decision on the transaction being taken.



iv. Overall sustainability for the provider sector is a priority

There are currently 93 NHS Trusts. A proportion of these will become Foundation Trusts, but many will not reach the required standards in their current organisational form. Equally, there are some Foundation Trusts that would not meet the requisite standards for authorisation today and may be significantly challenged both clinically and financially. Long-term solutions need to be identified for these organisations, supported by appropriate governance models, to ensure that all patients can continue to access safe and reliable high quality care.¹

Who	Recommendation
TDA	The TDA should publish the categorisation of and plans for each of the 93 NHS Trusts in the Foundation Trust pipeline, along with the trajectory and milestones for when and how each organisation will achieve Foundation Trust status or other sustainable organisational form.
Department of Health	The Department of Health should hold the TDA to account for meeting the trajectory and milestones for each of the 93 organisations.
TDA	The TDA should consider accelerating the solutions for patients and communities currently served by organisations in persistent difficulty, by running batched procurements for category B1 and B2 ¹ NHS Trusts.
Monitor and the TDA	<p>The buddying system should be expanded, beyond the special measures trusts, into a partnering system to allow organisations with the potential to improve early access to support and guidance from credentialed organisations.</p> <p>Arrangements should be developed to identify and remunerate trusts capable of providing support.</p> <p>Should buddying not result in the required improvement within a defined time period, a re-categorisation of the NHS body should be considered so that further action can be enacted quickly.</p>
Monitor	<p>Monitor should consider using their existing categorisation process to drive more rapid interventions.</p> <p>Where Monitor determines that a FT is in 'persistent difficulty', it should require that FT to produce a plan with clear improvement timescales. If the FT is subsequently unable to demonstrate improvement against this plan, Monitor should compel that FT to present a new sustainability plan. This may include adopting a new organisational form or pursuing a transaction with a 'credentialed' organisation.</p>

v. A dedicated implementation programme is needed to make change happen

In order to implement the ideas in this Report, two activities should occur in parallel: firstly, NHS leaders should be supported to develop awareness and knowledge of the available models and implementation approaches through a widespread programme of sharing learning and best practice; secondly, there should be a programme of demonstrator sites that can stimulate and accelerate change. This programme will support providers to develop and test new organisational forms in practice. Particular attention should be given to supporting successful organisations stepping in to improve delivery of high quality services in challenged health economies.

¹ Category B1 are described as organisations that cannot reach FT status in their current form and where an acquisition by another organisation is likely to be the best route to sustainability.

Category B2 are described as organisations that cannot reach FT status on their own and where a franchise, management contract or other innovative organisational form is likely to be the best route to sustainability.

Who	Recommendation
Department of Health	The evidence and findings from the Review should be communicated across the health sector, alongside the business planning round, through a national programme of learning and sharing best practice.
Department of Health, Monitor and the TDA	The national bodies should support a number of demonstrator sites where organisations implement a change to their organisational form. This should be evaluated and the learning shared with the wider sector.

Conclusion

The extent of variation of standards of care across the country and the challenges all providers of NHS services face must be addressed as soon as possible. The NHS Five Year Forward View signposts organisations to consider new and innovative solutions to address quality and financial challenges; the recommendations of this Review complement the NHS Five Year Forward View and support providers to deliver the changes required. The evidence from the Review suggests that addressing these five key themes will accelerate the transformational change that is required to help overcome the challenges facing the NHS. Effective and speedy implementation is now required in order to have the greatest impact for patients. The government, national bodies and patients should have confidence in NHS leaders to make the necessary changes a reality.



Introduction

1. The NHS is precious to both the public and its staff,² and is rightly viewed as a world leading healthcare system. People rely on its services to provide safe, high quality healthcare when they need it most.
2. However, whilst the NHS is established as a universal service, people do not experience the same standards of service from each of the organisations providing NHS care. Reliability of clinical standards is affected by issues including governance, leadership and financial viability and the factors driving these are many and varied.
3. Recent reforms have focussed on the regulation, inspection and commissioning elements of the health system. Over a number of years there has been an increased focus on commissioning against common service specifications and in greater public reporting of delivery against those standards, following regulatory inspection. Less attention has been given to the reform of the provider sector.
4. Despite the considerable changes experienced by the NHS, there is widespread consensus that the NHS must continue to transform in order to be able to meet the needs and expectations of patients in the 21st century. This need for change comes at a time of unprecedented financial challenge; 2015/16 will be the fifth consecutive year that providers have been required to meet challenging efficiency targets. Without transformational change, NHS providers will not be able to make the improvements required and will not be able to assure clinical and financial sustainability of services.

Why focus on the provider sector?

5. The provider sector is an integral part of the NHS and for many patients and the public it is what they think of as ‘the NHS’. It is highly varied, with NHS commissioned services delivered by a range of organisations spanning the NHS, voluntary, independent sector and social enterprises. In 2012/13, secondary care providers were allocated £70 billion of the £102.6 billion NHS budget³ making sustainability of this sector significantly important for the overall viability of the NHS.
6. Today, there are 242 secondary care providers of which 149 are Foundation Trusts and 93 remain NHS Trusts. The national policy intention is that all NHS Trusts should ultimately be authorised as Foundation Trusts, or an equivalent sustainable organisational form. While supportive of this aim, this Review is unequivocal in its view that the assessment criteria must remain and that the bar should not be lowered. It should be noted that the Expert Panel was of the view that a number of existing Foundation Trusts would struggle to meet the current assessment standards.
7. This gap between required and actual standards manifests itself in variation of standards across the country; reducing this variation and ensuring uniformly high standards of care across the provider sector is vitally important.
8. As demand and complexity continue to increase, it has become increasingly difficult for providers of all types to navigate the challenges that the NHS faces. The NHS Five Year Forward View identifies that the NHS needs better ways of delivering care at greater scale. It rightly identifies that:
 - a. care should be personal, whilst based on population health needs;
 - b. there should be a new focus on co-ordinated care systems and networks;

² Ipsos MORI (2014), Public perceptions of the NHS and social care survey

³ Nuffield Trust (2014), Into the Red; the state of the NHS Finances

- c. a greater emphasis should be given to redesigning out-of-hospital care;
 - d. centralisation should be supported where it demonstrably delivers improvements in quality and safety; and,
 - e. to achieve greater productivity, new approaches should adopt greater standardisation of processes, use of technology and shared information.
9. The new approaches to developing care models proposed by the NHS Five Year Forward View are welcomed, helping to address some of the key challenges faced by providers:
 - i. There are more people living with long term conditions: the number of people with three or more conditions is expected to rise from 1.9 million in 2008 to 2.9 million by 2018.⁴ Patients with chronic disease have complex and varied needs, often accessing services across a spectrum of care;
 - ii. Between 2011/12 and 2012/13 the number of emergency admissions increased by 1.8%; outpatient appointments by 3.9% and daycase episodes by 2.3% and this demand pattern further increased in 2013/14.⁵ Overall demand is predicted to rise to 7% per annum.⁶ This is coupled with an aging demographic where the number of patients over the age of 85 is expected to double by 2030,⁷ many of whom will have one or more chronic conditions.
 10. Establishing models and systems of care which meet the needs of individuals and communities is essential, and it is crucial for local leaders to determine what will work best for their locality. It is for provider organisations and their leadership, governance, structures and workforce to deliver the required transformational change.
 11. New models of care require new organisational responses. This Review provides options for providers of NHS care, together with support, to adopt the most appropriate organisational form for their clinical models.

The tightening financial climate

12. Since the inception of the NHS in 1948, health expenditure has increased by an average of 3.8% year on year in real terms.⁵ Government spending over the last four years has seen much lower growth, around 1% per year.⁵ In order to continue to meet demand within this budget, the NHS secondary care sector has been expected to achieve a 4% efficiency target year on year. The NHS has risen to this challenge and is becoming more productive, but rises in demand have started to outstrip the benefit of this increased efficiency.
13. Sustained financial constraint will continue for the foreseeable future. Many savings achieved in the previous years were non-recurrent and will not be of benefit in future years.⁵ A King's Fund report in 2014 suggested that a majority of providers are not confident they will achieve financial balance in 2015/16.⁸
14. The medium term outlook is equally challenging and NHS England have predicted that without reform and efficiency improvement by 2021 the NHS will have a funding shortfall in the region of £30 billion.⁹
15. The greater the financial challenge and uncertainty faced by organisations, the greater the risk to standards of clinical services. The reasons why some trusts are unable to achieve financial stability are

⁴ Department of Health (2012), Long Term Conditions Compendium of Information, 3rd Edition, May 2012

⁵ Nuffield Trust (2014), Into the Red; the state of the NHS Finances

⁶ Health Education England (2014), Framework 15; Health Education England Strategic Framework 2014-2029

⁷ Fairer Care Funding (2011), The report of the Commission on Funding of Care and Support

⁸ Appleby J, Thompson J, Jabbal J (2014b). *How is the health and social care system performing?* Quarterly Monitoring Report 11. London: The King's Fund

⁹ Monitor (2013), Closing the NHS funding gap: how to get better value healthcare for patients

many and varied. For most it is likely to be that the scale and scope of their service portfolio is unbalanced. This requires trust boards to make clear strategic choices and reach agreement with others on the need for wider system changes. For others, it will be a blend of leadership, cultural and workforce factors, with internal systems being misaligned and unable to meet the service and financial plans of the organisation.

16. The costs of supporting trusts that are persistently unable to demonstrate financial viability is considerable. In 2013/14, 31 NHS bodies were in receipt of interim revenue deficit support (9 Foundation Trusts and 22 NHS Trusts) totalling £509.5 million and 17 NHS bodies (6 Foundation Trusts and 11 NHS Trusts) were in receipt of interim capital deficit support totalling £95.3 million.¹⁰ This circa £600 million funding is spent on ensuring the continuity of services rather than improving patient care and quality standards.
17. Whilst recognising that from time to time it is appropriate to provide short term financial support to organisations whilst they manage change, the extent of long term support denies the NHS the use of resources that could be better utilised to improve care to patients.
18. The time is right for providers to examine their service portfolios, clinical models of care and be clear on the supporting organisational forms that are needed to ensure these are fit for the next five years and beyond to meet the changing needs and expectations of patients.

Increasing evidence of variation in care

19. The NHS has some of the best outcomes in healthcare, but there is also significant variation in outcomes and in both patient and staff experience. Whilst some variation in outcomes will relate to differences in the patients each organisation cares for and the types of treatment they provide, some variations in outcome – and almost all variation in patient and staff experience – will relate to the quality of care provision. This variation is increasingly being reported and should not stay hidden from the public. It should be an aim of our universal NHS that all parts of the service aspire to deliver the standards that the highest performing organisations are able to achieve.
20. The Keogh Review¹¹ and most recently the Care Quality Commission's State of Care report outlining the results of the Chief Inspector of Hospitals quality inspections,¹² has emphasised the unacceptable variation in care and the need for providers to tackle this in a more systematic way.
21. The NHS Safety Thermometer¹³ is a monthly survey of all patients in NHS care in any setting on one day. This data is used to provide information on the presence or absence of four harms – pressure ulcers, falls, urinary tract infections (UTIs) and new venous thromboembolisms (VTEs) – selected not only because they are common but also because there is clinical consensus that they are largely preventable through appropriate care.
22. Yet, for example, 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.¹⁴
23. Despite a sustained focus on infection control rates within the NHS, there still remains significant variation in the numbers of patients acquiring C-difficile infections. Over the 12 months to August 2014, the best performing trusts had an infection rate of 6.4 per 100,000 bed days with this increasing up to as many as 22.5 per 100,000 bed days for the worst performing trusts.¹⁵ This equates to almost 3,000 fewer patients acquiring C-difficile if all trusts worked to the best standards of care.

¹⁰ Department of Health (2014), Financial Assistance under section 40 of the National Health Service Act 2006: Report on the exercise of powers under subsection 40 of the National Health Services Act 2006 as amended by the Health and Social Care Act 2012; July 2014

¹¹ NHS England (2013), Review into the care and treatment provided by 14 hospital trusts in England: overview report

¹² Care Quality Commission (2014), State of health care and adult social care in England 2013/14

¹³ The NHS Safety Thermometer, <http://www.safetythermometer.nhs.uk/>

¹⁴ The extrapolated figure given here is based on NHS Safety Thermometer national data for September 2013 to August 2014.

¹⁵ Public Health England (2013/14), Monthly counts of trust apportioned Clostridium difficile (C. difficile) infections by NHS acute trust, <https://www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data-by-nhs-acute-trust>

24. When examining deaths in hospital, characteristics of the population served by the hospital must be taken into account. But even when factors such as age and type of illness are taken into account there is significant variation. For example, the best performing organisations on the Standardised Hospital Mortality Indicator (SHMI) showed 18% fewer deaths in hospital and at 30 days after discharge than would be expected. At the other end of the scale, the worst performing organisations show 16% more deaths than would be expected. This range of 34 percentage points between the best and worst performing organisations is concerning.
25. Over recent years it has become apparent that some organisations struggle to attract the right quality of clinical workforce, which has compounded the issues of clinical variation for trusts that are already challenged. The evidence shows that staff engagement has significant associations with patient satisfaction, patient mortality, infection rates as well as staff absenteeism and turnover.¹⁶
26. In all five of the NHS Trusts that the CQC has rated inadequate as of October 2014, more than 40% of staff said in the 2013 staff survey that the standard of care provided by the organisation would not be good enough for a friend or relative.¹⁷
27. In addition, recruitment of enough staff with the right skills to universally meet the seven day working requirements against predicted levels of future demand will prove an ongoing challenge for organisations.¹⁸ Trusts will need to think innovatively about how they redesign services and pool their workforce with neighbouring organisations in order to maintain clinical quality.
28. The recent inspections that the Care Quality Commission has started to undertake demonstrate that leadership and culture have a significant impact on other areas of quality. Its early findings show that being well-led correlates well with the overall rating of quality. As the CQC have stated, the variation they observe cannot be explained by money alone. In many cases money will be a factor, and in a few cases a critical one, but quality improvements can also drive productivity gains. There will be other drivers behind this level of variation, and these need to be fully explored and solutions implemented to ensure everyone gets the good quality care they deserve.¹⁹
29. This Review suggests that giving organisations greater flexibility in their clinical, service and organisational models and forms will support a reduction in the variation seen in standards of care.

Why focus on organisational form?

30. It is rightly stated that 'form follows function'. Organisational form should always be designed to support the delivery of models and standards of care, and should not be an end in itself. This Review encourages boards to consider fundamentally whether their existing form is best designed to deliver new models of care and ensure the delivery of required standards.
31. Organisational form and design are crucial for enabling organisations to deliver their goals and to create the circumstances in which to address the challenges they face. Changes to organisational form are likely to have an impact on the elements which influence the ability of organisations to improve and deliver services. These elements include:
 - i. leadership and culture;
 - ii. systems of governance;
 - iii. scale and scope of service offerings;

¹⁶ West and Dawson (2012), Employee engagement and NHS performance

¹⁷ Care Quality Commission (2014), The state of healthcare and adult social care in England 2013/14

¹⁸ Health Education England (2014), Framework 15; Health Education England Strategic Framework 2014-2029 seeks to start to address these challenges

¹⁹ Care Quality Commission (2014), The state of healthcare and adult social care in England 2013/14

- iv. systems/processes of service provision;
 - v. deployment of the workforce; and
 - vi. stakeholder relationships
32. The NHS Five Year Forward View, published in October 2014, outlined the collective system vision for the NHS. This outlined the *health and wellbeing gap*, the *care and quality gap*, the *funding and efficiency gap* and the transformation required to tackle all three.
 33. As organisations respond to the NHS Five Year Forward View they should review their current organisational form to ensure that they understand any changes required to deliver new models of care. In doing so it is expected that trust boards will gain a greater understanding of the organisational form which will be most appropriate to meet the needs of the populations they serve through a range of clinical models.
 34. The evidence of this Review has demonstrated that there are a range of different possible organisation forms with a range of associated benefits, but that barriers and confusion stand in the way of their wider adoption. This report makes recommendations for removing some of those barriers and to stimulate leaders to think across traditional organisational boundaries and the wider health system.
 35. In addition, this Review intends to encourage all organisations across the sector to think differently about how they might accelerate emerging innovative change, as well as focussing on challenged providers. The engagement and discussions undertaken for the Review generated significant enthusiasm from both inside and outside the sector, and a wealth of additional information was gathered at the events which informed the recommendations set out later in this report.

Findings

36. The Review has shown that whilst there is an appetite for change amongst leaders within the sector, support will be needed to navigate some of the identified ‘wicked problems’.²⁰ The sector must more quickly address its challenges, reduce variation in service standards and do so in more challenging financial circumstances. Those that have had success should be incentivised to support others to achieve clinical and financial sustainability across the whole sector, more quickly than would be possible by organisations working in isolation. There are, however, barriers preventing change from happening quickly and these must be addressed.
37. Throughout the Review there has been clear evidence of innovative practice, particularly in the mental health and community sectors, demonstrating the opportunity offered by strong relationships with a range of partners across the independent, voluntary, social care and social enterprise sectors. These opportunities should be more widely utilised by all types of provider.
38. Overall, the following five key themes have been identified:
 - i. **One size does not fit all** – the challenges faced by providers are often multi-factorial and derived from local geography, historical service changes and local demographics. System leaders understand their own population need and geographies, and therefore need to be enabled and supported to identify and implement the best clinical models for their patients. In doing so, they need to examine their current organisational form to determine whether or not an alternative form would deliver better outcomes for their populations.

²⁰ Grint, Keith (2008), *Wicked Problems and Clumsy solutions: The role of leadership*; originally published Clinical Leader Volume I Number II December 2008 – This defined a ‘wicked problem’ as one that is so complex it cannot be removed from its environment and solved and returned without affecting its environment. It shows no clear relationship between cause and effect and cites the NHS problems of an aging population and demand as an example of a ‘wicked problem’

- ii. **Quicker transformational and transactional change is required** – system leaders need to collectively own the transformation required across their local health economy. Historically transformation and transaction processes have been lengthy and protracted, particularly the early stages of planning and gaining consensus across the local health economy. Simplifying these processes will both accelerate opportunities for improvements in patient care and reduce the costs of transactions. The ‘rules’ also need to be explained and understood further, as perception of competition and legislative issues can cause organisations to become overly risk averse.
 - iii. **Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact** – transformational change requires strong and capable leadership. There are many successful NHS organisations and individual leaders with a track record of delivering consistently high quality healthcare to patients, but many have not thought beyond their current organisational boundaries. Leaders of successful organisations should become ‘system architects’, encouraged to use their entrepreneurial spirit to develop innovative organisational models and to codify and spread their success to other localities. Recognising these successful organisations, supporting them to develop enterprise strategies that expand their reach and developing new incentives will encourage more successful organisations to have a greater impact with less successful ones.
 - iv. **Overall sustainability for the provider sector is a priority** – there are currently 93 NHS Trusts. A proportion of these will become Foundation Trusts, but many will not reach the required standards in their current organisational form. Equally, there are some Foundation Trusts that would not meet the requisite standards for authorisation today and may be significantly challenged both clinically and financially. Long-term solutions need to be identified for these organisations, supported by appropriate governance models, to ensure that all patients can continue to access safe and reliable high quality care.
 - v. **A dedicated implementation programme is needed to make change happen** – In order to implement the ideas in this Report, two activities must occur in parallel: firstly, NHS leaders should be supported to develop awareness and knowledge of the available models and implementation approaches through a national programme of learning and sharing best practice; secondly, there should be a programme of demonstrator sites that can stimulate and accelerate change. This accelerated programme will support providers to test new organisational forms. Particular attention will be given to supporting successful organisations to develop entrepreneurial solutions to assure the delivery of reliable services in challenged health economies.
39. The evidence from the Review suggests that addressing these five key themes will accelerate the transformational change that is required to help overcome the challenges facing the NHS.
40. To ensure clarity of responsibility and accountability, each recommendation specifically identifies who should address its implementation.

Chapter One: Organisational Forms

One size does not fit all

A broader range of options is required

41. Organisational forms are different to legal entities.²¹ The same legal entity can accommodate more than one organisational form and providers should consider being as innovative as possible to develop delivery models which support improvements in the delivery of care. The Review found examples of organisations that had a number of different organisational forms already operating within their trust.
42. The work of the Review has demonstrated that effective use of different organisational forms can help to support the reliable delivery of high quality care. The Review has determined that the following factors are key:
 - i. no single organisational form is a panacea and there is no ‘one size fits all’;
 - ii. there should be local determination of care models, which should in turn drive local decisions on organisational forms. Central, top-down solutions should be avoided;
 - iii. multiple organisational forms can exist within a single legal entity;
 - iv. research²² has shown that different organisational models could help drive improvements in the quality of NHS services but emphasises the importance of execution in turning potential gains into real benefits; and,
 - v. boards should think differently about their own organisation and use their social entrepreneurialism to develop new ways of delivering care. Ambitious trust boards should consider the development of an Enterprise Strategy²³ to drive change within and beyond their organisational boundaries.
43. This Review considered seven different organisational forms,²⁴ which are categorised as collaboration, contractual or consolidation and are depicted in Figure 1 and outlined in more detail in the table below:

²¹ A legal entity has a generic framework of functions, duties, requirements and powers as set out in statute

²² The King’s Fund and Foundation Trust Network (2014), Future organisational models for the NHS: Perspectives for the Dalton review

²³ An Enterprise strategy is a plan for growth and development that utilises innovative and novel approaches to ultimately deliver increased value in healthcare provision. This strategy involves seeking out and capitalising on opportunities to deliver increased value to staff, patients and the public and deliver high quality care in a sustainable manner. It goes further than identifying standard opportunities that present themselves in a market but embodies a raised level of awareness of the external environment that is expressed through innovative and novel practices. These changes are capitalised upon and viewed as opportunities for increased operational efficiency and effectiveness through continuous improvement in cost and operating base

²⁴ For the purposes of this review, organisational models are defined as – the structures of governance, accountability and management that are created to achieve specific aims and objectives in delivering services

Organisational Form	Definition
Collaborative	Collaborative forms bring together two or more organisations voluntarily to pool their resources to achieve better outcomes for patients or for financial benefit, while retaining their original legal entity. Federation and joint venture are examples.
Federation	Several organisations come together to collaborate to deliver one or more type of service or back office provision. Each organisation retains its sovereignty and there does not need to be a legal agreement. However, it is best practice for one trust or other body to be the nominated lead for governance, quality and finance, set out in a Memorandum of Understanding (MoU) or equivalent.
Joint Venture	Two or more organisations pool their sovereignty in either a corporate arrangement to create a new legal entity to manage a particular service line; or in a contractual arrangement to create a shared services agreement with another organisation. In contractual arrangements one trust takes the lead responsibility for governance, quality, performance and finance reporting.
Contractual	Contractual forms have more formalised agreements and there are often performance and quality standards agreed as part of the arrangement. Service level chains and management contracts are examples.
Service Level Chain	One provider provides services for other providers. There are several ways that this could be contracted, such as the host provider outsourcing services to the service level provider, a service level agreement where the host organisation holds the service level provider accountable for delivery, or paying a fee to use the policies and protocols of the first provider.
Management contract	Some or all management control of the operations of an organisation is awarded to another organisation to manage for an agreed duration.
Consolidation	Consolidation forms are when a change of ownership occurs and organisations come together to form a new organisation potentially delivering different services than previously. Mergers and acquisitions, integrated care organisations (which can also be contractual) and Foundation Group are examples.
Integrated Care Organisation	Brings together some or all of the acute, community, primary care, social care and mental health services in a variety of forms. The organisation manages patients from a particular population across defined care pathways supported by shared data, IT and information systems. ²⁵
Multi-site trust	Two or more organisations are brought together to become one organisation through merger; all the relevant organisations would dissolve and a new organisation would be formed. Alternatively, one organisation may acquire the other one, which dissolves and becomes part of the acquiring organisation.
Multi-service chain or Foundation-Group	This model is distinct to a large merged organisation as it has a separate 'group' Headquarters that sets the governance, standards, protocols and procedures, often with centralised procurement and back office functions. Each site is managed on behalf of the group by a management team that have delegated decision-making within the parameters set by the HQ board.

²⁵ Integrated care models can also be supported through contractual arrangements such as an overarching contract with a prime contractor or an alliance contract that binds together a number of separate organisations. A new organisational form is not the only route. Further details can be found in the supporting evidence pack

Other models

44. There are other models that providers of NHS care may wish to consider:
- i. **Buddying** – introduced into the NHS as a result of the Keogh Review and the subsequent Special Measures regime. The Review commissioned an evaluation of the experience of the ‘buddying’ model,²⁶ which concluded that the concept of buddying has been generally well received by organisations in ‘special measures’, albeit with some exceptions. It recommended that any provider, not just those in ‘special measures’, can benefit from the two-way learning and improvement such relationships can offer;
 - ii. **Informal partnering** – providers should be encouraged to develop partnering arrangements to promote organisational learning and improvement. This report refers to this as informal partnering, which is considered to be an ongoing, voluntary process that organisations could enter into at any time.
 - iii. **Clinical and strategic networks** – clinical networks have been used by clinicians as a mechanism to develop best practice for a significant time in the NHS. In November 2012, NHS England (then the NHS Commissioning Board) set out its vision for a single operating model for Strategic Clinical Networks that would sit alongside Clinical Senates and focus on further improving patient outcomes in the areas of cancer, heart disease and other significant areas such as maternity, paediatrics, mental health, dementia and neurological conditions.²⁷
 - iv. **Mutual or social enterprise** – during the course of the Review, the King’s Fund report into staff engagement²⁸ and the benefit of the mutual²⁹ model was launched alongside a joint Cabinet Office and Department of Health programme of support;³⁰ Mutuals in Health: Pathfinder Programme research project into the benefits and barriers of mutual model in acute hospitals will be running in early 2015. This model was examined as part of this Review and was considered to be an ownership/governance model and as such could be applied to all of the different organisational forms described in this report.

Outline of each organisational form

45. More detail on each of the organisational forms considered by the Review is described below. The diagram outlines the different types of organisational form from collaboration through to consolidation and the relative benefits in terms of efficiency gains which they may offer.
46. The descriptions identify a set of circumstances for which each form may best be considered; associated benefits; potential pitfalls to avoid; and case studies outlining how they have been used by different providers to deliver high quality care for patients. Further detail on the organisational models can be found in the supporting evidence pack.

²⁶ Foundation Trust Network (2014), Review of buddying arrangements, with a focus on trusts in special measures and their partnering organisations

²⁷ NHS Commissioning Board (2012), Strategic Clinical Networks: Single Operating Framework

²⁸ The King’s Fund (2014), Improving NHS care by engaging staff and devolving decision-making – <http://www.kingsfund.org.uk/publications/articles/improving-nhs-care-engaging-staff-and-devolving-decision-making>

²⁹ Social enterprise, community interest company, employee-owned company, mutual are all terms used interchangeably. However, in this context ‘mutual’ is the formal term applied to the programme supported by the Cabinet Office and the Department of Health

³⁰ Mutuals in Health: Pathfinder Programme – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/343507/Letter_to_Foundation_Trusts_and_NHS_Trusts.pdf

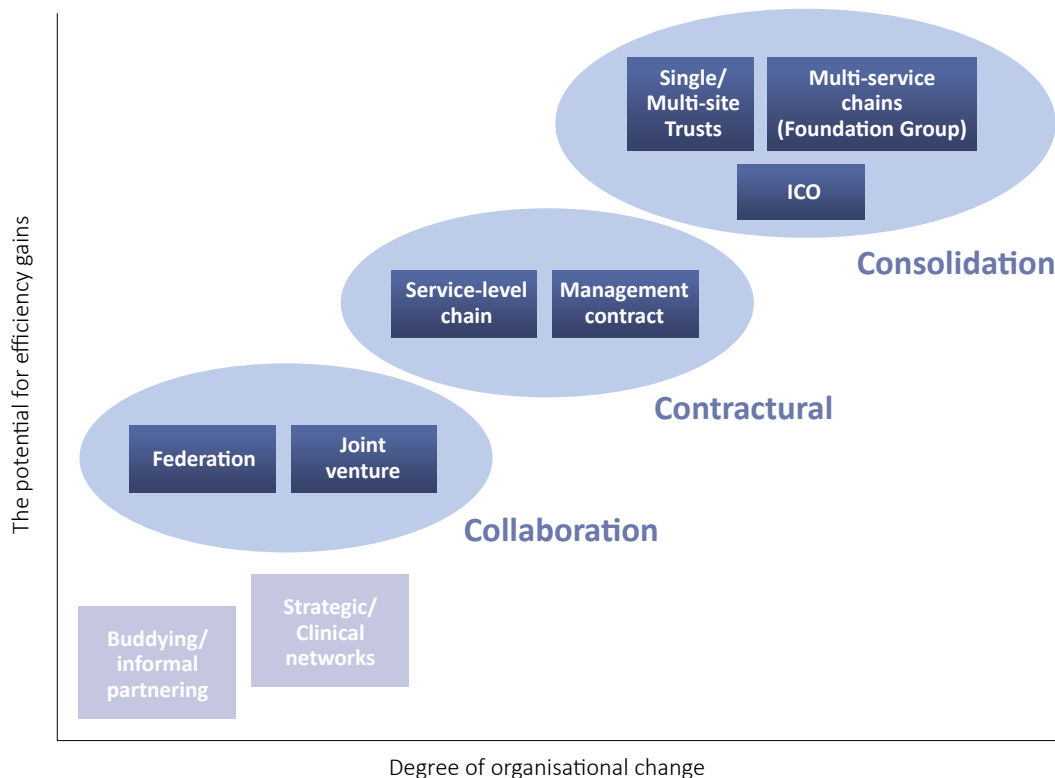
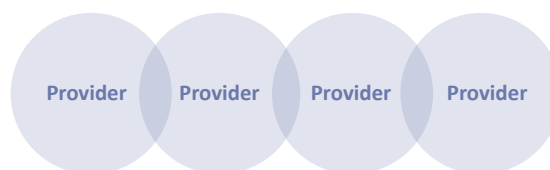


Figure 1: Different organisational forms and their potential ability to release efficiency gains³¹

Collaboration

Federation



47. A federation is when two or more providers agree to share resources for mutual benefit; they can be used to share support services, knowledge and expertise and even clinical resources between more than one provider. Each organisation retains its sovereignty and there does not need to be a legal agreement, but one trust or body would be the nominated lead for governance, quality and finance as reflected in a Memorandum of Understanding or equivalent.
48. A federation could be used to share best practice and quality improvement resources and to align patient pathways to improve patient outcomes and operational efficiency. An example of this is UCL Partners' work on the stroke pathway, as outlined in the case study below. Federation members in different parts of the country could share resources through technology, for example using a video-based clinical consultation platform to allow senior clinical staff to undertake outpatient and follow-up appointments across different sites without travelling. NHS providers in a federation may be able to access resources that are not available to all of them individually and to share the costs of existing resources.

³¹ Adapted from: Pearson, Jonathan (2011), "Options for healthcare group working", GE Healthcare Finnamore, – <http://www.gehealthcarefinnamore.com/insight/thought-leadership/10-thought-leadership/240-29-options-for-healthcare-group-working.html>

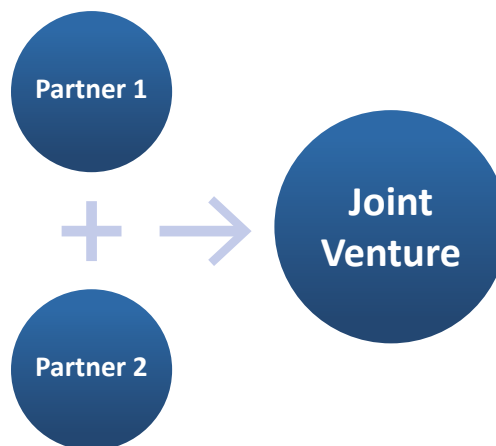
49. Two of the most important questions that a prospective federation must answer are:
- i. What is the precise situation that the federation is looking to address?
 - ii. Do all parties in the federation have complementary objectives and share a view of the nature and scope of its activities?
50. It is important to answer these and the further questions outlined in the supporting evidence packs, as without legal contracts enshrining the agreement, the success of a federation depends on the strength of the relationships between its provider members. These relationships must be able to endure the changes the federation is looking to execute.

Case study: UCL Partners

UCL Partners is an academic health science partnership containing over 40 higher education and NHS members, with a central team providing operational support and clinical academic leadership through a not-for-profit company. Together, its member organisations form one of the world's leading centres of medical discovery, healthcare innovation and education. By working together, UCLPartners' members are able to implement improvements in healthcare at a greater scale and pace to the benefit of their combined population of six million people.

UCL Partners have used their federated model to deliver commissioner's requirements to improve stroke care. This led to the consolidation of the treatment of all early-phase acute stroke patients in London into eight specialised centres. As a result of this consolidation, according to research funded by NHS London, over 400 lives have been saved since 2010.

Joint venture



51. A joint venture involves two or more providers of any sector creating a new legal entity to provide a particular service on their behalf. This can also be undertaken without forming a new legal entity if one provider takes responsibility for governance, quality, performance and finance reporting, which is known as a shared services agreement. Where a new legal entity is formed, the member organisations can agree a risk-share which allows each individual partner to gain from any surplus which could then be reinvested back into their core services. This is done via a special purpose vehicle.³²
52. This is a more formal version of the federation model, which when used effectively can drive efficiencies through greater patient flows, efficient use of staff and standardisation of approaches to procurement and clinical protocols, thereby improving patient outcomes across a wider geographical footprint.

³² A special purpose vehicle is a legal entity established to carry out narrow, specific or temporary objectives, which, in NHS terms typically pertains to a specialism or single task

53. Notably, joint ventures can offer a solution to organisations in geographic proximity that are unable in isolation to consistently meet the demanding service standards for emergency surgery and acute medicine across seven days. Creating a single shared service enables consolidation of workforce in designated specialities or services across organisations, allowing workforce planners to pool staff rotas across multiple sites.
54. One of the impediments to organisations pursuing service change, including consolidation of services, is that the leaders of organisations may consider that any consolidation results in the ‘loss’ of the service from their site and a corresponding ‘gain’ to another organisation who may receive that service on their site. The creation of a joint venture or single shared service means that affected organisations jointly own and govern the designated service(s) and are able to share in the benefits of economies of scale and scope of services, wherever they are provided. This can help overcome current objections, when trust boards are more or less enthusiastic about the need for change based on a judgement as to whether they will ‘win’ or ‘lose’ a service.
55. There are several joint ventures in place in the NHS. This organisational form has primarily been deployed where critical mass enables the more effective delivery of clinical standards or performance targets, such as in elective orthopaedics or as a result of the Carter pathology review³³ which recommended the development of larger pathology hubs. Despite demonstrated benefits, the model has not been adopted as widely as potentially it could, in part due to the lack of understanding competition rules, legislation and approval processes being perceived as barriers by organisations interested in forming joint ventures.
56. Questions that organisations that are considering joint venture more closely should consider are:
 - i. Will Monitor need to approve? Dependent upon the size of the income and the associated risk and if the organisation is a Foundation Trust then Monitor may need to approve. The guide is that any transactions, including joint ventures, worth more than 10% of the trust’s assets, revenue or capital³⁴ will need to be reported to Monitor.
 - ii. What are the processes for sharing the surplus or managing the risk of deficit within the new entity across the partner organisations?
 - iii. What impact will the joint venture have on staff? Who will employ and manage the staff and has TUPE³⁵ advice been sought?

Case study: South-West London Elective Orthopaedic Centre

Initially established in 2004 as an NHS treatment centre, The Elective Orthopaedic Centre (EOC) is a contractual joint venture between four NHS trusts in Southwest London to deliver strategic change in the delivery of planned orthopaedic care. The venture is hosted by Epsom & St. Helier University Hospitals NHS Trust, with its partners – St George’s Healthcare NHS Trust, Kingston University Hospital NHS FT, and Croydon Healthcare NHS Trust – all in a contiguous geographical area.

Some of the outstanding features of the EOC have been enabled by its status as a joint venture, which, crucially, has separated the activity of the centre from that of its member trusts, allowing them to plan care strategically and without disruption from other services. Major benefits of this separation have been the ability to standardise patient care pathways, pool clinical excellence and make sizeable savings on procurement.

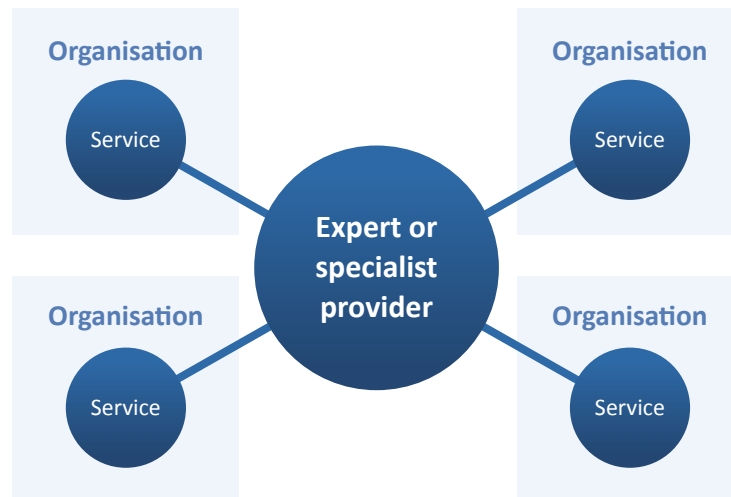
³³ Carter Review, 2008, http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Pathology/DH_075531

³⁴ Licence holders must report to Monitor any planned UK healthcare investments or other transactions worth more than 10% of their assets, revenue or capital. Monitor will then undertake a risk assessment proportionate to the impact on the continuity of services and the risk involved. Further information is contained in Monitor’s Risk Assessment Framework Guidance, August 2013, with particular reference within Appendix C as updated in April 2014. Also refer to the July 2014 CMA guidance on NHS mergers available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339767/Healthcare_Long_Guidance.pdf

³⁵ Transfer of Undertaking of Protected Employment, applies when 75% of the new role is the same as the role the employee is currently undertaking

Contractual

Service-level chain



57. One provider delivers a service or specialty from premises owned by another provider. This has been previously termed the 'at' or @ model and could be considered as a host provider 'outsourcing' their activity.
58. There are three main ways that this model could be contracted:
 - i. service delivery and accountability is wholly outsourced to the service level provider;
 - ii. service delivery is provided by the service level chain, which is held accountable for performance by the host provider; or,
 - iii. service delivery remains with the host provider using policies and protocols of the service level provider.
59. This organisational form is often deployed when trusts recognise that they are unable to provide the service to the required quality standards themselves. Outsourcing particular services to a service-level chain provides access to different expertise, new technology and helps resolve gaps in clinical workforce, accesses new technology. This allows the host provider to focus on delivering a smaller set of core services while providing greater patient benefit through the wider service offer for which it retains overall responsibility.
60. This is an important organisational form for developing the 'brand' of a provider organisation as well as expanding the scope and scale of the services to deliver greater economies of scale. It therefore requires the provider organisation to have the necessary capability and capacity to run services in distant sites that are not within its direct line of sight on a day-to-day basis.
61. This form has seen success, for example in ophthalmology services and cancer services, where organisations recognise that they are unable on their own to keep pace with the technological advancements in treatments. This organisational form drives a greater degree of standardisation as it is predicated on the provider organisation's ability to develop a replicable standardised operating model including protocols and pathways. Agreements need to be established between providers for arrangements when patients move across into other services, such as critical care, which require clear clinical governance and risk policies. This form therefore appears best suited to relatively self-contained specialities such as ophthalmology and cancer care, but has the potential to be widened to other specialities.

62. Questions that an organisation considering developing a service-level chain model should consider are:
- i. Who will be accountable for providing the services or speciality?
 - ii. Have a set of replicable, standardised operating protocols and procedures been developed that can be easily transferred to another organisation?
 - iii. What type of contractual arrangement will govern the service i.e. wholly outsourced, service-level agreement or provision of training on protocols and procedures?
63. It is important that the nature of the service arrangement is clear at the outset to ensure clinical governance, data gathering, performance reporting and quality inspections are undertaken correctly.

Case study: Moorfields Eye Hospital

Moorfields Eye Hospital is the largest provider of ophthalmology services in England, providing more than 33,000 episodes of inpatient treatment and more than 470,000 outpatient appointments each year. It operates a networked model of care across 23 locations in and around London. Apart from the hospital in central London, these locations are grouped into four distinct categories in discrete geographical clusters: District Hubs, such as Moorfields Eye Centre at Ealing, co-located with general hospital services; Local Surgical Centres; Community-based Outpatient Clinics, offering predominantly outpatient and diagnostic services; and Partnerships and Networks, where Moorfields offers medical and professional support to eye services managed by other organisations.

Approximately 50% of their total activity is delivered away from the central London hospital.

Management contracts



64. A management contract is the delegation of the management of whole or part of an organisation to a different organisation for a time-specified period. Management contracts can be let for single services, sites or whole organisations. These are particularly effective where there is poor clinical or financial performance which is not structural and can be transformed with a change of management and leadership. This is an asset-light way to allow alternative providers to deliver services to a population and provides access to expertise through the transfer of the operating model of the contractor.
65. Although the current example in the NHS is an independent sector provider, existing freedoms allow Foundation Trusts and NHS Trusts to enter into management contracts to manage operations or services on behalf of another NHS body.
66. NHS Trusts can be operated under management contract as at Hinchingsbrooke Health Care NHS Trust, and it is possible for Foundation Trusts to be operated under management contract voluntarily, or if

required by Monitor where there are compliance issues. There are, however, some limits on the types of arrangements that can be put in place for Foundation Trusts given the different statutory framework and accountability structures in place; the extent of delegation and the responsibilities of all parties should be carefully considered in these instances.

67. Standardised practices could be brought across wholesale from the organisation that is managing the contract. This allows the sharing of back office functions to a greater degree including procurement practices and operational and clinical policies and procedures. The assimilation of the standard operating model of the organisation managing the NHS body is key to how quickly service standards may be improved or efficiencies can be derived.
68. There are several ways in which a management contract might be considered:
 - i. in a situation where Monitor³⁶ or the NHS Trust Development Authority (TDA) deems that the leadership of the challenged organisation is the main issue, then it has powers to remove some or part of the trust board and contract out the management to another provider for a fixed period. This will support the TDA or Monitor to determine the future model that will ensure the clinical and financial sustainability of the organisation;
 - ii. to widen the opportunity to gain management expertise with particular skill sets, such as turnaround or clinical service reconfiguration;
 - iii. if there are particular issues such as asset management that require property management expertise, the separation of operations and property into an 'opco'/'propco' model could ensure the relevant skills are applied to the issues;
 - iv. as a first step towards a greater degree of consolidation, with reduced initial risk falling on the acquiring or lead Foundation Trust;
 - v. to enable Foundation Trusts to test the Foundation Group model, without the risks associated with a full acquisition. This could help to build the skills and expertise required to run a Foundation Group model or chain; and,
 - vi. these can take less time than a full acquisition and therefore could accelerate the turnaround of the organisation resulting in benefits to patients much more quickly.
69. Management contracts cannot be used to address underlying structural issues and should not be used as such.
70. Commissioners would performance manage the contract and would allow penalty clauses and break clauses to be added. This would give commissioners more confidence in supporting the service reconfiguration and change of management as there would be an exit strategy, which is far more difficult in a full acquisition.
71. NHS Trusts that enter into a management contract for a significant contract duration are still classed as NHS Trusts, and this poses a challenge under the current policy direction. There is provision in the legislation for these organisations to remain an NHS Trust at the end of the contract.³⁷ However, Monitor should give consideration to how it could authorise NHS Trusts as Foundation Trusts whilst under a management contract.
72. Questions that organisations interested in taking over the management control of an NHS body through a management contract route should consider are:

³⁶ In the case of a Foundation Trust this has to be triggered by quality concerns raised by the CQC and/or a breach or likelihood to breach a licence condition.

³⁷ Under s179(3) of the 2012 Act an NHS Trust may exist in this form when under management contract, and for three years following the contract end date, even after the repeal of the NHS trust legislation.

- i. Is there a clearly articulated operating model which is codified and replicable in another organisation?
- ii. Are all parties clear on the service and back office changes required and the level support for this both internal to and external to the organisation?
- iii. Is sufficient management capacity available to take on the management of another organisation without risking a detrimental effect on your own organisation?

Case study: Ribera Salud Grupo

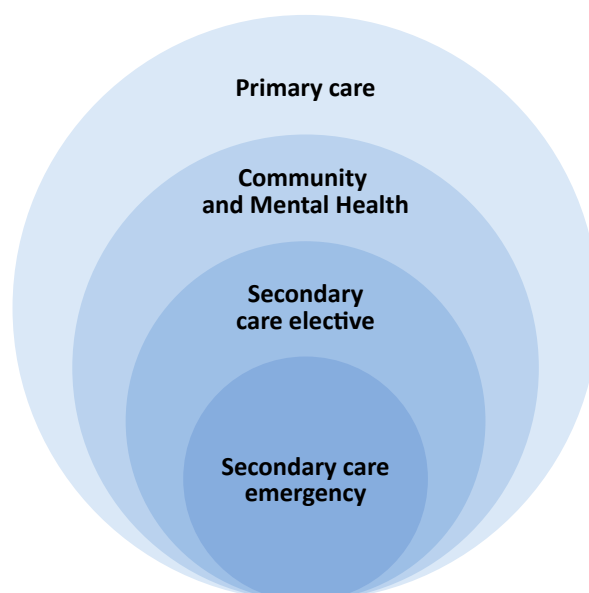
Ribera Salud Grupo was established in 1997 to design, build and operate a new hospital in La Ribera, Valencia Community, under a public-private partnership (PPP).

The Ribera hospital was the first privately run public hospital in Spain, and it expanded into primary health services shortly afterwards. The model has since expanded across Valencia and in other regions, with 4% of Spain's and 20% of Valencia's population now treated under these models. Ribera Salud operates the concession under contract with the government, which holds them to account, through a commissioner, for quality standards and outcomes. Ribera Salud assumes the risk for demand and outcomes over the duration of the contract.

They have a strong focus on decreasing clinical variability, with performance metrics intensively monitored and variation addressed. In addition, their capitated funding model and a 'money follows the patient' approach allows for defined public expenditure while encouraging quality and efficiency from the provider.

Consolidation

Integrated Care Organisation



73. Integrated care can be delivered through a formal or virtual vertically integrated model. The virtual model can be supported by alliance contracts across providers, or a prime contractor model whereby the commissioner enters into a contract with one organisation and that organisation sub-contracts with other providers to deliver care along the pathway. This organisational form is a type of the Primary and Acute Care System as set out in the NHS Five Year Forward View and offers providers the opportunity to 'dissolve

traditional boundaries³⁸ and deliver innovative care models for their population. More information on the different contracting types can be found in the supporting evidence pack to this report.

74. The formal integrated care organisation³⁹ involves the vertical integration of one or more providers across a spectrum of care that could include primary, secondary (acute and mental health), community and social care. These are population based and deliver services to a defined cohort of patients with the aim of improving their outcomes, particularly for long-term conditions, by managing the coordination of their care. As set out in the NHS Five Year Forward View, this could include the new option of the Multispecialty Community Provider organisations which could take on the running of the main district general hospital, community hospital or have delegated budgetary responsibility for their registered patients.
75. This organisational form could potentially realise benefit for either whole local health economies or for a relatively large and well-defined group of high-intensity patients such as frail older people. There are a variety of organisations that could be included in an integrated care organisation and therefore this needs to be carefully developed based on the needs of the local population. Further information on the options for these models are set out in more detail in the supporting evidence pack including a cross reference to the NHS Five Year Forward View.
76. This organisational form can be either primary care or secondary care led. Where it is secondary care led it allows hospitals to operate in new areas of out of hospital care and to balance an investment in community-based services with a divestment in hospital-based care, without undue financial risk to the organisation. This is considered to provide an attractive model for secondary care providers, who might otherwise resist a transfer of resources from their organisation.
77. There are a variety of methods that commissioners can use to contract with integrated care organisations. Clarity on commissioner intentions over the medium term, particularly regarding the future tendering of community and mental health service contracts, is critical to the development of an effective integrated care organisation. Commissioners working with emergent or existing integrated provider models should make decisions to tender as appropriate to the care models they wish to deliver in their five year commissioning plans, in line with the Procurement, Patient Choice and Competition Regulations. This model may work best for providers whose commissioners are seeking to move towards a capitation or outcome-based commissioning model over longer contract duration.
78. Integration will usually require investment in integrated data systems to account for patient activity in each element of the integrated service, and the return on this investment may take several years. Integration should primarily be considered for improving outcomes and patient experience over the medium to long term; it does not provide a quick route to cost saving and may require significant technical detail to be worked through. This organisational form is a good example of where getting the clinical model right first should lead to organisational form later.
79. Questions that organisations considering collaborating to start to develop an integrated care organisations should consider are:
 - i. Is there sufficient data available on your population? Is it possible to stratify their needs in order to determine the relevant care pathways and clinical models that need to be developed?
 - ii. Is there a strategy or system for aligning IT and information systems?
 - iii. What type of contracting arrangement will underpin the ICO?

³⁸ NHS Five Year Forward View, October 2014

³⁹ It is noted that this report uses the term integrated care organisation to represent the organisational form only. The payment mechanism such as capitated budget associated with Accountable Care Organisations is not considered as part of this report

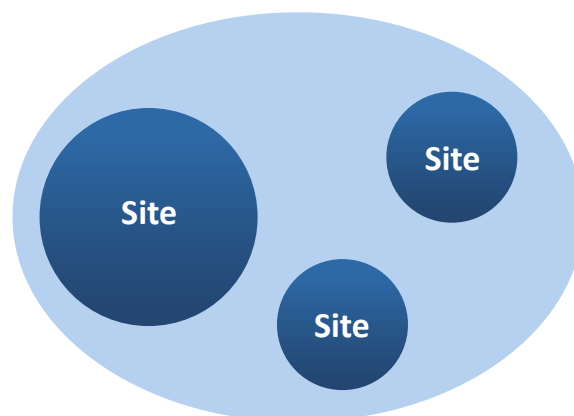
Case study: Integrated Care in Lambeth

The Lambeth Living Well Collective (LWC) brings together a number of mental health providers including the voluntary sector and South London and Maudsley (SLaM) NHS Foundation Trust, social care, public health, primary care as well as service users and commissioners.

Building on these existing strong relationships between providers and commissioners, the LWC decided to develop an integrated model through an alliance contract across a wide range of providers in the system, initially with a small group before expanding to bring in a wider spectrum of care. The alliance contract approach allows the providers and commissioners to build on the local collaborative approach, recognise all providers' contributions, reduce the risk of a dominant provider and to ensure that any changes are led by outcomes.

The CCG and local authority will co-commission the alliance contract, based around outcomes developed by the LWC. As well as delivering better outcomes and experience for patients, the contracting approach is expected to deliver shared savings across the system.

Multi-site Trust



80. A multi-site trust is the most common organisational form for larger organisations in the NHS. This is where, through a series of transactions, mostly contiguous, one provider owns and operates a number of hospital facilities in close geographical proximity.
81. There are infrastructure, clinical, and corporate synergies that can be realised through the merger or acquisition of neighbouring or nearby organisations. Due to this being most widely used within close geographical boundaries, competition regulations will need to be considered as part of any transaction. The patient benefit case that underpins a transaction of this type will need to be carefully considered and thought through. Monitor and the Competition and Markets Authority (CMA) have recently issued new guidance to support organisations interested in undertaking a transaction.⁴⁰
82. As this model involves full change of management control to the acquiring organisation or the newly formed trust board of the merged organisation, there are considerable opportunities to standardise practices. Evidence from the European models was that a focus in the first instance on back office functions such as IT, transactional HR, finance, payroll etc. produces efficiencies that can then be applied to future acquisitions with greater benefit.

⁴⁰ Monitor and Competition and Markets Authority (2014), Supporting NHS providers considering transactions and mergers, <https://www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers>

83. Questions that organisations interested in merger or acquisition should consider are:
- i. Does this acquisition or merger align with strategic aims?
 - ii. Is there a suitable governance and accountability structure to incorporate a new site?
 - iii. Is there a clear transition plan to integrate the organisation quickly, post-transaction, paying particular attention to cultural aspects?
 - iv. Are staff going to be affected? Has TUPE advice been sought?
 - v. Has the patient benefit case been clearly articulated?

Case study: Royal Free London NHS FT's acquisition of Barnet and Chase Farm Hospitals

In July 2014, Royal Free London NHS FT acquired Barnet and Chase Farm Hospitals, moving from a single site trust to a multi-site trust with three separate sites. Barnet and Chase Farm Hospitals was struggling financially and judged to be unable to achieve Foundation Trust status on its own. Several hospitals in the vicinity were considered as merger partners in a process of options appraisal, with Royal Free London NHS FT identified as the most suitable partner.

It is too soon to judge the success of the merger, but there are clear realisable benefits for both organisations resulting from the organisational change. All three sites will be able to achieve efficiency savings and realise greater economies of scope, as well as exchange clinical expertise so as to most appropriately configure provision and optimise services for the benefit of patients.

Multi-service chain (Foundation Group)



84. A multi-service chain or Foundation Group is a model in which one provider owns and operates a number of separate subsidiaries across a large, dispersed geographical area. Chains have separate group headquarters (HQ), which set standards, protocols and procedures with centralised management and procurement functions. All sites in the chain are managed on behalf of the group by a management team that have delegated decision-making responsibilities within the parameters set by the HQ board. Organisations in a Group structure often have a Growth and Development strategy⁴¹ that underpins their approach to the development of the Group.
85. There are several ways that a Foundation Group structure could be formed:
- i. acquisition by the organisation of another single organisation;
 - ii. simultaneous multiple acquisitions by the provider of more than one organisation; or,
 - iii. the merger of two or more organisations to create a new large group organisation (this would require all legal entities to be dissolved and a new single organisation, with a new name, to be created).

⁴¹ A growth and development strategy sets out the strategic aims of the organisation and how it intends to derive greater value for the organisation as a whole through increasing in size either through commercial success through the winning of more business or to increase in size through acquisitions either particular service lines or specialities or at the scale of whole organisation. This Report also refers to this as an Enterprise Strategy.

If at least one NHS FT is merging with any number of other FTs or NHS Trusts to create a group, authorisation by Monitor is required.

86. It is possible for Foundation Trusts to adopt a Group structure (Foundation Group) within the current legislative framework. The key requirement is to ensure that the local populations served by all of the different subsidiaries (or individual sites) are represented on the trust headquarters' Council of Governors. Accordingly, Foundation Trusts considering adopting a group structure should consider whether their governance structures are fit for purpose, and make any necessary adjustments to ensure appropriate representation and accountability in all their sites including changes to their constitution. NHS Trusts could merge to form a Group structure but this would need to be able to demonstrate the requisite clinical and financial standards to be authorised as a Foundation Trust Group in order for this to be supported by the TDA and Monitor.
87. As with the multi-site trust, this structure gives the greatest opportunity for organisations to improve service standards and derive efficiencies through standardisation. The evidence of this Review found that European models have successfully created benefits through efficiencies from procurement, back office and clinical pathways – and that this has been through both contiguous and non-contiguous organisations being acquired by the Group and brought into its standard operating model.
88. The Review commissioned research by the Nuffield Trust⁴² to understand the difference between a group structure and a large merged organisation. This highlighted that the skill set of the leadership of a chain or group structure is very different to that of a large, merged single organisation. It requires a separation of strategic management (at HQ level) from operational management (at each managed entity) and the creation of a standardised operating model, with standard policies and protocols. The trust board at the HQ level would need to be detached from being the trust board of the primary organisation so that the latter would become one of the operating entities and so that the HQ trust board could give equal consideration to all of the subsidiaries.
89. Foundation Group structures can contain a blend of acute, mental health and community services. As long as the patient benefit case and the business cases are comprehensive there should be no barrier to a mental health trust acquiring an acute trust (or vice versa) in this way. The patient benefit and efficiencies to be gained may require greater consideration if there are not clinical synergies to be derived.
90. Lessons from the Academy schools model suggest that some academy chains grew too big, too quickly, stretching managerial capacity and exposing the whole chain to risk. Schools are much smaller entities than hospitals, as organisations should consider this carefully when considering their Growth and Development (Enterprise) Strategy.
91. Questions that organisations that are considering developing the Foundation Group should answer are:
 - i. Does the acquisition of this organisation support the realisation of strategic aims? Does this meet the aims set out in the Growth and Development Strategy?
 - ii. Is there a clearly articulated and codified standard operating model that can be transferred to the new entity?
 - iii. Is there sufficient management capacity to undertake the necessary transition and transformation of the acquired organisation?

⁴² Nuffield Trust (2014), Provider chains: lessons from other sectors. A report for the Dalton Review into new options for providers of NHS care

Case study: AMEOS German Hospital Group

AMEOS is one of the major hospital groups in the German speaking world with 68 facilities across Germany and Austria. Although the organisation is for-profit it undertakes a significant proportion of publically funded health provision on the same terms as the public healthcare.

AMEOS's management structure is a key enabling factor in being able to operate very successfully over such a large geographical area. Their headquarters is in Zurich with four regional offices all of which mirror the structure of the central office – providing support hubs for the facilities in each region.

The group's business model is to identify and acquire failing hospitals and invest in their facilities and services to provide long-term value. Conducting procurement exercises centrally in Zurich enables the organisation to save up to 20% on procurement when new sites are taken over. This, combined with the implementation of group methodologies, means they are able to assimilate and turn-around failing sites, effecting collective processes and standards to realise efficiencies.

Considerations

92. The evidence gathering, research and advice from the Review have demonstrated that all of these organisational forms are possible within the current legislative and regulatory framework.
93. During the Review, five countries were visited and case studies from nine different hospital groups examined. Learning from these international visits has consistently demonstrated that the benefits driven through the group structure are based on the ability to drive standardisation and include:
 - i. standardisation of back office processes;
 - ii. collective procurement strategies which enable large savings to be made through reduction in the number of product lines and greater guaranteed volumes, particularly when adding new sites to the group;
 - iii. consolidation of clinical support services;
 - iv. standardised clinical protocols and clinical pathways agreed across the network of clinicians in the group, enabling reliable delivery of service standards and improved outcomes;
 - v. standardised approach to improvement methodology;
 - vi. standardised approach to the adoption and spread of innovation, particularly for new technologies and devices; and,
 - vii. group culture and values reinforced and supported across all of the subsidiaries.
94. Trust boards should consider the relevant benefits of standardisation that each of the organisational forms can deliver. This will require trust boards to consider acting outside their existing boundaries in either of the three types of organisational form *collaborative*, *contractual* or *consolidation*.
95. For trusts that are seeking to ensure they are able to continue to meet quality standards reliably over seven days and make best use of their clinical workforce, particular attention should be paid to the collaborative models.
96. Boards of NHS Trusts considering their sustainability plans should consider whether the existing scale and scope of their service portfolio enable them to meet required quality and financial standards; and if not, whether alternative organisation forms could better support the clinical models required.

97. When working with other providers to develop innovative solutions, trust boards should be clear that the changes are for the benefit of patients. When such arrangements would significantly harm choice and competition, such that there might otherwise be an adverse impact on patients, trust boards should be clear that the expected benefits outweigh these potential adverse effects. Working in this way will help ensure solutions work well for patients and therefore comply with the competition rules.
98. Exploratory work is currently underway through the Mutuals in Health: Pathfinder Programme to determine how trusts could adopt alternative governance forms such as social enterprises or community interest companies. These forms can be licensed and regulated by Monitor under their current powers. This flexibility opens up opportunity for existing NHS Trusts to think differently about their future. Monitor should identify how they would license those NHS Trusts that may become a new legal form, ensuring that requisite standards for Foundation Trust status are applied.
99. Organisations should consider developing an Enterprise Strategy that responds to the commissioning intentions and other external factors to identify novel and innovative approaches for transformational change. Leaders of successful organisations should consider how to grow and develop their organisations, using an appropriate organisational form as the vehicle to enable this.

Recommendation to trust boards

As part of the 2015/16 business planning process, trust boards should consider their response to the NHS Five Year Forward View and determine the scale and scope of their service portfolios. They should consider whether a new organisational form may be most suited to support the delivery of safe, reliable, high quality and economically viable services for their populations.

Recommendation to trust boards

Trust boards of successful and ambitious organisations should develop an enterprise strategy and should consider developing a standard operating model that could be transferred to another organisation or wider system.

Chapter Two: Making change easier and quicker

Quicker transformational and transactional change is required

100. The previous section of the report set out the various options open to providers of NHS care in considering how they might do things differently. This section focuses on providers they might be enabled to adopt these models, particularly for those delivered through transactions, addressing key areas such as gaining agreement, speeding up the process and supporting organisations to deliver transformation.

Speeding up the transformation of local health economies

101. It is very difficult to create the right organisational form to deliver sustainable services if there is uncertainty over the future care or service model. Commissioners – along with the wider system and with political support – will need to work with providers and engage with patients to determine sustainable service models, supporting providers to develop the organisational forms which can deliver those models. It is imperative that local commissioners and other local health partners commit to the models of care they co-design to best meet local need.
102. The NHS Five Year Forward View outlined a range of care models and approaches that commissioners and providers should seriously consider as part of their five-year strategic planning. Commissioners will need to work closely with providers to understand how these care models could be delivered across their respective health economies and, along with NHS England, consider how best to collectively meet the costs of transformative change which may include providers adopting an alternative organisational form. All parties should act on the commitment in the NHS Five Year Forward View that “we will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together”.⁴³
103. Where commissioners agree plans for service transformation, they are responsible for ensuring that there is sufficient funding to achieve these plans. In limited cases where entrenched challenges mean that a solution within the current resource is not possible, consideration might be given by the Department of Health as to whether central investment can be justified based on the future returns for the health economy. This will be on a case by case basis.
104. Monitor and NHS England should play a role in helping commissioners to understand how they can work within the Procurement, Patient Choice and Competition Regulations to bring about transformational change. This support could include, for instance, helping commissioners understand how to consider and incorporate the views and needs of providers and the public while meeting the goals of good procurement.

⁴³ NHS Five Year Forward View, October 2014

Recommendation to NHS England and Clinical Commissioning Groups

NHS England should require Clinical Commissioning Groups (CCGs) to set out in their five year strategic commissioning plans:

- a. the future care/service models they wish to support; and,
- b. how they will use their allocated funds for service transformation to support providers to deliver the agreed transformational and organisational change.

Where multiple CCGs and providers are taking forward service transformation across a shared geographical area, NHS England should help broker agreement as to how costs are met between all parties.

Speeding up the transaction negotiation

105. Mapping of the transactions carried out over the past two years was undertaken for the Review. This demonstrated that the transactions assessment undertaken by Monitor and the approvals and negotiations with the Department of Health, TDA, NHS England and HM Treasury were usually the most straightforward part of the process. The most time consuming element of the process was – rightly – gaining local consensus regarding the appropriate service model; this highlights the importance of ensuring that all parties are committed to the transformational change required.
106. Too often, the NHS has entered a transaction intended to drive change without a full understanding of the transformational change required. Not only have these transactions taken a long time, often they have not realised the anticipated benefits. Providers and commissioners must be clear that not all transformational change requires a transaction, but where change of ownership or management control has been decided upon, this should happen quickly.
107. In the case of distressed organisations, the speed of the transaction is vital to ensuring the on-going sustainability of the services delivered to the population. Long and protracted negotiations can lead to a deterioration of the position of the organisation to be acquired. In order for these options to remain affordable, it is very important to complete transactions as quickly as possible whilst ensuring the right checks and balances have taken place. It was evident from the mapping exercise that it is not always clear which organisation should be funding which elements of transactions, when and who needs to be involved at each stage of the process and what their expectations are. This should be clearly laid out in a more transparent process.
108. The average cost of undertaking a transaction is £5m per organisation,⁴⁴ which includes due diligence fees, legal fees, interim staffing, project management and other costs. These fees are often incurred by both the acquiring organisation and the vendor. This is money that could be better spent on patient care; reducing the costs whilst maintaining the integrity of the process would achieve better value for money and deliver better care for patients.
109. The work of the Review examined the factors that could both reduce the costs of undertaking transactions and speed up the time taken. In any transaction, the following factors need to be taken into account:
 - i. an assessment that a transaction is the best option to resolve long standing clinical and financial viability issues and that a transaction would be in the interests of patients and most likely to result in the long term clinical and financial sustainability of the local health economy;
 - ii. cost of undertaking the transaction (advice and due diligence); and,
 - iii. implementation costs for service transformation.

⁴⁴ Department of Health; NHS Group Financial Management estimate

110. In order to reduce the cost and time taken for these transaction processes, three areas have been identified which, if brought together, would bring greater transparency to potential bidders. These are:
- i. An **independent due diligence** – this would be both financial and clinical due diligence and would be commissioned by national bodies covering a sector wide remit. This would establish:
 - a. the ‘day one running costs’ of the organisation, including the size of the operational deficit and any structural deficits;
 - b. the known risks or legacy issues within the organisation including performance issues such as CQC enforcement notices; and,
 - c. the unknowns going forward i.e. potential issues that are not able to be quantified but could arise.

This would form the basis for negotiations and would be agreed as reliable by both the Department of Health and the bidding organisations. The contract could be extended by the potential acquiring organisation to examine particular aspects and assure its own due diligence requirements. The negotiation would then be based on a mutually agreed approach to any future risk that may emerge following the transaction.

- ii. The parameters of any **financial package** would be based on the results of the independent due diligence. This would include:
 - a. maximum level of revenue support available and the number of years over which the deficit would need to be reduced;
 - b. level of support of any structural deficit (case-by-case based on due diligence);
 - c. maximum capital financing available;
 - d. any ‘pass through’ costs that the Department of Health would be willing to fund such as the impact of nationally agreed pay increases (case by case based on due diligence); and,
 - e. level of indemnity against unknown risks.
 - iii. Commissioning intentions should be made as clear as possible as part of this prospectus to allow potential bidders to develop their patient benefit case and service reconfiguration model as accurately as possible.
111. Pre-packaging this information together into a **tender prospectus** would provide much greater transparency for potential bidders on the parameters and therefore the potential risk that would be contained within the deal. This would enable negotiations to focus on whether the proposed solution, change of ownership and organisational model are right for patients rather than on the detail of the support available.

Streamlining the transaction process and understanding the rules

112. Transactions should take no longer than a year to complete after the decision is reached that the transaction is the route to sustainability.⁴⁵ This will help ensure that the quality of care delivered to patients does not deteriorate excessively throughout this period.
113. Once an organisation has decided it wants to enter into a transaction, there are often requirements to submit multiple documents requiring similar information for the approval of different external organisations, both locally and nationally. Each document may have different judging criteria, resulting in

⁴⁵ Once agreed by the Monitor or TDA board

inconsistent decision-making processes and subsequent requirements for clarification. Completing these documents can result in substantial losses of managerial time and can be off-putting for organisations, particularly smaller ones that may not have previous experience of transactions.

114. The introduction of standardised documentation with clear judging criteria and a unified process with clear guidance would make transactions much easier for bidders and reduce the overall time taken. This process should be open and fair so that all types of providers and potential bidders can develop their cases accordingly.
115. Competition law is not and should not be seen as a barrier to developing innovative solutions that work well for patients, but it is still often perceived to be. The Competition and Markets Authority (CMA) and Monitor have sought to explain the roles in the review of NHS transactions that meet the relevant thresholds. For example, the CMA and Monitor published a helpful short guide for NHS Managers explaining their review of NHS transactions in July 2014.⁴⁶ Monitor also published revised guidance on how it assesses and provides advice to the CMA on the benefits of NHS transactions.⁴⁷ In addition, Monitor supports organisations in the early stages of their planning to better understand the nature of any potential competition issues, so solutions that work well for patients can be taken forward. The CMA may also offer advice on transactions which are reviewable under merger control provisions. It is the responsibility of trusts and commissioners to engage with Monitor or the CMA, and familiarise themselves with the process they should undertake.
116. Those organisations that are not considering a large transaction but may be considering a joint venture, development of a service-level chain or federation should also be aware of the need to consider any potential competition issues that may arise. Monitor has recently published guidance on arrangements which could give rise to violations of competition law.⁴⁸ Monitor and the CMA should continue widely engaging and assisting the sector. The supporting evidence pack to this report has a high level guide to competition issues.
117. Choice and competition can bring about benefits for patients, meaning that some arrangements can harm these benefits. Even where this is the case, such arrangements can lead to improvements in services – the key consideration for the CMA, with advice from Monitor, is whether these lead to overall patient benefits. Where changes to organisational form are being considered to support better models of care, patients should not receive a poorer quality service due to perceptions about barriers from competition requirements. In October 2013 Monitor, the OFT and Competition Commission issued a joint statement outlining the latest steps in ensuring an effective process for the competition review of transactions that acts in patients' interest.⁴⁹ Monitor should continue engaging early and support the trusts to ensure that the patient benefit case is well developed and articulated.

⁴⁶ The CMA also published detailed guidance on the review of NHS transactions that qualify for review. Competition Markets Authority (2014), CMA Guidance on the review of NHS Mergers, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339767/Healthcare_Long_Guidance.pdf

⁴⁷ Monitor and Competition and Markets Authority (2014), Supporting NHS providers considering transactions and mergers, <https://www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers>

⁴⁸ Monitor (2014), NHS healthcare providers: working with choice and competition, <https://www.gov.uk/government/publications/nhs-healthcare-providers-working-with-choice-and-competition>

⁴⁹ Office of Fair Trading, the Competition Commission and Monitor (2013), Ensuring the patients' interests are at the heart of assessing public hospital mergers, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283809/131017_of_t_cc_monitor_merger_statement_final.pdf

Recommendation to the Department of Health

A single, unified process with standardised documentation outlining clear criteria should be developed to support future transactions. This should include guidance for all parties including Foundation Trust Governors.

Recommendation to Department of Health, Monitor and the TDA

A Tender Prospectus approach that has the parameters of the transaction clearly laid out should be made available to all potential bidders in the interests of speed and transparency.

Recommendation to the Secretary of State

The Secretary of State should set a requirement to the national bodies that, except in exceptional circumstances, all transactions are completed within one year or less from the time the decision is taken by the Board of the TDA or Monitor that a transaction is the route to sustainability for an organisation.

Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact

A new 'kitemark' of success should be developed for ambitious organisations to aspire to

118. With 242 separate organisations, the NHS appears relatively unconsolidated compared to its European and US counterparts. If quicker solutions are to be found for the most challenged organisations in the health sector, it is right to look to successful organisations with a strong track record of success to provide the leadership to deliver reliable, high standards of care more widely across the system. This may be through informal support, but in some situations will mean those successful organisations taking extended management responsibilities over other organisations.
119. Foundation Trust status was introduced in 2004 and recognised excellence in quality, governance, leadership and financial management. Achieving FT status brought with it the rewards of independence from Whitehall and new freedoms which were designed to lead to innovation and entrepreneurial spirit in the NHS. This spirit existed in the first few waves of FT authorisations, but has not been as widespread as hoped; the Review heard that for some organisations FT status has become an 'end in itself'. Creating a new status to which the most successful organisations can aspire would not only recognise high performance, but has the potential to reignite an entrepreneurial spirit that could spread best practice across the country.
120. A new credentialing system should be developed that would 'kitemark' the most successful organisations. This credential would build upon the current oversight and assessment frameworks of the CQC and Monitor and would additionally measure the ability of an organisation not only to define its standard operating model, culture and approach but also to transfer and encourage assimilation of its practices into another organisation, thereby improving that organisation's performance. CQC assessment remains the most important measure of quality, but for organisations interested in expanding their offer it is right that their ability to do this is also tested. Credentialing would be open to all providers of NHS care, irrespective of speciality or sector.
121. As part of the Review, the Kings Fund examined the factors which a credentialing approach could measure.⁵⁰ This concluded that the Monitor and CQC processes include most of the elements required; however, to drive up standards more widely it is also necessary to assess the collection of systems and processes used by organisations to deliver success. Examples that could be measured include having an explicit improvement methodology or a replicable approach to leadership development or staff engagement.

⁵⁰ Credentialing providers to take on additional responsibilities – an analysis of the evidence and stakeholder views; The Kings Fund, September 2014

122. The Kings Fund report also considered the supplementary evidence which could also be assessed for the purposes of credentialing, one example of which was the characteristics associated with the High Reliability Organisation (HRO) as defined by the Agency of Healthcare, Research and Quality (AHRQ).⁵¹

The qualities of a highly reliable organisation are recognised within five key characteristics:

- i. **Sensitivity to operations** – a constant awareness by leaders and staff of the state of systems and processes that affect patient care, including high visibility of leaders engaging with staff.
- ii. **Reluctance to simplify** – simple processes are good, but simplistic explanations of why things work or fail are risky. Avoiding overly simple explanations of failure (unqualified staff, inadequate training, communication failure etc) is essential to understand the real reason that patients are placed at risk.
- iii. **Preoccupation with failure** – when near-misses occur, these are used as evidence of systems that should be improved to reduce potential harm to patients. Rather than viewing near-misses as proof that the system has adequate safeguards, they are viewed as symptomatic of areas in need of more attention.
- iv. **Deference to expertise** – leaders should listen and respond to the insights of staff who know how processes really work and the risks patients really face. Leaders must recognise that the ideas for improvement are found deep inside their organisations.
- v. **Resilience** – leaders and staff need to be trained and prepared to know how to respond when system failures do occur.

123. The credentialing system would identify those organisations capable of disseminating best practice and excellence more systematically throughout the NHS. Monitor is well placed to lead on further determining the assessment criteria that would underpin a credentialing framework and should take on this additional responsibility, working with other national bodies. A good or outstanding CQC well led assessment should be a prerequisite for any credentialing process.
124. Recognising such excellence where it exists would encourage high performing providers to assess their operating model and consider their strategic capability to extend their systems and culture into other areas. Credentialing should also go further than just providing public recognition for a provider's high standards; additionally an organisation should benefit from its track record of high achievement. A procurement framework should be developed with categories for management contract and acquisition which organisations could opt into as appropriate.
125. The effect of a framework would be that organisations successful in meeting the requisite credentialing standards could be considered to automatically pass the pre-qualification questionnaire (PQQ) stage of any tendering processes.⁵² This framework would then be used to arrange support for challenged organisations, providing faster solutions than are currently possible.
126. Local commissioners and providers would be able to approach credentialed organisations – knowing they have both high performance and strategic capability – when seeking new service delivery or partner organisations. In addition, regulators and national bodies could have confidence that, where credentialed organisations are supporting locally determined transformational change, there will be lower risk attached to these changes so that the maximum patient benefit can be delivered in the shortest time.

⁵¹ Hines et al (2008), *Becoming a High Reliability Organization: Operational advice for hospital leaders*: Prepared by the Lewin Group for the Agency for Healthcare Research and Quality

⁵² It is noted that the Invitation to Tender (ITT) stage would be open to all organisations on the framework

127. Acquisitions and letting of management contracts to support challenged organisations should not be held up during the establishment of the credentialing process and procurement framework. The assessment criteria should be developed and tested through the next few transactions, clearly identifying through the tender process the key characteristics and capabilities that an organisation will need to demonstrate in order to be credentialed.
128. Given that most organisations will not yet have developed an enterprise strategy for growth and development, it is expected that few organisations will have the requisite experience to be credentialed in the first instance. The breadth and depth of the framework will take some time to develop. Over time, however, it is anticipated that as more organisations codify their standard operating model and develop the required skill set, there will be an increase in the number of credentialed organisations and therefore a strong pool from which to draw through the framework.
129. The TDA and Monitor should be able to go outside the framework if the credentialed organisations do not match the specification or if a stronger patient benefit case can be derived through a local solution. However, once fully established, such deviation from the framework should be exceptional.

Recommendation to Monitor and the Care Quality Commission (CQC)

A new credentialing process, to recognise successful organisations capable of spreading their systems and processes to other organisations, should be developed by July 2015. This should build on CQC and Monitor ratings, with a good or outstanding rating a prerequisite.

Once agreed, Monitor should be responsible for the process and the first wave of credentialing should be completed by October 2015.

Recommendation to Monitor and the Care Quality Commission (CQC)

A list of all credentialed organisations should be published on both Monitor and the CQC websites and made available to every Clinical Commissioning Group.

Recommendation to CCGs and trusts

CCGs and trusts should use this list of credentialed organisations to identify new partner organisations most likely to deliver transformational improvement

Recommendation to Monitor and the TDA

A procurement framework should be developed which allows interested credentialed organisations the ability to register for management contract and acquisition opportunities. This framework should be live from or before April 2016.

Inclusion on this register would mean that an organisation automatically passes the pre-qualification questionnaire (PQQ) stage of any tendering processes. The framework should then be used by the TDA and Monitor to procure support for challenged organisations.

Leadership capacity and capability is crucial to the delivery of transformational change

130. In order to deliver the transformational change outlined throughout this report, the NHS will require a substantial cadre of strong, capable leaders with a range of skills.
131. Sir Stuart Rose will be publishing his review of NHS Leadership later in 2014/15, addressing the challenges and solutions for the future of leadership in the NHS. Separately to this, this Review considers that there are insufficient leaders in the NHS with the required skill set to meet the upcoming challenges of delivering new models of care. This needs to be addressed.

132. There are many highly accomplished, capable leaders in senior leadership roles on trust boards, many with a strong operational background. However, the very best operational managers do not necessarily make the best strategic Chief Executives. There is a difference between the skill set required to drive strong operational performance within an organisation and the skills to set strategic direction and develop an organisation to its fullest potential. That is not to say that one set of skills is better than the other, but rather that they are different.
133. If entrepreneurial organisations are interested in pursuing options such as Foundation Group or management contracts, this will require trusts boards to think and act very differently. Clearer governance and decision-making parameters will need to be created and the trust board will need strong strategic and enterprise leadership capability. This need was identified in the recent Framing the Future⁵³ work undertaken by the London Leadership Academy.
134. Operational roles are hugely important, particularly those who are supporting clinical leaders or are clinical leaders themselves. But these roles are often underrated. The development of the Foundation Group structure or the management contract approach offers the opportunity for a 'dual track' career path for leaders. New governance structures that require a separate headquarters running multiple subsidiaries, all with a separate Hospital Management Team, 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.
135. Leaders of trust boards in successful organisations who are willing and credentialed to take over the management control of a struggling organisation, either through management contract or acquisition, should have the benefit they are bringing to the wider NHS adequately recognised through their remuneration and reward, in line with their organisation's remuneration policies.

There should be a greater degree of headroom created for leaders to turnaround struggling organisations

136. One of the biggest disincentives for successful organisations considering whether to acquire a struggling provider is the potential for their overall performance and financial position to be negatively affected. This can be mitigated by allowing a grace period for financial and operational performance to be agreed with the relevant national bodies in advance. Monitor's current practice of requiring organisations to recover performance according to a trajectory, rather than an absolute standard, should be adopted and understood more widely. This would allow the Board of the acquiring organisation the time and headroom to make the necessary changes within the acquired organisation. As part of this, trust board members and Chief Executives should be confident that their performance will not be unfairly assessed and that acting in the interests of the wider health system will not negatively affect their future careers.
137. As the Care Quality Commission's new inspection regime continues to operate more widely, it is increasingly likely that quality issues will be identified in some trusts which may lead, or may already have led, to an enforcement notice. As with Monitor's oversight, a trajectory should be agreed with the relevant national bodies and in particular the CQC as to the amount of time needed to address these challenges. Acquiring organisations should not be penalised for legacy issues if they are otherwise on an agreed improvement trajectory.

⁵³ Work undertaken (not yet published) by the London Leadership Academy to determine what the challenges of London will be in 2034 and therefore what the future leaders will require

138. A considerable amount of risk is inherent in transactions, which can affect the liquidity ratio or Continuity of Services Rating (CSR)⁵⁴ for an organisation to an extent trust boards may deem unacceptable. In some cases boards seek external financing to rebalance this ratio; this does not always make long term financial sense. Organisations can apply to have investment adjustments applied by Monitor, by which they assess the underlying risk in the transaction and adjust the reported rating to take this into account. This has not been widely used, but could offer an opportunity to improve value for money for some transactions.
139. If an NHS Trust has been deemed in need of a transaction, once a preferred acquirer or contractor has been identified and Heads of Terms have been agreed, work should be undertaken quickly to create integrated operational structures and prevent further deterioration in performance caused by ongoing uncertainty. Where possible, shadow running of governance and management structures should be established, for example through a management contract, without prejudice to the final decision by the Secretary of State on the transaction, to ensure patient safety is paramount.

Recommendation to Trust Boards

Trust boards should consider the new operational and strategic leadership roles required in order to support the new organisational model, and put developmental plans in place accordingly.

Recommendation to the Leadership Academy

The Leadership Academy should support the development of the requisite skills and experience for the new operational and leadership roles and build these into the career paths and leadership and development training of current and future NHS leaders.

Recommendation to Department of Health, Monitor and CQC

The Department of Health, Monitor and the CQC should agree a 'grace period' for acquiring organisation with an agreed trajectory of finance, performance and quality standards improvement for the acquired or contractually managed organisation, separate from the overall performance of the combined organisations. This 'grace period' should take into account historical quality issues and the impact of any agreed financial investment adjustments.

Recommendation to Monitor and the TDA

Monitor and the TDA should ensure that – where appropriate – an acquiring or contractually managed organisation can start to create integrated operational structures, once the Heads of Terms have been agreed, so that these may be run in shadow form prior to the final decision on the transaction being taken.

⁵⁴ This replaces the previous Financial Risk Rating (FRR)

Overall sustainability for the provider sector is a priority

Monitor and the NHS Trust Development Authority need more options to prevent further deterioration in quality of care

140. This section outlines tools which, when combined, have the ability to drive considerable transformational change throughout the health sector at pace and scale. In addition, these could be used to great effect by Monitor and the TDA to address the deeply ingrained challenges faced by a small number of organisations.
141. As Monitor, the TDA and the Department of Health identify solutions for challenged organisations, they must also not neglect the potential benefits offered from the expansion of successful providers. Time is of the essence and therefore a wider range of options will be required in order for change to happen quickly.
142. The TDA is currently working through all NHS Trusts' five year strategic plans to identify their likelihood of achieving a sustainable organisational form and categorise them accordingly. As part of this work, the TDA is working with NHS England to ensure that commissioner and provider plans are consistent. Those NHS Trusts that are deemed unsustainable in their current form will be clearly identified as part of this process and an accelerated solution will need to be found. This segmentation is planned to have been completed later in 2014/15.

The TDA have segmented the NHS Trust sector into the following categories:⁵³

- i. Organisations with a clear and credible plan for reaching Foundation Trust status and a timeline of less than two years for doing so (Category A1)
- ii. Organisations with a clear and credible plan for reaching Foundation Trust status and a timeline of less than four years for doing so (Category A2)
- iii. Organisations with the potential to reach Foundation Trust status but which currently lack a clear and credible plan and timeline for doing so. The intention is that this would be a small, time-limited group which can be targeted for intensive development support (Category A3)
- iv. Organisations that cannot reach Foundation Trust status in their current form and where acquisition by another organisation is likely to be the best route to sustainability (Category B1)
- v. Organisations that cannot reach Foundation Trust status in their current form and where a franchise, management contract or other innovative organisational form is likely to be the best route to sustainability (Category B2)
- vi. Organisations where further work is needed to determine the best route to sustainability. This would be a small, time-limited group with any further work to be undertaken by April 2015 (Category C)

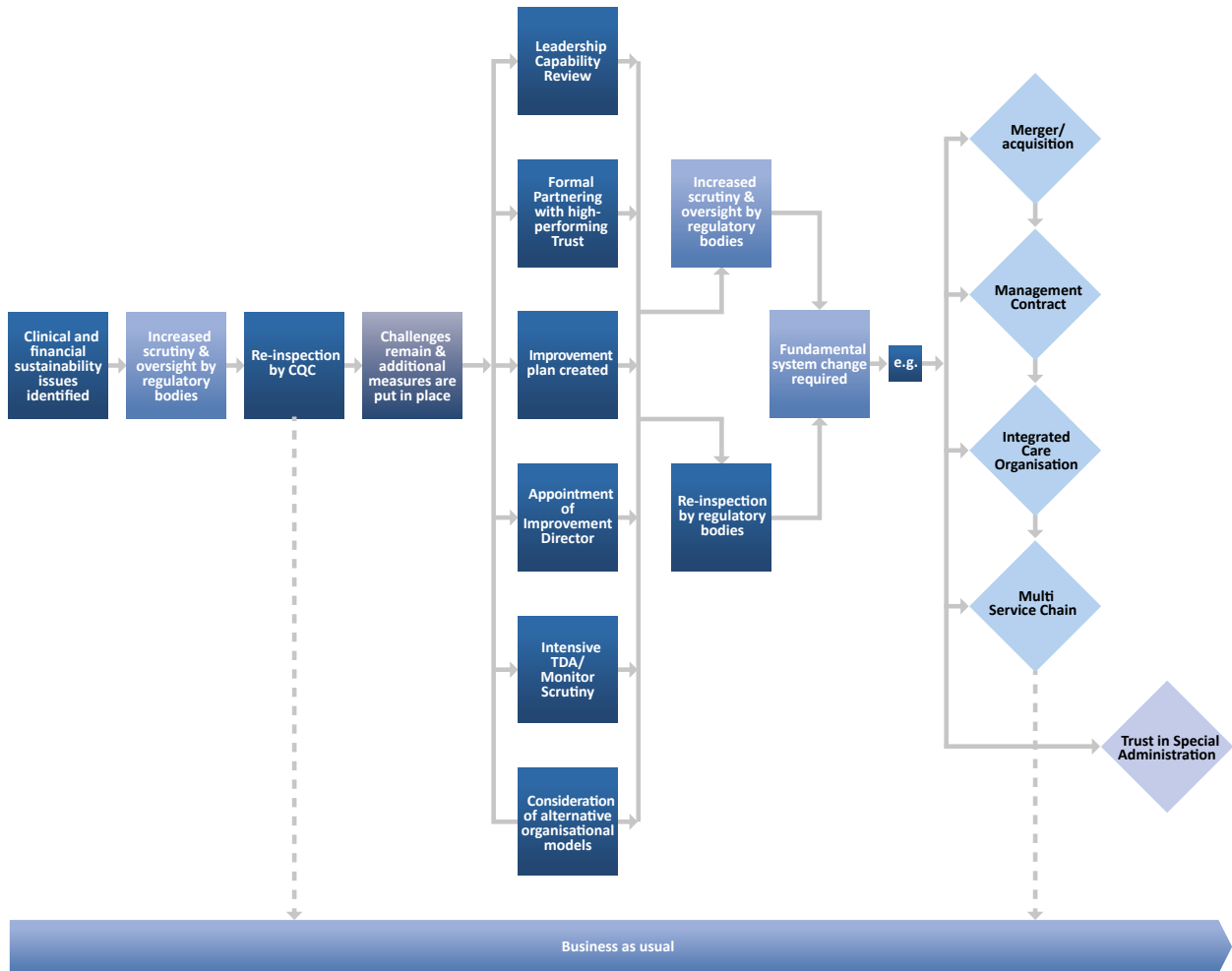
143. The TDA should publish, at the earliest opportunity, the categorisation for each NHS Trust and its associated plans for achieving FT status or an alternative organisational form. The Department of Health should then use its regular accountability arrangements to hold the TDA to account to ensure the plans remain on track.
144. Challenged organisations (categories B1 and B2) should be supported to adopt an alternative organisational form through the implementation of a management contract or via an acquisition. This implementation could happen in one of two ways, sequentially or in parallel.

⁵³ NHS Trust Development Authority (2014), Board Paper B: TDA Board meeting. 18 September 2014

145. The *sequential* route would see the TDA determining the individual plans for each organisation and running one process at a time. This could take several years to complete, which would not ensure a timely reduction in clinical variation to patients. Additionally, these organisations would most likely continue to be in receipt of interim revenue deficit funding from the Department of Health throughout this period which will not deliver best value for the taxpayer.
146. In contrast, the more radical parallel approach would be for the TDA to examine its segmentation of NHS Trusts and to further categorise similar organisations based on geography or other categories, in order to undertake transactions in ‘batches’. This could deliver a more accelerated solution, capable of restoring reliable, high quality services. This approach could also encourage ambitious providers, with enterprise or growth strategies, to respond with innovative solutions. For example, Foundation Trusts may form joint ventures with other Foundation Trusts or the independent, voluntary, or social care sectors, in order to run management contracts.
147. For those organisations that face short term difficulties or who are judged by Monitor or the TDA to be making satisfactory progress on an improvement trajectory (eg, TDA categories A1 and A2), formal improvement support provided by another organisation should be considered. Since the introduction of special measures and ‘buddying’ in 2013, it has become more apparent that expanding the reach of successful organisations into challenged ones can yield benefits for the NHS. This has opened up new options for the TDA and Monitor. If support does not result in improvement, an escalated intervention will be required.
148. As part of the Review, research was commissioned from the Foundation Trust Network to evaluate the success of the ‘buddying’ model. This research found that a precondition for success was a ‘good fit’, particularly compatibility across the two organisations’ culture and values compatibility across the two organisations in culture and values.⁵⁶ The buddying trust provides advice, guidance and experiential and technical know-how without delegated decision-making authority, so this approach cannot drive significant change. The Report advises that an expanded and formalised buddying approach from successful and stable organisations could provide significant support to challenged organisations which have improvement potential in their current form.
149. Monitor and the TDA should identify organisations interested in offering buddying support, with minimum qualifying criteria including a CQC assessment of ‘good’ overall. Fair and appropriate fees should be paid to organisations providing support, with consideration given to using target driven incentives within the fee structure.
150. As part of its ongoing work Monitor should ensure that any Foundation Trust which it identifies as being in ‘persistent difficulty’ produces a five year strategic plan that determines the appropriate organisational form, matched to innovative models of care. The plan must have clear implementation timescales for achievement.
151. Where Monitor judges that a Foundation Trust is unable to turn around its performance and quality issues within the agreed timescales, it should continue to intervene quickly using its formal powers. This includes attaching licence conditions, such as suspending board members, to ensure that solutions are implemented quickly. This intervention should also include an assessment of the merits of the FT in persistent difficulty pursuing a transaction with a ‘credentialed’ organisation, once this process has been developed, to ensure the interests of patients are always above preservation of traditional organisational boundaries. Figure 2 below sets out a suggested route for regulatory intervention, including where consideration of an alternative organisational form might take place.

⁵⁶ Foundation Trust Network (2014), Review of buddying arrangements, with a focus on trusts in special measures and their partnering organisations

Figure 2: Suggested stages of regulatory oversight and intervention, including where consideration of alternative organisational form should take place.



Recommendation to the TDA

The TDA should publish the categorisation of and plans for each of the 93 NHS Trusts in the Foundation Trust pipeline, along with the trajectory and milestones for when and how each organisation will achieve Foundation Trust status or other sustainable organisational form.

Recommendation to the Department Of Health

The Department of Health should hold the TDA to account for meeting the trajectory and milestones for each of the 93 organisations.

Recommendation to the TDA

The TDA should consider accelerating the solutions for patients and communities currently served by organisations in persistent difficulty, by running batched procurements for category B1 and B2 NHS Trusts.

Recommendation to Monitor and the TDA

The buddying system should be expanded, beyond the special measures trusts, into a partnering system to allow organisations with the potential to improve early access to support and guidance from credentialed organisations.

Arrangements should be developed to identify and remunerate trusts capable of providing support.

Should buddying not result in the required improvement within a defined time period, a re-categorisation of the NHS body should be considered so that further action can be enacted quickly.

Recommendation to Monitor

Monitor should consider using their existing categorisation process to drive more rapid interventions.

Where Monitor determines that a FT is in 'persistent difficulty', it should require that FT to produce a plan with clear improvement timescales. If the FT is subsequently unable to demonstrate improvement against this plan, Monitor should compel that FT to present a new sustainability plan. This may include adopting a new organisational form or pursuing a transaction with a 'credentialed' organisation.

Chapter Three: Making change happen

A dedicated implementation programme is needed to make change happen

Implementation of the different organisational forms at scale

152. The extent of variation across the country in the delivery of high standards of care must be addressed as soon as possible. Whilst many organisations are considering new and innovative solutions to address quality and financial challenges, the recommendations of this Review need to be implemented quickly and widely in order to have the greatest impact for patients.
153. It is highly likely that new **collaborative arrangements** can enable improvements in care by shifting the mindset of trust boards towards one of joint ownership and governance with other organisations. Commissioning and regulatory bodies should engage with leaders of provider organisations to rethink 'business as usual', encouraging them to think outside their organisational boundaries and consider partnerships and new collaborations across their health and social care economy. This could lead to the implementation of new organisational forms, without the need for organisations to feel like 'winners' or 'losers'. These collaborative approaches will be crucial to the development of new models of care cited in the NHS Five Year Forward View.
154. A wide programme, delivered through health sector membership organisations, should be made available to support leaders to consider the options presented here in more detail as part of the 2015/16 planning round. An additional web-based resource would ensure all materials are easily accessible as well as providing a forum for organisations to share best practice and debate. Webinars, action learning sets and newsletters would support wider information sharing.
155. Practical checklists should be developed in order to assist organisations in planning. These should ask a series of questions that organisations considering any of the different organisational forms will need to ask themselves, in addition to practical tips on where to go for information, when to seek professional advice and pitfalls to avoid. These would be distributed through the national programme of learning and sharing best practice.

Further development of the ideas in this Review

156. Although the Review has undertaken a large amount of research, evidence gathering and testing of legislation and other technical challenges, it has not had the opportunity to test these in 'real life scenarios'. Some of the issues that organisations will face will require additional support to help the management team to navigate the issues.
157. In order to do this effectively, it is recommended that a number of organisations are supported to become a **demonstrator site**. These would be organisations that already have relatively well thought out plans that include implementing one of the organisational forms outlined in the report. The demonstrator sites would commit to sharing their experience and to being evaluated, such that the learning can facilitate wider and faster adoption over time.
158. Supporting the implementation of the models and disseminating the learning from a number of demonstrator sites will drive locally appropriate, sector led – rather than top down – approaches to addressing the challenges faced by all providers.
159. Those organisations interested in becoming demonstrator sites should consider the recommendations

of this Report – in conjunction with their response to the NHS Five Year Forward View – as part of the 2015/16 planning round and develop business cases accordingly.

160. The programme of demonstrator sites would support interested organisations in implementing new organisational forms in practice. The demonstrators should receive financial support for implementation costs and be formally evaluated as part of the process. Learning from the process of adoption and impact of the organisational forms would be shared with the wider sector to facilitate subsequent development of new organisational forms in non-demonstrator sites.
161. Although the demonstrator programme would provide additional funding to support transactions, there should be clear criteria that any transaction must also stand up to scrutiny on its own merits; the demonstrator programme should not subsidise inappropriate transactions or business plans. However, intervening earlier in appropriate cases to support preventative transformational change would have clear benefits for patients and the taxpayer.
162. The Department of Health, NHS England, Monitor, the TDA and CQC should consider quickly taking forward the recommendations made in chapter two of this report to develop a new approach so that, in the future, options such as management contracts and transactions are far easier and quicker to enact.

Recommendation to the Department of Health

The evidence and findings from the Review should be communicated across the health sector, alongside the business planning round, through a national programme of learning and sharing best practice.

Recommendation to Department of Health, Monitor and TDA

The national bodies should support a number of demonstrator sites where organisations implement a change to their organisational form. This should be evaluated and the learning shared with the wider sector.

Appendix 1: Sir David Dalton appointment letter

*From the Rt Hon Jeremy Hunt MP
Secretary of State for Health*

Sir David Dalton
Chief Executive
Salford Royal NHS Foundation Trust

14 February 2014

Dear Sir David

I am writing to confirm your appointment to lead a review into how we enable the best leaders and organisations in the NHS to expand their reach and deliver more for patients. I am grateful for your agreement to undertake this important work, drawing on your experience at high-performing Salford Royal and from buddying Buckinghamshire NHS Trust while it is in special measures.

It is already clear that the CQC's new inspection regime has revealed some fantastic care in our NHS. But it has also unveiled some stark variation – some poor care, weak leadership and patients not being looked after as they deserve to be. The hospitals placed in special measures by Monitor and the Trust Development Authority (TDA) are a decisive response to this.

The findings from the inspection regime have also indicated that hospital leadership has a profound effect on the quality of care and treatment that is provided. Frontline staff are the bedrock on which all our fantastic NHS care is delivered, but it is also clear that inspiring, innovative and brave leadership teams are behind the very best that the NHS has to offer. And yet their influence is limited in a UK hospital sector which is, by international comparisons, relatively unusual in having a structure of large, stand-alone hospitals.

Leading hospitals want to expand and work in new and innovative ways to provide better care, more efficiently, and not leave struggling providers isolated. You have seen first-hand how the buddying system introduced as part of the special measures process has offered external advice and leadership from the best in our NHS to the places where problems are most acute.

I believe that the best organisations, stewarded by the best leaders, should be able to provide more outstanding care to more patients. Other sectors and international healthcare systems have embraced models including networks of hospitals and clinical services, non-geographical chains, management contracts and other joint ventures. Some examples of similar enterprise exist in parts of the NHS but I would value your help in understanding how we can learn from and extend this work.

As we discussed, I would like the review to cover:

- The extension of the buddying and mentoring schemes in the special measures hospitals programme;
- Management contracts so that outstanding leadership teams can take on a more formal relationship;
- Improving incentives for our best NHS hospital trusts to take on turnaround projects and extended management responsibilities;
- A new framework for NHS providers who are certified as outstanding and the go-to people for turnaround projects and extended management responsibilities; and
- The arrangements which could enable local and non-geographical networks of hospitals or services under one leadership team.



I would like this review to give prominence and drive to consideration of these issues, on which my officials have done some preliminary work. You will be the figurehead, leading the review, providing direction and a focal point for engagement with other Chief Executives and interested stakeholders more widely. You will need to work closely with Monitor and the TDA in undertaking this review. A small team of my officials will support you in this work, and in the preparation of a report by June 2014. At least as important as this report, though, will be the conversation with the sector and the momentum you generate.

Thank you once again for agreeing to lead this review, and I look forward to working closely with you in the coming months.

Yours sincerely

JEREMY HUNT

Appendix 2: List of Review Panel Members

The review was chaired by Sir David Dalton, CEO of Salford Royal NHS Trust. Sir David was supported by an expert panel comprising the following individuals:

Name	Title	Organisation
Sir Andrew Cash	Chief Executive	Sheffield Teaching Hospitals NHS Foundation Trust
David Behan – deputised by Paul Bate	Chief Executive	Care Quality Commission
Miranda Carter	Executive Director, Provider Appraisal	Monitor
Chris Hopson	Chief Executive	Foundation Trust Network
Jim Mackey	Chief Executive	Northumbria Healthcare NHS Foundation Trust
Steve Melton	Chief Executive	Circle Healthcare
Stephen Dalton	Chief Executive	Mental Health Network NHS Confederation
Rob Webster	Chief Executive	NHS Confederation
Dame Julie Moore	Chief Executive	University Hospitals Birmingham NHS Foundation Trust
Jim Easton	Chief Executive	Care UK Healthcare Division
Ian Dodge	National Director, Commissioning Strategy	NHS England
Anna Dugdale	Chief Executive	Norfolk and Norwich University Hospitals NHS Foundation Trust
Mark Newbold	Chief Executive	Heart of England NHS Foundation Trust
David Flory- deputised by Ralph Coulbeck	Chief Executive	Trust Development Authority

Sir David Dalton and the Review Team led the writing of the report with expert guidance and advice from the Expert Panel members. The Panel members met six times to discuss the findings and recommendations. They advised in a personal capacity rather than as representatives of their organisations. The governance of the review panel meetings can be found at www.srft.nhs.uk/dalton-review/.

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